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A Survey on the Relationship between Quality of life and Happiness among Children and Adolescents under the Supervision of Welfare Organization of Ahwaz in 2017

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Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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ABSTRACT

Background: Childhood and adolescence is one of the most important, most sensitive and also most decisive periods of human life. Events during this period, for children and adolescents under the supervision of the welfare organisation, can lead to behavioural-cognitive and emotional problems and face the natural process of transition from this period with serious challenges. This study was conducted to evaluate the relationship between quality of life and happiness among children and adolescents under the supervision of welfare organisation of Ahwaz in 2015.

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Methodology: This descriptive-analytical cross-sectional study was conducted on 75 children and adolescents aged 8-18, under the supervision of the welfare organisation, using the available sampling method. The data collection tool was a demographic information questionnaire, the Kidscreen quality of life and the Oxford happiness. The collected data were analysed using SPSS software version 20 and independent t-test, Pearson correlation coefficient, Spearman and Chi-square tests. P value less than 0.05 was considered significant.

Results: The results showed that there was a significant and direct correlation between quality of life and happiness in children and adolescents under the supervision of the welfare ($P < 0.001$ and $r = 0.656$). All aspects of the quality of life in the group who did not show happiness reported to be lower.

Conclusion: The quality of life of children and adolescents under the supervision of welfare is related to their happiness. The effect of the use of pharmaceutical supplements/drugs and its relationship with the happiness of children should be studied in future.

Keywords: Happiness; quality of life; children; adolescents.

1. INTRODUCTION

In recent decades, the goal of social development programs has been to improve the quality of life and well-being of individuals including children and adolescents [1]. One of the critical issues currently is the establishment of a healthy physical and social environment for children and adolescents, because factors that disturb their living environment will also affect their health, Therefore societies should provide the appropriate environment for care, education and socialisation of children and adolescents [2]. The Geneva Declaration on the Rights of the Child of 1924 and the rights of the child, adopted by the General Assembly of the United Nations on November 20, 1959, stipulated that children need special care, including proper legal protection because they do not reach full development until adulthood [3].

Adolescence is also considered to be one of the most important, most sensitive and at the same time most decisive periods of human life [4]. Adolescence begins around the ages of 9 and 12, and the WHO defines the age of adolescence as between the ages of 11 and 21 [3]. This process is associated with rapid physiological changes, the ability to think abstractly; increased imbalance and instability of mood; concern for the future; accountability; the endeavour to obtain approval and confirmation from others, especially age mates and imagination. These changes can help the normal growth of the adolescent, but can also lead to behavioural, cognitive and emotional problems. These problems, especially when accompanied by other harmful factors such as indifferent parental upbringing or divorce and separation at home, will undoubtedly jeopardise adolescences and greatly complicate the natural process of overcoming such life challenges [4]. Children who have lost their parents or been deprived of a normal family upbringing for other reasons are commonly held in orphanages around the world [5]. Studies show that the population of children living in such institutions is increasing every year, has tripled since the 1980's currently numbers more than 530,000 children in the United States [6]. The main reasons for keeping these people in these centers can be parents' deaths, physical-psychological problems, parental divorces, familial and financial problems [5] which can lead to a wide range of problems including low self-esteem, an increased risk of physical and psychological damage, especially depression and other similar disorders [7,8]. Research has shown that the early years of life have a major role in forming an individual's personality and the manner in which self-identity and self-esteem establish itself at this age manifests throughout the person's lifetime, and environment and quality of life can powerfully affect the child's interactions and personal attachments [9]. The study by Fawzy and Fouad [10] showed that prevalence of mental disorders in the children in pediatric care was 23% for depression, 45% for anxiety, 23% for self-confidence issues and 61% for developmental disorders. Moreover, emotional disorders have reported to be high among the pediatric children [10] Children's and adolescents' quality of life will affect various aspects of their life including their happiness [11]. The WHO defines this quality of life as "their mental and mutable sense on their health," and believes that this feeling reflects the wishes, hopes and expectations of children and adolescents in relation to current and future of

their life [12]. From the viewpoint of Vinhon, happiness refers an individual's judgment of how desirable quality of life is as a goal. Happiness means how much a person loves his or her life [13].

Also, one of the factors that can affect the quality of life and the condition of children's development is the use of pharmaceutical supplements, such as multivitamins and drugs that affect the development of the child, which most families now use as advisers to their physicians. However, this is not evident in the welfare centers or it is not fully completed. According to Sing and Ellis, [14] psycho-pharmacology is a rapidly developing area in child and adolescent psychiatry. They also suggested that it is important for clinicians to work with children with psychiatric disorders to remain up-to-date with the research literature in this field. It will be helpful for the clinicians to have a working knowledge about the pharmaco-logy of psychiatric drugs for treating the childhood problems. Singh et al. mentioned that children differ widely in terms of the drug dose that produces a given effect. Thus, clinicians must have a good knowledge of current pharmacodynamic principles to understand a child's response to psychotropic drugs Dingemanse et al. [15]; Paxton & Dragunow, [16]. According to Singh and Ellis the clinical import of pharmacogenetics is that clinicians should be aware of the possibility of differences in drug response and dose requirements among children from various ethnic and racial groups. Therefore, the inappropriate use of pharmaceutical supplements for well-being children can be one of the important factors influencing the development of these children and, accordingly, their quality of life. This is a very complex and specialised area and has not been covered here.

Happiness is a time when people's life activities have the highest degree of convergence or harmony with their deeply-held values, abilities and effectiveness in different areas of life, and they are committed to these values and abilities. In such conditions, there is a sense of vitality and confidence. Waterman has said this state as the manifestation of the individual hope and high correlation between it and the dimensions of happiness [17]. Since life in orphanages can have a great impact on the emotional state of children and adolescents and make them prone to psychiatric and emotional disturbances, identifying the characteristics and problems that result from living in orphanages can provide an appropriate context for preventing and mitigating their effects [5], hence the present study aimed at investigating the relationship between quality of life and happiness among children and adolescents under the supervision of the welfare organisation of Ahwaz in 2015.

2. MATERIALS AND METHODS

The present study is a descriptive-analytic study investigating the relationship between quality of life and happiness in adolescents and children under the supervision of a welfare organisation in Ahwaz in 2015. The research samples consisted of 75 children and adolescents aged 8-18 who have been residing in Ahwaz's orphanages for more than one year. Participants unwilling to take part in or continue in the study were excluded from results. The data collection tool consisted of a questionnaire for demographic information, the Kidscreen quality of life, and the Oxford happiness questionnaire. The demographic information questionnaire included information such as age, sex, degree of education, and duration of stay in the orphanage. The Kidscreen questionnaire covered the participant's previous week and investigated five aspects of the participant's quality of life. One of the aspects is physical aspect with five items covering physical activity and levels of energy and fitness. Another one is psychological wellbeing with seven items evaluating positive emotions, satisfaction, and balanced feelings. The social dimension with seven items, covering closeness and autonomy in parental relationships, home environment, freedom corresponding to the participant's age, and the availability of financial resources. Then social support and age mates with four items examining the participant's relationship with peers and another four, school environment aspect, looked at mental capability, including cognitive capacity, learning, concentration and feelings about school. This tool is based on a 5-point Likert scale that ranges from "never" to "forever" and shows the frequency and intensity of a particular behaviour, feeling or attitude [18]. In the research of Nik Azin et al. [19], the Cronbach's alpha coefficients for all dimensions except for the school environment were higher than 0.77, and the two-week re-test coefficients for all dimensions were strong ($p < 0.01$) ($p < 0.01$) [19]. To investigate happiness, the Oxford happiness questionnaire was developed and provided by Argya and Lew in 1989 [20]. The questionnaire consists of 29 questions with a 6-point Likert

scale, which ranges from “totally disagree” to “totally agree”. After collection, Data were analysed by SPSS software (version 20). Independent t-test, Pearson correlation coefficient and Spearman and Chi-square were used to compare the differences between the groups. P value less than 0.05 was considered significant.

3. RESULTS

The study was included 75 children, of which (40%) were 30 girls and (60%) 45 were boys. The mean age of the girls was 12.06 ± 3.07 years and the mean age of boys was 11.84 ± 3.4 and the mean age of all individuals was 11.93 ± 3.24 Age did not show a significant correlation to happiness and quality of life (P >0.05). Furthermore, boys and girls showed similar levels of happiness and life satisfaction (P >0.05). The average happiness in all samples (44.97 ± 15.73) was in the range of (14-74), of which 45 (60%) reported happiness. Children and adolescents’ mean quality of life (80.57 ± 8.92) showed a range of changes (56-97). Quality of life was shown to be (17.49 ± 3.26) for physical health, (22.76 ± 2.26) for emotions and mood in general, (12.72 ± 2.51) for family relationships and leisure, (12.72 ± 2.51) for relationships with friends, and (14/01 ± 3.12) for school.

Data distribution was reported normal using the Kolmogorov-Smirnov test (P >0.05). There was a significant and direct relationship between quality of life and happiness (P <0.001 and r = 0.65), as well as between the aspects of quality of life, including physical activity and health (p = 0.001, r = 0. 50), and friends with happiness (P <0.001 and r = 0.55). There was a statistically significant difference between those that reported happiness and those that did not in terms of physical and health activities (P <0.001) and friends (P = 0.002). Quality of life in all categories was lower in the group that did not report happiness. There was a direct and significant relationship between happiness and the category related to school life (P <0.001 and r = 0.371), but the category related to family and leisure showed no significant relationship to happiness and emotions (p <0.05). Mean quality of life was differed significantly between those that reported happiness and those that did not (P <0.001) (Table 2).

Table 1. Frequency and percentage of frequency of demographic information of participant samples

Demographic information		Number (percentage)
Gender	girl	30(40/0)
	boy	45(60/0)
	8-9	27(36/0)
Age	10-11	13(17/3)
	12-13	6(8/0)
	14-15	12(16/0)
	16-17	17(22/7)
Education level	Elementary school	44(58/70)
	Guidance school	14(21/33)
	High school	15(20/00)

Table 2. Mean scores of quality of life dimensions in the case group

Quality of life dimensions	happiness	Number	Mean and standard deviation	t-test	p-value
Physical health	No	30	(15/87±2/66)	**-3/84	0/000
	Yes	45	(18/58±3/2)		
Emotions	No	30	(22/50±2/56)	-0/810	0/421
	Yes	45	(22/93±2/04)		
Family and leisure	No	30	(12/40±2/64)	-0/899	0/371
	Yes	45	(12/93±2/42)		
Friends	No	30	(12/26±3/54)	**-3/27	0/002
	Yes	45	(14/46±2/28)		
School and learning	No	30	(13/16±3/44)	-1/95	0/055
	Yes	45	(14/57±2/75)		
quality of life total	No	30	(76/20±10/30)	**-3/76	0/000
	Yes	45	(83/48±6/41)		

***significant at the level of 0.01; *significant at the level of 0.05*

4. DISCUSSION

The findings of the present study show that there is a direct and significant relationship between happiness and quality of life. Kajbaf et al. (2011) conducted studies focused couples in Isfahan's counselling centers, providing them with psychological training in fostering happy attitudes to life. It was found that couples' quality of life increases with happiness education [21]. Islami and colleagues (2011) also noted a strong relationship between happiness and quality of life. In their study aimed to investigate the effectiveness of a group-based reality-therapy approach on happiness and quality of life for Mashhad teenagers who had poor parental upbringing, reported that a poor family environment is strongly correlated to a loss of happiness and a general sense of dissatisfaction in life [18]. This is consistent with the result of the present study. This study found no significant difference between girls and boys regarding happiness and quality of life. Demographic happiness studies by *Safari* (2009) and Siamian (2012) also concur, finding no observable relationship between gender and happiness in interpersonal communication [22,23].

This study found a positive and significant relationship between happiness and physical health. These findings are supported by Shakirinia and colleagues (2015), who showed that increasing physical activity and physical health led to higher levels of happiness [24]. Rodriquez-Ayllon et al. (2017) stated that increased levels of physical fitness could have significant benefits to the mental health of children and increase their mental happiness [25]. This is consistent with the result of the present study. According to the findings of this study, there was a positive and significant relationship between happiness and relationships with friends, that is, those who had higher happiness could have better and more creative interaction with their friends, classmates and community. This is consistent with - Meyzari Ali et al. (2016) found in their study that happy people have a more cooperative disposition and derive greater satisfaction interacting with those who live around them. They also stated that happiness, as one of the basic positive emotions, has a decisive role in creating altruism and empathy in individuals and society [26]. Montazeri (2012) stated that happy people enjoy better social relations than others [27]. Nasratinejad and colleagues (2015) showed in their research that participation has the greatest impact on the happiness of young people, and young people who have a stronger social participation have report higher levels of happiness [28]. This is consistent with the result of the present study. The school and learning dimension also directly and significantly impacted happiness and quality of life. That is, people who had higher levels of happiness had more academic achievements and learned more effectively at school. In Saffari's study (2013), which investigated the relationship between happiness and self-confidence and academic achievement in students, showed that happiness leads to more academic achievements [29]. kimarati (2013), in his research on the relationship between social capital and happiness with academic achievements in female high school students, showed similar results [30]. Neaz Azeri (2012), in her study examining the effect of happiness and vitality on the academic achievement of high school students in Sari, reported that a lively and caring environment greatly impacted the flourishing of talents, creativity, dynamic and creative training, academic achievement, health and happiness of students, so it is clear that vitality can powerfully influence students' mental and physical wellbeing [31] The "feeling and mood" and "family and leisure time" did not show a strong relationship to happiness. Shakiba's study (2011), showed that a warm and friendly family environment as well as good emotional relationships between family members improve children's mental health and promotes a happy and healthy personality whereas disrupted families and a lack of emotional support from parents cause social disturbances and psychological problems as well as a weak mental state [32]. The results of Islami's (2015) and kardeh kar 's (2011) study, which examined the relationship between leisure time with happiness and the self-confidence of teachers, showed that leisure time has an impact on the happiness and self-confidence of teachers, meaning that engaging in more leisure activities, namely physical exercise, increases levels of happiness and positivity [33,34]. Also, kardeh kar reported that there is a significant relationship between leisure time and all dimensions of happiness, which include life satisfaction, self-esteem, mental well-being, satisfaction, and positive mood [34]. The results of these studies contradict the findings of this study. The reason for this discrepancy could be differences in age, place of residence and living conditions of the participants. The current study showed that participants

who reported low happiness also showed lower results in all aspects of quality of life. The results of published research by Islami [28], Meyzari Ali [26], Kajbaf [21], Shakirnia [24], Nasratinejad [28] showed a significant relationship between happiness and quality of life subscales, which is consistent with the results of this study.

5. CONCLUSION

In general, this study indicates that increasing the happiness of children and adolescents under the supervision of welfare organisations can be an effective step in improving their quality of life in all aspects. It is suggested that in a future study, the extent of the use of pharmaceutical supplements and its relationship with the quality of life and happiness of children covered by well-being should be examined.

CONSENT

As per international standard or university standard, patient's written consent has been collected and preserved by the author(s).

ETHICAL APPROVAL

It is not applicable.

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COMPETING INTERESTS

Authors have declared that no competing interests exist.

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