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The comparison of quality of life in male and female deaf chess and non-chess players of Khorramabad city

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Abstract

The purpose of this study was to compare the quality of life in male and female deaf chess and non-chess players of Khorramabad city. The statistical population of this study were all male and female deaf chess and non-chess players in Khorramabad city. 24 subjects were randomly selected that the statistic sample of non-chess players was included 12 men and 1 woman and the statistic sample of chess players was included 3 men and 8 women. The instrument of this study was included the Quality of Life Questionnaire (SF-36). The collected data were analyzed by Mann-Whitney U test. The results of this study showed that there was a significant difference between male and female deaf chess and non-chess players in general health and physical function subscales but there was no significant difference between male and female deaf chess and non-chess players in other subscales of quality of life.

Keywords: Life quality, chess, deaf

Introduction

The hearing loss is the most common sensory defects in humans. Its prevalence rate is one of every 1000 to 2000 newborns (Foroughmand, *et al.*, 2011) [15]. The detection of hearing loss is delayed due to reasons such as the lack of appearance, the unfamiliar of family with early symptoms and lack of information about service centers (Jeddi, *et al.*, 2012) [16]. Mental game plays an important role in chess. It can even be said that psychological factor is as important as the technical skills in the World Championships. These psychological issues were considered trick in the past, but today, they are an important part of the weapons that elite chess players should have at their disposal (Euwe, 1998) [1]. Individuals' view has changed than life and they try to promote various aspects of quality of life (Naeeniyan *et al.*, 2005) [7]. However there is the variety and change about the concept of quality of life from different social groups and persons' view, but here is a general agreement about the overall definition and pattern of quality of life. For example, according to the World Health Organization, quality of life includes dimensions of physical, psychological, and social health and the relationship with the environment (Newa & Taylor, 1999) [17]. Quality of life has a close relationship with the concept of its life because some good indicators of life (health and mental health) is the same quality of life and the good life has no meaning without physical and mental health (Ramazaninejad, 2007) [4]. Everyone tries to do measures at the individual level to achieve standards of quality of life in the field of physical and mental health. The participation in sports and recreational activities is one of these measures until individuals benefit advantages of physical and mental activities and increase their quality of life and they may even be at a higher level in this respect (VaezMousavi, 2000) [10, 11]. Quality of life has been equated with welfare and health (Ghahramani & Jafarpour Alavi, 2006) [6]. The main orientation of studies related to quality of life was focused on people with disabilities, sick people, prisoners, drug addicts and other social groups (Raised, 2001) [20]. Elasky (2006) [14] provided a national pattern for life satisfaction and he achieved its positive relationship with sport and physical activity (Elasky, 2006) [14]. The review of the results of studies about the role and effect of physical activity and exercise on quality of life (Health, job satisfaction, creativity, social and family relationships) shows the indubitable role and effect of these activities and training interventions on the wellbeing, mental health, and social development.

Physical activities reduce depression (%21), anxiety (%80), and cardiovascular risk factors (Sadigh, 2006) [5] and those increase cheerful spirit and social interaction and self-concept (VaezMousavi, 2000) [10, 11]. BoroonVelina (2001) examined the relationship between recommended levels of physical activity and related quality to health life (Sadigh, 2006) [5]. The results of this study showed a significant relationship between recommended levels of physical activity and related quality to health life (Sadigh, 2006) [5]. Chen, *et al.*, (2005) concluded that health related quality of life is associated with lifestyle, physical health, and mental health (Niyazi, 2007) [8]. The same results are obtained about the positive social effect of sport activities (VaezMousavi, 2001; Vahdaninia, 2005) [12]. Wrisberg and Johnson (2002) have considered quality of life as synonymous with life satisfaction in their study (Gentner, 2004) and they have considered job satisfaction as an index for quality of life (Elasky, 2006; Gentner, 2004) [14]. The role of exercise on quality of life was more interesting in this approach. For example, quality of life of a group of 10 different nationalities of female runners and non-athletes' quality of life were compared in one study. The results showed that athletes had significantly better quality of life than non-athletes (VaezMousavi, 2000) [10, 11]. Varka, *et al.*, (1984) examined the relationship between participation in sport and quality of life in 2000 male athletes. They expressed that the participation in sport led to the increasing of long satisfaction in life (VaezMousavi, 2000) [10, 11]. McIister (2001) compared quality life in athletes and non-athletes. He found that athletes had better quality life than non-athletes. Domestic studies have not paid much attention to the issue of quality of life and most studies are about patients' quality of life and the QLQ questionnaire is used in most of these studies. Hamedinia and Gholestani (2004) examined health related quality of life in active and non-active members of science committee in universities of Sabzevar. They concluded that active members had better quality of life than non-active members of science committee (VaezMousavi, 2001) [12]. VaezMousavi (2000) [10, 11] studied female and male athletes' quality of life in individual and team sports. He concluded that individual female athletes had better quality life than team female athletes, but team male athletes had better quality life than individual male athletes. He compared athletes and non-athletes' quality of life and he concluded that athletes had better quality of life than non-athletes (VaezMousavi, 2000) [10, 11]. Badri Azin (2013) [2] expressed that there was a significant difference between athlete and non-athlete elderly people in components of quality of life (general health, physical performance, energy and vitality, mental health and role limitations due to physical and emotional reasons, but there was no significant difference in the variables of bodily pain and social function. Hamidzadeh, *et al.*, (2005) concluded that different dimensions of quality of life especially physical function can be increased by using a regular sport program (Bazrafshan, *et al.*, 2008) [13]. Hemayattalab *et al.*, (2003) [3] showed that athlete students had higher life satisfaction than non-athlete students (Hemayattalab, *et al.*, 2003) [3]. Therefore, the purpose of this study was to compare the quality of life in male and female deaf chess and non-chess players of Khorramabad city.

Materials and Methods

The method of this study was causal-comparative.

Participants

The statistical population of this study were all male and

female deaf chess and non-chess players in Khorramabad city. 24 subjects were randomly selected that the statistic sample of non-chess players was included 12 men and 1 woman and the statistic sample of chess players was included 3 men and 8 women.

Instruments and Tasks

The instrument of this study was included the Quality of Life Questionnaire (SF-36). The first part of the questionnaire included questions about subjects' demographic information such as age, gender, field of study, chess player, non-chess player, marital status, and education level. The second part of the questionnaire included questions about subjects' quality of life. SF-36 questionnaire has proven its efficiency for applications in the clinical work, the evaluation of health policies as well as studies of the general population. Quality of Life Questionnaire (SF-36) measures the rate of quality of life from both physical and mental state. It was included the general health, physical function, role limitations due to physical reasons, role limitations due to emotional reasons, bodily pain, social function, fatigue or vitality, and mental health. The lowest score was zero and the highest was 100 in this questionnaire. The reliability and validity of the Persian version of this questionnaire has been confirmed in Iran ($r = 0.7-0.9$).

Procedure

The purpose of study was explained to subjects. The participants were assured that their data will be kept confidential and those will not be available to anyone. All subjects completed a consent form to participant in this study and they attended with the complete satisfaction in this study. The researcher distributed questionnaires among subjects. He explained the inventory for the subjects before its completing. The subjects completed questionnaires without name due to the subjects' security sense. Each subject had 30 minutes to complete the questionnaire.

Data Analysis

The collected data were classified by descriptive statistical methods and were analyzed by Mann-Whitney U test. The SPSS software (version 19) was used for data analysis ($\alpha \leq 0.05$).

Results

The mean and standard deviation of the analysis of each of the subscales of the quality of life showed in this section in the form of tables and figures (Table 1). The mean of quality of life subscales has been shown in figure (1).

Table 1: Descriptive indicators

Factors	Mean		SD
	Chess player	Non-chess player	
General health	Chess player	62.97	0.53
	Non-chess player	55.26	0.69
Physical function	Chess player	63.41	0.68
	Non-chess player	61.33	0.54
Role limitations due to emotional reasons	Chess player	47.15	0.78
	Non-chess player	46.19	0.87
Bodily pain	Chess player	68.55	0.83
	Non-chess player	69.53	0.66
Social function	Chess player	48.33	0.66
	Non-chess player	48.68	0.89
Fatigue or vitality	Chess player	46.73	0.93
	Non-chess player	45.34	0.53
Mental health	Chess player	49.64	0.84
	Non-chess player	49.12	0.53

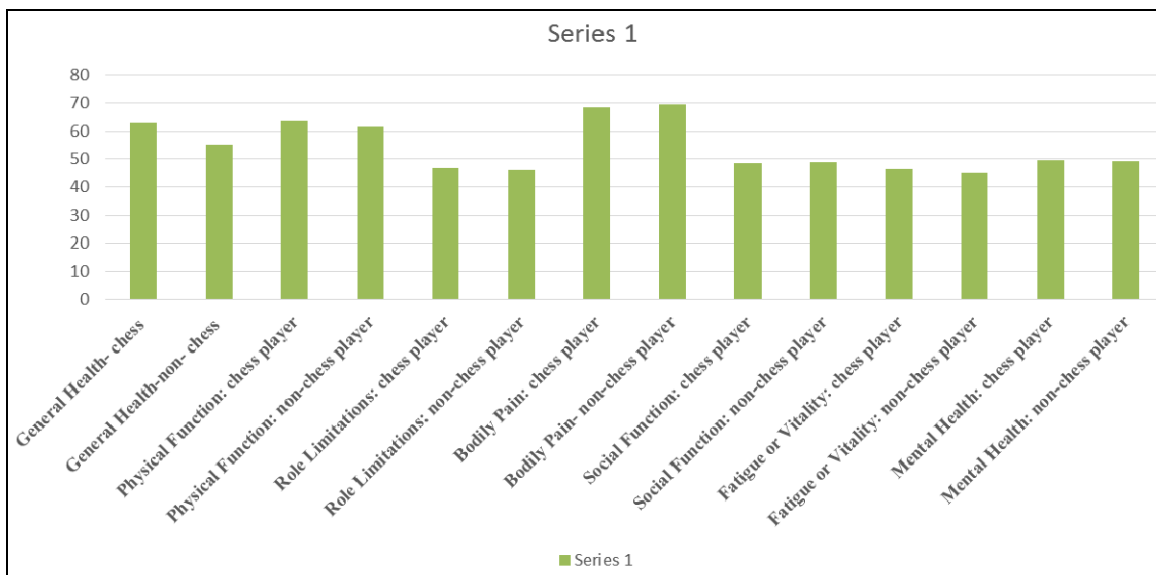


Fig 1: The mean of quality of life subscales

The results of Kolmogorov-Smirnov test showed that the data distribution was not normal (table 2).

Table 2: The results of Kolmogorov-Smirnov test for the determination of normal distribution of data

Variable	Z	P
General Health	1.433	0.001
Physical Function	0.823	0.001
Role limitations due to emotional reasons	1.453	0.001
Bodily Pain	1.456	0.001
Social Function	1.450	0.001
Fatigue or Vitality	1.456	0.001
Mental Health	1.456	0.001

The results in table (3) showed that there was a significant difference between chess and non-chess players in general health subscale (P=0.001).

Table 3: The results of Mann-Whitney U test for the determination of difference between chess players and non-chess players in general health

Variable	Statistics of Mann-Whitney U test	Statistics of Wilcoxon test	Z	P	Variable status
General Health	87.98	45.96	6.313	0.001	Different in the two groups

Table 4: The results of Mann-Whitney U test for the determination of difference between chess players and non-chess players in physical function

Variable	Statistics of Mann-Whitney U test	Statistics of Wilcoxon test	Z	P	Variable status
General Health	73.18	49.415	3.069	0.001	Different in the two groups

The results in table (4) showed that there was a significant difference between chess and non-chess players in physical function subscale (P=0.001).

Table 5: The results of Mann-Whitney U test for the determination of difference between chess players and non-chess players in role limitations due to emotional reasons

Variable	Statistics of Mann-Whitney U test	Statistics of Wilcoxon test	Z	P	Variable status
General Health	53.45	67.441	8.007	0.313	Different in the two groups

The results in table (5) showed that there was no significant difference between chess and non-chess players in role limitations due to emotional reasons (P=0.313).

Table 6: The results of Mann-Whitney U test for the determination of difference between chess players and non-chess players in bodily pain

Variable	Statistics of Mann-Whitney U test	Statistics of Wilcoxon test	Z	P	Variable status
General Health	69.451	44.476	3.426	0.126	Different in the two groups

The results in table (6) showed that there was no significant difference between chess and non-chess players in bodily pain subscale (P=0.126).

Table 7: The results of Mann-Whitney U test for the determination of difference between chess players and non-chess players in social function

Variable	Statistics of Mann-Whitney U test	Statistics of Wilcoxon test	Z	P	Variable status
General Health	69.237	45.486	7.460	0.113	Different in the two groups

The results in table (7) showed that there was no significant difference between chess and non-chess players in social function subscale (P=0.113).

Table 8: The results of Mann-Whitney U test for the determination of difference between chess players and non-chess players in fatigue or vitality

Variable	Statistics of Mann-Whitney U test	Statistics of Wilcoxon test	Z	P	Variable status
General Health	75.22	33.46	2.019	0.223	Different in the two groups

The results in table (8) showed that there was no significant difference between chess and non-chess players in fatigue or vitality subscale (P=0.223).

Table 9: The results of Mann-Whitney U test for the determination of difference between chess players and non-chess players in mental health

Variable	Statistics of Mann-Whitney U test	Statistics of Wilcoxon test	Z	P	Variable status
General Health	64.741	56.084	4.151	0.108	Different in the two groups

The results in table (9) showed that there was no significant difference between chess and non-chess players in mental health subscale (P=0.108).

Table 10: The results of Mann-Whitney U test for the determination of difference between chess players and non-chess players in quality of life

Variable	Statistics of Mann-Whitney U test	Statistics of Wilcoxon test	Z	P	Variable status
General Health	76.015	58.625	4.507	0.114	Different in the two groups

The results in table (9) showed that there was no significant difference between chess and non-chess players in quality of life (P=0.114). Finally, it was found that although some subscales were different in the two groups, but there was no significant difference between chess and non-chess players in quality of life.

Discussion and Conclusion

The results of this study showed that there was a significant difference between male and female deaf chess and non-chess players in general health and physical function subscales but there was no significant difference between male and female deaf chess and non-chess players in other subscales of quality of life. These results are consistent with the results of Hamidzadeh, *et al* (2005) and Badri Azin's (2013) [2] study. He concluded that there was a significant difference between athlete and non-athlete elderly people in general health and physical function, but there was no significant difference in bodily pain and social function. Hamidzadeh, *et al.*, (2005) concluded that different dimensions of quality of life especially physical function can be increased by using a regular sport program (Bazrafshan, *et al.*, 2008) [13]. The results of this study is conflict with the results of Vaez Mousavi, (2000) [10, 11] BoroonVelina (2001); Varka, *et al.*, (1984); Hamedinia and Gholestani (2004); McIister

(2001); Badri Azin (2013) [2]; Hamidzadeh, *et al.*, Hemayattalab *et al.*, (2003) [3]; and Wrisberg and Johnson's (2002) study. Vaez Mousavi (2000) [10, 11] concluded that athletes had better quality life than non-athletes. Physical activity can reduce depression and anxiety, and it can increase social interaction, cheerful spirit, and self-concept (Vaez Mousavi, 2000) [10, 11]. BoroonVelina's (2001) study showed a significant relationship between recommended levels of physical activity and related quality to health life (Sadigh, 2006) [5]. Varka, *et al.*, (1984) expressed that the participation in sport led to the increasing of long satisfaction in life (Vaez Mousavi, 2000) [10, 11]. Hamedinia and Gholestani (2004) concluded that active members had better quality of life than non-active members of science committee (Vaez Mousavi, 2001) [12]. McIister (2001) found that athletes had better quality life than non-athletes. Badri Azin (2013) [2] expressed that there was a significant difference between athlete and non-athlete elderly people in role limitations component due to physical and emotional reasons. Hamidzadeh, *et al.*, (2005) concluded that physical activity can increased different dimensions of quality of life (Bazrafshan, *et al.*, 2008) [13]. Hemayattalab *et al.*, (2003) [3] showed that athlete students had higher life satisfaction than non-athlete students (Hemayattalab, *et al.*, 2003) [3]. Wrisberg and Johnson's (2002) concluded that athletes had better quality of life than non-athletes. These results showed that only athletes do not benefit from physical, mental, and social advantages of sport. Many studies in the field of health, physiology health, and weight management using regular exercise programs and special facilities have shown these useful and constructive effects. Therefore, we can increase physical function and indicators related to general health with the participation in daily physical activities. This issue is very important due to the age and culture conditions in our country. Physical activity is the first sign of health. It plays a vital role in the promotion of physical fitness and health-related behavior, long life, the improvement of the quality of life, the promotion of weight management, and the reduction of the risk of illness and death and it has a positive effect on the elimination of numerous medical disorders (Peterson, 2000) [19].

Conflict of interest

The authors declare no conflict of interest.

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