RESEARCH ARTICLE

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Adolescent Mothers' Postpartum Sex Life Quality: A Cross-Sectional Study

ABSTRACT

Objective: This study was planned to review adolescent mothers' sex life quality for the time till 12th month postpartum.

Methods: This is a descriptive study that was composed of 60 adolescent mothers who met the criteria and appealed to a family health center in Turkey's southeast region between January-June 2018. Inquiry form and Sex Life Quality Scale-Female (SLQS-F) that determine the socio-demographic attributes of participants were used as the data collection tool.

Results: Age average of adolescent mothers was found as 18.50±0.74. With reference to another findings, there is a statistically significant relationship ($p<0.05$) between marriage age and sex life quality; smoking affects sex life quality adversely; sex life quality of companionate marriages is higher ($p<0.05$) in comparison with arranged marriages; mode of delivery affects the sex life quality; sex life quality of adolescents who experience vaginal delivery is lower in comparison with adolescents who prefer cesarean. Sex life quality of adolescents was found as ultra-low.

Conclusions: It was determined that adolescents whose marriage age is more advanced have better quality of sexual life than adolescents who married younger. It is revealed at the end of the research that as the age decreases, the sex life quality becomes poor at the same time.

Keywords: Adolescent, Pregnant, Sex Life Quality

Adölasan Annelerin Doğum Sonu Cinsel Yaşam Kalitesi: Kesitsel Bir Çalışma

ÖZET

Amaç: Bu çalışma 12. ay postpartum döneme kadar olan adölasan annelerin cinsel yaşam kalitelerini incelemek amacıyla planlanmıştır.

Gereç ve Yöntem: Tanımlayıcı tipte yapılan bu çalışma Türkiye'nin Güneydoğusundaki bir aile sağlığı merkezine Ocak 2018-Haziran 2018 tarihleri arasında başvuru yapan araştırma kriterlerini sağlayan 60 adölasan anneden oluşmaktadır. Veri toplama aracı olarak kişilerin sosyo-demografik özelliklerini belirleyen sorgulama formu ve Cinsel Yaşam Kalitesi Ölçeği-Kadın (CYKÖ-K) kullanıldı.

Bulgular: Elde edilen bulgular doğrultusunda, adölasan annelerin yaş ortalamaları 18.50±0.74 olarak bulundu. Evlilik yaşı ile cinsel yaşam kalitesi arasında istatistiksel olarak anlamlı fark olduğu, evlilik yaşı arttıkça cinsel yaşam kalitesinin arttığı ($p<0.05$) görüldü. Sigara kullanımının cinsel yaşam kalitesini olumsuz etkilediği, anlaşarak evlenen adölasanların cinsel yaşam kalitelerinin görücü usulü evlenenlere oranla daha yüksek olduğu ($p<0.05$) ve doğum şeklinin cinsel yaşam kalitesini etkilediği, normal doğum yapan adölasanların sezeryan ile doğum yapan adölasanlara göre cinsel yaşam kalitelerinin daha düşük olduğu belirlendi.

Sonuç: Evlenme yaşı daha ileri olan adölasanların daha küçük yaşta evlenen adölasanlara oranla cinsel yaşam kalitelerinin daha iyi olduğu gösterilmiştir. Araştırma sonucunda küçük yaşta evlenenlerin cinsel yaşam kalitelerinin de azaldığı belirlenmiştir.

Anahtar Kelimeler: Adölasan, Gebe, Cinsel Yaşam Kalitesi

INTRODUCTION

Adolescence is a transition period from childhood to the adult life in which physical growth, sexual growth, and psychosocial maturation actualized. Adolescence is also characterized by rapid physical, psychological and social changes. This period is one of the most significant phases of the human developmental period. Since the adolescence varies by the personal characteristics, it is pretty hard to specify that starting time and how long it will take. The individual experiences several physiological and psychological changes in adolescence. Developing the secondary sexual characters, accelerating the growth, menarch, and changes in body shape are the main factors of physiological changes (1). Pregnancy period is also the time when the person has physiological, psychological and social changes just as adolescence. Experiencing pregnancy and adolescence in the same period may bring along several problems. The young who have not completed mental development, whose education mired down, whose social status is unknown and finally who is obliged to wrestle with economic problems become mother and father in addition to all these (2). Following reasons cause adolescent pregnancies; marriage age that varies in the social structure, educational background, socio-economical status, religious beliefs and attitudes, the status of access to family planning services. With reference to the World Health Organization (WHO), low education level and living in the rural area increase the adolescent pregnancy and deliveries (3). Ertem et al. is conducted a study and determined that family types, educational background of father and mother, residence (rural area), feudal system and ethnic/cultural factors are the components that increase the adolescent marriages (4). Adolescent pregnancies are frequently seen in both rural area and socio-economic groups who are poor and also migrated from the country to the towns. Death and diseases are mostly observed in early pregnancies as well as emotional and social problems are also mostly experienced in adolescent pregnancy. Both mothers and their baby are affected negatively in case of being pregnant before completing the mental and social development (6). Therefore, adolescent pregnant is considered as the risk group (7).

Unfinished sexual developments, anxiety, fear, excitement, hopelessness, and stress are mostly observed in adolescent pregnants (8). It is determined in the studies that depression in adolescent mothers is higher in comparison with adult mothers (9). While the individual has not maturated and developed his/her identity yet, the marriage causes them to face several problems. One of these problems is the sexual life. This study was conducted to review the sex life quality of adolescents.

MATERIAL AND METHODS

This research was actualized as descriptive and cross-sectional.

Sample Description: The study was conducted with adolescent pregnant women who applied to family health center between 15.01.2018-15.06.2018. A total of 82 adolescent pregnant women who applied to the family health center between the dates of the study constituted the universe of the study.

In order to determine the sample size, n = N.t2.pq / d2 (N-1) + t2.pq formula was used and the sample calculation was made with reference to 80% of the frequency of changes in sexual life during pregnancy with Özçelik's (2010) study the size was found to be 56. (10)

60 adolescent mothers who met the criteria, appealed to the family health center and accepted to participate in the study were taken to the sample.

The research was actualized in a family health center in Turkey's southeast region between January-June 2018. Criteria for the research are as follow;

- Mothers in the adolescent period (between 10-19 years)

–Mothers in the postpartum 12th month and before

–The mothers who have no psychological/perception problem

–Mothers who have not a problem with communication and language

Data Collection Tools and Data Collection: Sex life Quality Scale (SLQC) that involves 18 questions measure socio-demographic attributes and sex life quality of mothers have been used. Data were obtained by face-to-face interview method. Filling upon each of the forms took 10 minutes approximately.

Sex Life Quality Scale (SLQS): The scale was developed by Symonds et al. in 2005 (11). Validity studies of the scale were conducted by Turgut and Golbaşı in 2010 (12). Much as the scale can be applied to all the women over the age of eighteen, the validity and reliability studies were conducted for the women who are between 18 and 65 age group. It is pointed out that the scale which has a high-reliability level can be used to evaluate the sex life quality of women in Turkish society. The scale is a six-point Likert scale and composed of 18 items. It is asked for answering each of the questions by considering the sex life in the last four weeks. Each of the items can be graded between 1 and 6 or 0 and 5 in the original of the scale. This

study used the grading system as 1-6 (1=Absolutely agree, 2=Considerably agree, 3=Rather agree, 4=Rather disagree, 5= Considerably disagree, 6=Strongly disagree). The score interval is between 18 and 108. Scores of 1, 5, 9, 13, 18 numbered items need to be reversed before computing the total score. The total score is turned into 100 without noticing the scoring system. Following formula is used for this transformation; [(raw score-18) x100/90]. For example, the scale score of a participant whose raw score total is 63 is [(63-18) x 100/90=50]. The response categories could be scored either 1 to 6 or 0 to5 giving a total score of 18–108 or 0–90. Higher score indicates better female sexual quality of life

Ethics of Research: The written permission was received by 2017/16407 numbered Ethical Committee Decision from Medical Research and Publication Ethics. Verbal consents of the participant mothers were received before applying the questionnaire form by explaining the research objective.

Evaluation of Data: Data were evaluated in the computer environment by using IBM SPSS (version 21) packaged software. Average and percentage (%) were used to define the variables. T-tests were used for significance values.

RESULTS

As is seen in Table 1, the age average of adolescent mothers is 18.50±0.74. About the marriage ages, 15.0% (n: 9) of them married between 15 and 17 ages; 85.0% (n:51) of them married between 18-19 ages. Even though 61.7% of the adolescent mothers do not smoke, 78.3% of their partners smoke. It is seen when the educational background of adolescent mothers is analyzed that 21.7% (n:13) of them are literate; 38.3% (n:23) of them graduated from primary education; 40% (n:24) of them drop out from the secondary education. About the educational background of the partners of adolescent mothers, 55% (n:33) of them are literate; 15% (n:9) of them graduated from the primary education; 28.3% (n:17) of the dropout from the secondary education. According to the marriage style data of adolescent mothers, 56.7% (n:34) of them experienced companionate marriage; 41.7% (n:25) of them experienced arranged marriage. About the types of families that adolescent mothers live in, while 81.7% (n:49) of them have extended family; 18.3% (n:11) of them have an elementary family. 53.3% (32) of them have less income in comparison with the expense; income of 41.7% (n:25) of them is equal to the expense; income of 5.0% (n:3) of them is more than their expense. 63.3% (n:38) of adolescent mothers live in a village; 11.7% (n: 7) of them live in a city. With reference to another data, 84.9% (n: 51) of them live with 6-8 people in the home; 15% (n:9) of them live with 2-5 people in the home. While 93.3% (n:56) of them have not a private bedroom for her and his partner; 6.7% (n: 4) of them have. About the delivery method, 63.3% (38) of them experienced cesarean; 36.7% (n: 22) of them preferred vaginal delivery.

Table 1. Reviewing the Sociodemographic Attributes of Adolescent Mother and Their Partners

	n	**X±SS**
Age	60	18.50±0.74
	n	**%**
Marriage age		
15-17	9	15.0
18-19	51	85.0
Smoking		
Yes	23	38.3
No	37	61.7
Smoking by the partner		
Yes	47	78.3
No	13	21.7
Educational Background		
Literate	13	21.7
Primary education	23	38.3
Dropout from secondary education	24	40.0
Educational Background of the Partner		
Literate	33	55.0
Primary education	9	15.0
Dropout from secondary education	17	28.3
Marriage style		
Companionate	34	56.7
Arranged marriage	25	41.7
Type of family		
Extended Family	49	81.7
Elementary Family	11	18.3
Total monthly income		
Income is more than expense	3	5.0
Income is less than expense	32	53.3
Income is equal to expense	25	41.7
Where is the settlement you live longest?		
City	7	11.7
District	15	25.0
Village	38	63.3
Number of family members		
2-5	9	15.0
6-8	51	84.9
Do you have a room for you and your partner to live together?		
No	56	93.3
Yes	4	6.7
Delivery method		
Cesarean	38	63.3
Vaginal delivery	22	36.7

As is seen in Table 2, while 83.3% (n:50) of the mothers use a birth control method; 16.7% (n: 10) of them do not. 56.7% (n:35) of them have not taken an education about sex; 41.7% (n:25) of them took the education mentioned. There is not a chronic disease in 96.7% (n:59) of the mothers. 43.3% (n:26) of these mothers love their partners so much; 35% (n:21) of them used 'so-so' expression for the same question. 40.0% (n:24) of the mothers find the sex as enjoyable; 23.3% (n:14) of them find the sex as felicific; 20% (n:12) of them accept the sex as cold; 5% of them find the sex as the repellent. About being passive or shy, 45.0% (n: 27) of them marked 'bare minimum' choice; 38.3% (n: 23) of them marked 'so-so' choice; 8.3% (n:5) of them are considerably shy; 6.7% (n:4) of them are not shy in no way.

Table 2. Reviewing the Distribution of Some of the Attributes on Sex Life Quality of Adolescent Mothers

	n	%
Do you use any birth control method?		
Yes	50	83.3
No	10	16.7
Have you ever undergone a training about sex?		
Yes	35	56.7
No	25	41.7
Do you have any chronic diseases?		
Yes	1	1.7
No	59	96.7
How much do you like your partner?		
So much	8	13.3
Considerable	26	43.3
So-so	21	35.0
Bare minimum	5	8.3
How do you perceive the sex?		
Hot	7	11.7
Enjoyable	24	40.0
Felicific	14	23.3
Cold	12	20.0
Repellent	3	5.0
Being passive-shy: How shy are you?		
So much	1	1.7
Considerable	5	8.3
So-so	23	38.3
Bare minimum	27	45.0
In no way	4	6.7

As is seen in Table 3, while the sex life quality of mothers who married between 15 and 17 ages is 44.19±14.93, score averages of sex life quality of mothers who married between 18 and 19 ages is 45.40±21.13. The difference is significant ($p<0.05$) when the sex life quality in marriage is analyzed by the age groups. While the sex life quality score average in adolescent mothers who smoke is 41.53±19.87, this same average is 48.93±20.36 for the mothers who do not smoke. The difference between mothers who smoke and who do not is statistically significant ($p<0.05$). Sex life quality of mothers who smoke is found as lower in comparison with the mothers do not smoke.

Table 3. Comparison of the Sex Life Quality Scale Score Average of Adolescent Mothers by Introductory Attributes

	n (%)	SLQS Total Score Average (X±SS)
Marriage age		
15-17	9(15.0)	44.19±14.93
18-19	51(85.0)	45.40±21.13
		t : 16.28
		p : .000
Smoking		
Yes	23 (38.3)	41.53±19.87
No	37 (61.7)	48.93±20.36
		t :16.30
		p : .000
Educational Background		
Literate	13 (21.7)	24.55±11.54
Primary school	23 (38.3)	42.63±23.02
Dropout from the secondary school	24 (40.0)	44.87±17.83
		f: 1.095
		p:.359
Marriage style		
Arranged marriage	34 (56.7)	42.57 ±17.78
Companionate marriage	25(41.7)	45.98±22.10
		t : 16.39
		p: .000
Type of family		
Elementary family	11(18.3)	45.75±19.17
Extended family	49(81.7)	44.05±20.62
		t:16.55
		p:.000
Do you have a room for you and your partner to live together?		
No	56(93.3)	34.32±25.49
Yes	4(6.7)	55.00±25.49
		t : 16.58
		p : .000
Delivery method		
Vaginal delivery	22(36.7)	40.05±14.71
Cesarean	38(63.3)	46.87±22.61
		t : 16.43
		p:.000

While the point average of literate mothers is 35.55±11.54, the point average of mothers who dropout because of the marriage is 44.87±17.83. This research confirmed that educational background does not affect the sex life quality; accordingly, the difference is not statistically significant ($p>0.005$). It is seen when the sex life quality is analyzed by the marriage style that sex life quality point average of mothers who preferred arranged marriage is 42.57±17.78, the sex life quality of mothers who preferred companionate marriage is 45.98 ±22.10; accordingly, the difference is statistically significant. About the family environment, while the sex life quality of mothers who live in the elementary family is 45.75±19.17, sex life quality of mothers who live in the extended family is 44.05±20.62. The sex life quality of adolescent mothers who have a private bedroom for her and her partner is 55.00±25.49, this same average is found as 34.32±25.49 for the mothers who have not such a room. Accordingly, the difference between these two variables is statistically significant. About the delivery method, the sex life quality point average of mothers who experienced vaginal birth is 40.05±14.71, this same average is found as 46.87±22.61 for the mothers who preferred cesarean. Sex life quality of adolescent mothers is accepted as low. The difference for the delivery method is statistically significant as well ($p<0.005$).

DISCUSSION

This descriptive study was conducted to determine the sex life quality of adolescent mothers. Much as there are studies on adolescent pregnants in Turkey, there is not a research about the sex life quality of adolescents. Our research confirms that sex life quality of adolescents in the 18-19 age group is higher than that sex life quality of adolescents in the 15-17 age group. The difference between age groups is found as statistically significant ($p<0.05$) by the sex life quality. It is specified that the marriage has an effect on the sex life quality. Age is a remarkable factor in the sexual function. It is another remarkable finding that as the women grew older, their sex life quality increases at the same time (Table 4). Marangoz performed a survey and explained that as the women grew older, their sexual activities are in the tendency to increase (13).

Those findings show parallelism with our finding. As the women grew older, their sex life quality increases at the same time. This finding can be explained by the reasons such as the experiences of women increase over the years and also their attitudes change positively (14).

There is a statistically significant difference ($p<0.05$) in sex life quality of mothers who smoke and who do not. Sex life quality of mothers who smoke is found as lower than the sex life quality of mothers who do not smoke.

It is pointed out in the studies that are conducted with the males that smoking causes decrease in erection; this circumstance is rooted in the decrease in plasma testosterone and nitric oxide synthase in smooth muscles. Öksüz and Malhan accepted smoking as the risk factor for the sexual function disorder (15). Research results that were found before show parallelism with this research results

It can be seen when the educational background of adolescent mothers is analyzed that 40% of them was obliged to discontinue to the education (Table 1). Çırak and Özdemir conducted a survey in 2015 With reference to their research findings, the age interval of adolescent pregnant is 15-19; 55.8% of them is 19 years old; 82.4% of them graduated from the primary school (17). Kalpal, mentioned in his study that 26,7% of the adolescents are literate (18). Atay conducted a study in 2017 and did not find a statistically significant relationship between educational background and the average of the sex life quality scale (19). Findings of the studies that were conducted before having parallels with this research's findings. The research sample was composed of the adolescent mothers who discontinued the primary and secondary education. To continue the education is a good and meaningful reason for adolescents to postpone the marriage (20). There is a strong relationship between education and adolescent fertility level. It is also mentioned that as the education period extends, the adolescent fertility ratio decreases (21). Thus and so, as the educational level increases, adolescent pregnancy ratio decreases (22).

According to the data of TPHS 2013, while 17% of females who are not literate or did not graduate from the primary school start to give birth to a child, this ratio is at 8% level among the females who completed at least elementary school Adolescent pregnancies are mostly seen in uneducated women as well as these pregnancies mentioned cause them to participate in the working life. In conclusion, the young become economically dependent .

Ege et al. performed a survey on healthy women and specified that women whose education level is low have more difficulties in the sexual relationship (23). Results show that as the education level of women increases, their sexual function averages increases at the same time. A study that was actualized in Brazil confirms that educational background does not affect the sex life quality (24). It is determined when the income status is analyzed in adolescent marriages that the income of 53.3% of them is lower than their expense. Some of the factors affect the economic condition are as follows; comprising the desire for marriage before

having a profession, cannot go on the educational background. Early marriages hinder adolescent who has not completed bio-psychosocial development to receive training and have training (25).

As is seen in Table 2, 56.7% of adolescent mothers have not received any training. Pınar et al. confirmed that 59% of the adolescents got information on the sexual health before; they use sources such as media, friends, and internet; 81.9% of them want to have knowledge about sexual health in university life (26). With regard to the findings of studies on high school students, the information on contraception, veneral diseases, family planning, menstruating and pregnancy are insufficient (27,28).

İşler, Taş, Beytut, and Conk made an investigation and pointed out that adolescents with mental deficiencies are not educated for sexuality; accordingly, those adolescents mentioned have insufficient knowledge about sex and adolescence developmental stages (29). 43.3% of adolescents love their partners so much. This circumstance may result from companionate marriages. 40% of adolescent mothers perceive the sex as enjoyable. About being passive in sexual life, 45% of them marked 'bare minimum' choice. It is seen when the marriage styles of adolescent mothers are reviewed that while 56.7% of them preferred companionate marriage, 41.7% of them experienced arranged marriage. There is found a statistically significant difference between marriage style and the sex life quality. Adolescents who preferred companionate marriage have higher sex life quality ($p<0.05$).

The reason for preferring companionate marriage is that the decision-making skills of adolescents have not developed yet and also they have not understood the importance of taking big responsibilities for their future. It is determined in our research that sex life quality of adolescents who preferred companionate marriage is more statistically significant in comparison with the adolescents experienced arranged marriage ($p<0.05$). Erdoğan specified that the marriage style considerably affects the marriage satisfaction (30). Moreover, the people who preferred companionate marriage have higher marriage satisfaction. We can easily see when the point average of the sex life quality and the family types are analyzed by Table 3 that sex life quality of adolescents who live in the elementary family is higher than the sex life quality of adolescents who live in extended families. Accordingly, the difference is statistically significant ($p<0.05$). As is seen in this study, 81.7% of adolescent mothers live in extended families, 84.9% of them live with at least five people in the same home. One of the factors that affect the sex life quality is the absence of a special room belong to the partners. 93.3% of adolescent mothers have not a special bedroom that belongs to them. The absence of such a room is one of the reasons affecting the sex life quality. Sex life quality of adolescents who have not a private bedroom is found as low. Çırak and Özdemir researched the adolescent pregnant and mentioned that 66.1% of pregnant live in extended families (17). Following factors affect the sex life quality; absence of private bedroom, economic status and being obliged to live with extended family. 63.3% of adolescents preferred cesarean. With reference to the scientific surveys, the cesarean method is safer for individuals in adolescence when the anatomic structure has not formed yet. According to the study of Özsoy, delivery method of adolescent methods is not different from the mature mothers (31). The cesarean ratio is so high in both adolescent and mature mothers. Also, this study confirmed high ratios on the same subject. About the effect of delivery method on the sex life quality, it is determined in a research that sexual function disorder is mostly observed in women who preferred vaginal birth in comparison with women who prefer cesarean (32). Moreover, following factors have effect on forming and continuing of the sexual function disorders; curettage, infertility, sexual mythos, culture and other social factors, smoking and alcohol, disharmony between the partners, communication problems and sexual function disorders of the partner (33-36). With reference to other research findings, women explained that episiotomy and spontaneous perineal that form during the vaginal delivery affects the sexual function parameters negatively (37). The inadequacy of social support and tiredness are among the factors affect the sexual life (38). Being taken responsibilities by mothers more than fathers about the health problems of the children cause women to get tired and steer away from the sexual life.

One of the other findings of this research is that sex life quality of women whose income is lower than the expense and also who have not a social security is lower. However, it is found in other studies that income and social security status do not affect the sex life after postpartum period (24-39). According to the literature, most of the problems with sustaining the postpartum sex life emerge in the third and fourth months. It is found in studies that sex life quality of women who make the vaginal delivery with episiotomy is lower than the sex life quality of women who prefer cesarean (40-43). With reference to our study, being glad of the delivery method affects the postpartum sex life. There are also surveys support that delivery method affects the sex life of women (24,44-46). It is pointed out that episiotomy and lacerations in women who make vaginal delivery with episiotomy, make spontaneous delivery and also the women who have with perineal laceration negatively affect the sexual life parameters (37,39). It is emphasized in other research that there is a sexual function at a considerably low ratio in women who preferred planned cesarean in

comparison with the women who make the vaginal delivery.

These results show parallelism with our research findings (44-47). A research that was performed in Turkey reported that more than half of the deliveries in pregnant who are 18 and below are over with cesarean; cephalopelvic disproportion is shown as the reason for cesarean indication (48). Following complications were frequently seen for adolescent mothers in some of the studies; cervicovaginal infections, preeclampsia, eclampsia, perineum rupture, Apgar 1-5 evaluation, birth weight (49). Pregnancy complications and prenatal problems are frequently seen in adolescent pregnants (3).

CONCLUSION

Since the adolescent pregnant are under higher risk more than grown pregnant, the responsibility of the nurse is pretty much for the adolescent pregnant. Adolescents need a special care during the pregnancy (50). The nurse needs to know the general developmental process of the adolescent period and help in evaluating the attitudes of the adolescent (51). It is revealed at the end of the research that as the age decreases, the sex life quality becomes poor at the same time. Besides, the nurses should give priority to this group for the consultancy and education services. As this research is planned cross-sectionally, the results cannot be generalized to the whole universe.

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