

Quality of life in patients with hypertension

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Abstract:

The aim of this study is to know the level of quality of life within a sample of patients with hypertension and to search for differences in quality of life according to age and gender. To test the study hypotheses, we use the abbreviated Quality of Life Scale(WHOQOL),consisting of four dimensions (physical dimension, psychological dimension, relationship dimension, and environmental dimension). We find that hypertensive patients have an average level of quality of life, and there are differences due to the age variable and gender in favor of males.

Keywords: quality of life- health quality of life –hypertension.

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1. INTRODUCTION

Quality of life is one of the most important psychological and social variables that emerged after the middle of the twentieth century, as it was initially limited to the economic and political aspect, then it included the psychosocial aspect and finally the health aspect, and this concept is complex and difficult to find an agreed definition because it differs from one field to another, and the term health-related quality of life is used in the medical and psychological field to distinguish it from the quality of life in other fields, but this does not mean that they are different from each other, they are interrelated and intertwined. Improving the quality of life has become the objective of all global policies, especially for people with chronic diseases, which do not threaten the life of the individual in the short term, but their effects and consequences on his daily life are significant such as the inability to continue his daily activities. Mitigating their effects and complications is the goal of medical care, in order to improve the quality of life of patients, because what matters is not how many years an individual lives, but how he lives. Quality of life is not only about the environment in which the individual lives, as it was previously perceived, but after entering the psychological field, the subjective aspect has been added, i.e. the individual's perception of these conditions.

2. Study problematic

The enhancement of the quality of life for patients suffering from hypertension represents a key objective within the domain of health psychology, a pursuit that numerous nations are presently undertaking. Hypertension, akin to other chronic diseases, persists throughout an individual's lifetime, encompassing numerous medical, psychological, and social



dimensions. Consequently, the evaluation of quality of life necessitates a comprehensive consideration of patients' diverse life aspects.

According to the World Health Organization (WHO), quality of life is defined as an individual's perception of his or her place in life, in the cultural context and value system in which he or she lives, in relation to his or her goals, expectations, norms and fears. (Agence nationale de l'évaluation et de la qualité des établissements et services sociaux et médicaux sociaux [Anesm], 2011).

This means that quality of life is a broad conceptual field that includes, in a complex way, the individual's physical health, psychological state, degree of autonomy, social relations, personal beliefs and relationship with the particularities of his/her surroundings. (Ferron, 2011, p.6) Consequently, the physical aspect cannot be regarded as the only criterion that expresses the quality of life. Rather, it is a composite of several other factors, such as the psychological and relational aspects. This definition also incorporates the word 'perception', signifying that all these factors are interrelated under the individual's perception of them, who evaluates the quality of his or her life.

In this context, a study on hypertension found that although 100% of physicians reported that their patients' quality of life improved with regular use of blood pressure medication, only 50% of patients endorsed this, and none of those around the patient did. (Taylor, 2008, p.515) Yousef Al-Habash's (2003) study on blood pressure patients found an association between blood pressure disease and quality of life, while no differences attributable to the gender variable were identified. In contrast,

Ahsubraty et al. (2004) reported that patients with heart conditions exhibited a high quality of life, with males demonstrating superior outcomes in the psychological domain, independence, and environmental factors. Jamal Karim Shaker's (2015) study, which examined the quality of life of patients with diabetes mellitus and hypertension, revealed that the quality of life of these patients was low, with females and the elderly experiencing particularly poor quality of life. The results of the study by Khalil and Zaben (2019) in the Jordanian environment indicate that patients suffering from acute coronary syndrome experience a reduction in quality of life in the three domains of physical, emotional and social functioning. The study therefore concludes that health interventions are necessary to improve the quality of life of these patients.

The study of Sayel and Qalati (2021), which was conducted on 32 patients suffering from heart disease, found that the quality of life of cardiac patients is, on the whole, average in its social and emotional dimensions, while it appears to be below average in its physical dimension. Al-Jabri et al. (2017) conducted a study with the objective of describing the quality of life of patients with acute coronary syndrome in Jordan. The study was conducted on a sample of 372 patients in six different hospitals in Amman, and the results showed that the average quality of life score for all domains was low. Rajab (2018) advances the argument that an individual's sense of quality of life is associated with their emotional development and their capacity to regulate their negative emotions and adapt to the pressures they encounter.

In order to know how hypertensive patients, assess their quality of life we asked these questions:

1- What is the level of quality of life in a sample of hypertensive patients?

2-Are there statistically significant differences in the level of quality of life of hypertensive patients attributable to the age variable?

3-Are there statistically significant differences in the quality of life of hypertensive patients attributed to the gender variable?

3. Study hypotheses

To answer these questions, we make three hypotheses:

1-Hypertensive patients have a low level of quality of life.

2-There are differences in the quality of life of hypertensive patients due to age.

3-There are differences in the quality of life of hypertensive patients due to gender.

4.Study objectives

The current study aims to understand how hypertensive patients assess their quality of life and search for the existence of differences according to age, gender. This is through:

1-To identify the level of quality of life in patients with hypertension.

2-Search for differences in the quality of life levels of hypertensive patients according to the variables of age.

3-Search for differences in the quality of life levels of hypertensive patients in relation to the variables of gender.

5-Study concept

5.1. The definition of quality of life

The term quality of life is a keyword used in Index Medicus (1977) and defined by the National Library of Medicine as 'a general concept that translates the concern for changes and enhancement of the physical, political, moral, social environment and overall conditions of an individual's life. (Baumann and Briançon, 2010, p.20)

Blondeau (2010) contends that the concept of quality of life necessitates the consideration of the human experience in its manifold and intricate dimensions, without being constrained by its biological dimension. (St-Cyr, 1997)

Schalock (2000) defines it as a concept that reflects the conditions that an individual wishes or desires in his life, which is related to eight dimensions of his life, namely: Emotional happiness, personal relationships, material happiness, personal growth, personal development, physical happiness, self-direction, social security and social rights. (Al-Ajouri, 2013, p.38) Dijkers (2003) defines general quality of life as the integration between aspirations (e.g. goals, values, norms, desires and needs) and current achievements as perceived by the individual. (Gagné, 2010, p.9) El-Sherbini (2007) adds that quality of life is an individual's sense of personal fulfilment in areas of life that are important to them in the context of the culture to which they belong, at a consistent level with their goals, interests and expectations. (Al-Ajouri, 2013, p.39)

Despite the absence of a universally accepted definition of quality of life, consensus has been achieved on providing a definition derived from the aggregate of events and their repercussions on the life of each individual, and it was

synthesized from Corten's proposal that 'life is of good quality if it has meaning' (Gayral-Taminh et al., 2005, p.37).

Gayral-Taminh and others posit that this definition situates work related to quality of life within the domain of positive psychology, which is concerned with the ability of each individual to intervene in their circumstances, without constraining health to the absence of disease or disability. The advent of the World Health Organization's definition of health as a state of physical, psychological, and social well-being precipitated the evolution of the concept of quality of life and engendered inquiries into the concept. This evolution gave rise to two distinct concepts:

- a. Quality of life from an environmental perspective, which is primarily predicated on objective criteria such as salaries, social indicators, and material satisfaction.
- b. The concept of health-related quality of life emerged from early research focusing on the impact of functional disorders on health, subsequently incorporating social functioning, and ultimately, in the 1980s, the mental dimension was added to the concept of quality of life as it became imperative to consider psychological symptoms in addition to physical symptoms. (Rotonda, 2011)

The study of quality of life has evolved beyond the mere evaluation of symptoms associated with the disease to encompass the assessment of depressive symptoms, anxiety symptoms and the impact of the disease on the environment. That is to say, the subjective aspects of quality of life emerge in the context of suffering, both physical and psychological.

The concept of quality of life is predicated on two principles: firstly, that quality of life is measured and evaluated by the individual themselves; and secondly, that quality of life is a factor that must be considered at all stages of the disease because it is directly affected by the physical, psychological and social complexities of the disease.

A distinction must be made between quality of life and health status, which is exemplified by the divergent perspectives on the concept. Health status is characterized by a set of symptoms and indicators ascertained by a medical professional or disclosed by the patient. Conversely, quality of life encompasses a broader array of dimensions, including the physical, psychological, social, and economic aspects of the patient, in addition to their subjective evaluation of these dimensions. It is important to recognize that quality of life is the result of the individual's self-assessment, even if it does not accurately reflect reality.

According to Brousse and Boisaubert (2007), quality of life can be defined as the extent to which an illness can be quantified in terms of its impact on life or the satisfaction or dissatisfaction of the individual with their life. It can also be defined as 'the impact of diseases, treatments and health decisions on daily life by trying to approach it from the patient's point of view'. (p.459) The World Health Organization Quality of Life Group (WHOQOL) defines quality of life as an individual's perception of their place in life in the context of the culture and value system in which they live, and its relationship to their goals, expectations, standards and concerns. (Land et al., 2012, p.13) Consequently, the concept of quality of life in health has evolved to encompass the environmental dimension, and the majority of

research on health-related quality of life is predicated on this definition.

The definition of quality of life has evolved to place greater emphasis on the subjective aspect than the objective aspect, that is to say, quality of life is not merely an objective indicator, but rather the individual's perception and evaluation that imbues it with meaning. Despite the differences in the various definitions of quality of life, they share the commonality that this concept is complex and multidimensional. This is due to the interaction between an objective aspect, which is related to objective factors in an individual's life such as work, illness, housing and others, and a subjective aspect, which is related to the individual's perception of these factors. This dynamic interaction between objective and subjective factors contributes to the concept's instability over time, as the individual's environment and self-perception are in a constant state of flux. Consequently, the quality of life can be subject to change in accordance with the individual's standards or external environmental shifts. The World Health Organization's definition of quality of life is the most widely adopted.

5.2. Health-related quality of life

Health and quality of life are interrelated concepts. When looking at quality of life measures, the majority of them focus on evaluating health. This is also what patients believe; 42% of hypertensive patients, when asked what is the most important thing in their lives, answer that it is health. (St-Cyr, 1997) The concept of health-related quality of life and its domains has

emerged since the 1980s to include the aspects of quality of life that affect health, whether physical or psychological. At the individual level, this concept encompasses an individual's perception of physical and psychological health and the correlation between them, health risks and conditions, and functional status. At the community level, health-related quality of life encompasses resources, conditions, policies and practices that influence individuals' perception of their health and functional status. The concept of health-related quality of life has expanded the notion of health to encompass the physical and psychological needs of individuals (Centers for Disease Control and Prevention [CDC], 2000).

The concepts of quality of life and health-related quality of life are often used interchangeably. However, it is important to note that the assessment of quality of life is inherently linked to the field of health, as health influences other areas of life, and vice versa. This relationship can be exemplified by the influence of health on various aspects of life, including relationships, social activities, and daily living. economic aspect through treatment costs and the effects of the disease on the ability to carry out daily activities; in the social aspect through the impact of the latter on the relationships and social activities of the individual and his ability to maintain them in the case of an illness.

6.Study methodology

The study looks at how gender and age affect quality of life in patients with high blood pressure. It uses a descriptive-analytical approach, which means it focuses on describing and analyzing the phenomena being studied.

6.1. Study sample

The study sample consisted of 100 randomly selected patients between the ages of 25 and 91 who were diagnosed with hypertension, defined as a systolic blood pressure of 140 mmHg or higher and/or a diastolic blood pressure of 90 mmHg or higher.

The following tables show the distribution of cases according to the variables of the current study:

Table. 1 Distribution of the sample according to gender

Total	Gender		
	Female	Male	
100	76	24	
%100	%76	%24	Percentage

- Distribution of sample members according to age variable

Table .2 Distribution of the sample according to age

Age	Repetition	Percentile
20-40	11	%11
41-50	15	%15
51-60	26	%26
61-70	22	%22
Over 70	26	%26
Total	100	%100

6.2. Study tools

In this study, the abbreviated Quality of Life Scale(WHOQOL) Brief was used to assess the quality of life variable and the

following statistical techniques were used to confirm the study hypotheses

- T. Test
 - Standard deviations
 - Arithmetic means.
 - univariate analysis of variance
- (SPSS) programme to test the hypotheses.

7.Presentation and discussion of the results of the hypotheses

7.1. Presentation and discussion of the results of the first hypothesis

This hypothesis states that hypertensive patients have a low level of quality of life. In order to test this hypothesis, the K-squared goodness-of-fit test was used, where the quality of life scores were divided into three levels of low, medium and high, and the frequencies of each level were determined, as shown in table 3.

Table .3 Frequencies of Quality of Life Levels

	Low	Medium	High	Total
Number of individuals	7	65	28	100
Percentage	7.0%	65.0%	28.0%	%100

K-squared value is illustrated in table 4.

Table .4 the results of K-squared value

Levels	Frequencies	K-squared value	Degree of freedom	Probability value
Low	7	51.740	2	<0.001 .
Medium	65			
High	28			

As demonstrated in table 4, the result of K-squared (2) = 51.740, with a probability value of <0.001, indicates statistical significance. This finding suggests that the distribution of quality of life levels within the community is not uniform. The predominant level of quality of life for hypertensive patients is therefore deemed to be average, as it is the most prevalent among this sample. Consequently, the first hypothesis, which postulated a low quality of life for hypertensive patients, was refuted, indicating instead an average quality of life. These findings corroborate the conclusions of Sayel and Qalati (2021) and Shweil (2017).

Skaia and Nikolopov (2002), Ahsubraty et al. (2004), Mohammed et al. (2020), Al-Ghamdi (2002), Poljicanin et al. (2003) demonstrated that hypertensive patients exhibited a low quality of life score in comparison to healthy individuals (2004), a finding that aligns with the results reported by Al-Jabri et al. (2017). Zaatout's (2013) study revealed that patients suffering from chronic cancer exhibited a moderate to good quality of life, a finding that is consistent with the study conducted by Pacian and al. (2012). The results of the study demonstrated that,

despite the presence of hypertension in the sample, it did not exert a significant influence on their quality of life, with the majority of them rating it as moderate. This phenomenon can be attributed to the new definition of health and disease promulgated by the World Health Organization (WHO), which conceptualizes health not merely as the absence of disease or disability, but as a state of physical, psychological and social well-being, and its definition of quality of life, can be understood as the individual's perception of their place in life, within the cultural context and value system that is in place. This is in relation to their goals, expectations, standards and fears. Therefore, it can be concluded that quality of life is related to the individual's perception and evaluation of their life. These two definitions indicate that health and quality of life are two different concepts, although they are interrelated, and a distinction must be made between health status and quality of life, where we differentiate between the objective and subjective components of these two concepts. While health is a significant factor in assessing a person's quality of life, it is not the sole determinant. A person's quality of life is influenced by their personality, beliefs, aspirations, and goals, in the context of social, economic, and political data relevant to their environment. This subjective assessment varies among individuals, particularly in the presence of chronic conditions, such as hypertension. This is not necessarily indicative of a low quality of life in patients, as even in the absence of a chronic disease, an individual can assess his quality of life as poor or, conversely, the presence of the disease does not negatively affect the assessment of quality of life. This is due to the involvement of other factors, such as personality traits, emotions and their

regulation, social support, self-efficacy and health control centre, in the assessment of quality of life.

Nucci and Martins posit that quality of life is a multidimensional component which encompasses numerous facets of an individual's existence. It surpasses the concept of well-being or good health, even according to the definition of the World Health Organization, which conceptualizes health as a state of complete physical, psychological and social well-being. The researchers contend that the presence of a chronic and life-threatening illness has a discernible impact on quality of life, though the severity of this impact is contingent on numerous factors and can even influence the patient's own quality of life. The outcomes can be elucidated by invoking the notion of the disability paradox, which posits that individuals afflicted with chronic diseases or disabilities, even those that are life-threatening, can exhibit elevated levels of quality of life. This lends credence to the proposition that a distinction is made between health status and quality of life, with a differentiation between the objective and subjective components of these two concepts. (Zaatout, 2013)

The findings of this study can also be explained by the observation that hypertensive patients have attained a commendable degree of adaptation and management over their condition. This progression can be ascribed to the evolution of medical research and the emergence of pharmaceuticals capable of stabilising blood pressure, thus empowering patients to pursue a normal lifestyle without compromising their health, consequently leading to enhanced quality of life assessments.

7.2. Presentation and discussion of the results of the second hypothesis

This hypothesis states that there are differences in the quality of life of hypertensive patients due to the age variable. Individuals were divided into four groups according to age: the first group from 20 to 40 years, the second group from 41 to 60 years, the third group from 61 to 70 years, and the fourth group above 70 years. The arithmetic means and standard deviations were calculated for each group, as illustrated in table 5.

Table .5 Arithmetic means and standard deviations of group scores

	Number	Arithmetic Mean	Mean standard error	Standard Deviation
Group1	11	93.27	4.779	15.850
Group2	41	85.68	2.726	17.458
Group3	22	79.18	2.587	12.133
Group4	26	79.73	2.231	11.376
Total	100	83.54	1.526	15.260

As demonstrated in table 5, the arithmetic means of the four groups are relatively proximate. The results of the univariate analysis of variance are presented in table 6.

Table .6 The results of univariate analysis of variance

Source of variance	Total score	Degree of freedom	Mean squares	F-value	Probability value
Between groups	2025.392	3	675.131	3.082	0.031
Within Groups	21029.448	96	219.057		
Total	23054.840	99			

As demonstrated in table 6, the F value is statistically significant ($F(3,96) = 3.082$, $p\text{-value} = 0.031$), thereby indicating that the observed discrepancy in the arithmetic means of the four groups in terms of quality of life scores is genuine and not attributable to random. To ascertain the statistically significant differences between two groups, dimensional comparisons were conducted, as illustrated in table 7.

Table .7 Results of dimensional comparisons

Groups	Mean differences	Standard error	probability value	Statistical significance
group I and II	7.590	5.026	0.134	not significant
Group I and III	14.091	5.465	0.011	Significant
Group I and IV	13.542	5.323	0.013	Significant
group	6.501	3.912	0.100	not

II and III				significant
groupII and IV	5.952	3.711	0.112	not significant
group III and IV	-0.549	4.287	0.898	not significant

As demonstrated in table 7, the discrepancy between the means of the first and third groups, and the means of the first and fourth groups, is statistically significant. This indicates that the observed difference is not merely a chance occurrence, but rather a genuine phenomenon. Consequently, the second hypothesis is substantiated, suggesting that there are disparities in the quality of life of hypertensive patients attributable to age. Individuals aged between 20 and 40 years have a higher level of quality of life compared to individuals aged between 61 and 70 years, and individuals aged over 70 years. The findings of this study contradict the results reported by Abdelhamid Said (2007), who found that the elderly reported a higher quality of life in the psychological and environmental domains than adults and young people. The results also contradict the findings of Bat (2007), Eldelman et al. (2002) and Badr Al- Maarif (2001), who found no differences in quality of life due to age.

The findings can be elucidated by considering the nature of the condition. The majority of individuals within the 20-40 age group have been ill for less than five years. Consequently, the impact of the condition on their lifestyle is minimal. Furthermore, the disease does not significantly impact the daily

lives of these individuals, particularly given that hypertension does not manifest with pain or symptoms that hinder their routine activities. This is due to the fact that hypertension does not cause a substantial disruption in the organization of life for individuals in its early stages. The treatment of hypertension often involves medication, diet and exercise, which differs significantly from the treatment of other diseases, such as cancer, where the treatment itself is arduous. Furthermore, hypertension does not directly threaten the life expectancy of patients, which is why having high blood pressure does not affect their assessment of their quality of life. However, Individuals over the age of 61 years have typically been affected for more than 10 years, and most cases involve complications of hypertension, such as heart disease and comorbidities, including diabetes and high cholesterol. These conditions can hinder their ability to perform daily activities. In addition to the symptoms associated with the ageing process, these factors can have a detrimental effect on their quality of life when compared to the 20-40 age group.

This is what Taylor (2008) presented in what she calls the achievement self and the private self, which are important in self-esteem and self-concept. These factors are important in dealing with chronic illness, as the achievement self at the professional and vocational level is the basis from which many people derive their satisfaction from their work and activities, while others derive it from their hobbies and recreational activities. The greater the threat posed by chronic illness to these significant aspects of an individual's life, the more profound the negative impact on the self and its concept. Conversely, when

patients' work or hobbies remain unaffected, the fundamental sources of fulfilment in their lives persist. The patient's own self is also affected by chronic illness, as it may generate the need to rely on others and thus reduce the patient's level of independence, and the burdens on others represent a threat to the self. Since quality of life is a multifaceted concept that is explained by psychological and social factors in addition to several other factors, the low level of autonomy, self-esteem and self-concept will affect the patients' quality of life.

7.3. Presentation and discussion of the results of the third hypothesis,

It states that there are differences in the quality of life of hypertensive patients due to the gender variable. In order to test this hypothesis, it will be necessary to use two independent samples t-test, after verifying its most important assumptions.

The t-test for two independent heterogeneous samples will be used to compare the mean scores of females and males. This will be illustrated by table 8, which shows the arithmetic mean and standard deviation of the two groups.

Table .8 Results of arithmetic mean and standard deviation

Group	Number of individuals	arithmetic mean	standard deviation
Male	24	88.83	8.943
Female	76	81.87	16.464

As demonstrated in table 8, the mean score for males in terms of quality of life exceeds that of females. The results of the t-test are presented below in table 9.

Table .9 T-test for the difference between the mean scores of the two groups

limits confidence 95% for the differences		Standa rd error	means differen ce	Probabili ty value	Degre e of freedo m	T- test
Uppe r	Low er					
12.20 0	1.73 0	2.627	6.965	0.010	72.957	2.65 2

As demonstrated in table 9, the t-test value is statistically significant ($t(72.957) = 2.652, p = 0.010$), thereby substantiating the authenticity of the observed discrepancy in mean scores between the two groups, which cannot be attributed to mere chance. Consequently, the third hypothesis, namely the existence of gender-based disparities in quality of life among the sample members, is substantiated.

These outcomes are consistent with the findings of Grassi (2005), who identified gender disparities in quality of life, with males reporting higher satisfaction in the psychological, physical, independence, and environmental domains compared to females. Bat (2007) also observed gender differences in quality of life, with males demonstrating higher satisfaction in the physical domain and independence. This finding is corroborated

by Magiley (2012), who discovered gender disparities in favour of males in the quality of social relationships and independence, and in favour of females in the psychological and environmental domain among blood pressure patients. Nelson (2002) identified gender disparities in quality of life, with males demonstrating superiority in the domains of social relations and independence, and females exhibiting superiority in the psychological and environmental domains among blood pressure patients. In contrast, Nelson (2002) observed that females exhibited lower quality of life in the physical, psychological, and environmental domains, in contrast to males who demonstrated an enhancement in independence and social relations. Conversely, studies by Kendy (2002), Yousef Al-Habash (2003), Ahsubraty et al. (2004), Ismail (2008), and Sayel and Galati (2021) reported no significant differences between males and females in quality of life.

Society is defined as a culturally, socially, economically, politically, and religiously distinctive structure, whose members face pressures and life events, and are subject to the values and standards of this society. Therefore, the assessment of quality of life is a subjective evaluation of all these aspects of life. According to D. Good (1994), quality of life is the product of interactions. He defined it as the degree to which the individual enjoys his important possibilities in his life, or in other words, the extent to which the individual sees his life as good. This is further defined as the degree to which an individual considers his life to be satisfactory. It is further asserted by Good (1994) that the concept of quality of life reflects the desirable life situations of the individual in three main areas: family and social life, profession or work and health. This judgement is dependent on

the individual's self-perception, objective life situations, and the perception of others who are important to the individual (Shuweil,2017).

We can hypothesize that the disparity in quality of life between males and females is attributable to the social upbringing within Algerian society, which inculcates behaviors such as assertiveness and independence in males, while females are often subject to guardianship, resulting in restrictions imposed by a set of prohibitions and taboos stemming from traditions, religious beliefs, and historical contexts. Education in this society is characterized by the differentiation of roles and status assigned to males and females, resulting in a divergence of pressures and events experienced by the two genders. Women face greater pressures and challenges than men, in addition to the fact that both genders deal with hypertension and the changes it brings to their lives. Furthermore, women are assigned numerous social roles that may not align with their personal aspirations. Consequently, it can be posited that the social and cultural milieu has imposed constraints on women that occasionally impede their ability to express their concerns. In contrast, men enjoy a greater degree of autonomy and are less encumbered by societal restrictions, enabling them to more effectively address and resolve challenges and maintain a more positive outlook on life.

We can add to this the results of The Longitudinal Study on Women's Health (Women's Health Australia) and other large-scale social surveys indicate that women's objective conditions of life continue to be perceived as inferior to those of men (job opportunities, access to power and decision-making, leisure time, competing roles). Some quality of life measurements,

particularly those that assess both objective conditions and subjective perceptions, reveal that women's quality of life is lower than that of men (Land et al., 2012). In this study, we have used the WHOQOL-Bief, a scale that measures both the objective and subjective dimensions of quality of life.

4. CONCLUSION

Medicine has made significant strides in combating infectious diseases such as plague, typhoid fever and tuberculosis. However, the late 20th century witnessed a paradigm shift as chronic diseases emerged as a predominant health concern. This change in the epidemiological landscape necessitated a paradigm shift in healthcare delivery, with medical care now focusing on addressing the needs of individuals living with chronic conditions. Historically, the primary objective of medical care was to treat and cure diseases. However, the emergence of chronic diseases has led to a shift in this goal, as these conditions do not pose an immediate threat to life. The advent of chronic diseases has prompted a shift in medical policies, with greater emphasis being placed on the quality of life of the individual patient. This paradigm shift underscores the significance of quality of life research, as it encompasses not only the quantity of life span but also the quality of life experienced. Chronic diseases are distinguished by their protracted progression and their physical, psychological and social complexities. Moreover, the treatments that patients undergo can exert significant effects on their daily lives. The enhancement of the quality of life for individuals afflicted with chronic ailments has emerged as a pivotal objective in the realm of healthcare policy. Consequently, research in this domain is of paramount importance, as it facilitates a comprehensive

understanding of the factors that influence quality of life. This understanding, in turn, paves the way for the development of effective interventions aimed at enhancing the quality of life, benefiting both the general population and individuals grappling with chronic conditions.

5. Bibliography List :

العجوري احمد حسين إبراهيم. (2013). *الذكاء الاجتماعي وعلاقته بجودة الحياة لدى المعلمين والمعلمات بمحافظة شمال غزة* [رسالة ماجستير غير منشورة]. جامعة الأزهر

تايلور، شيلي. (2008). *علم النفس الصحي* [وسام دريك درويش وفوزي شاكرا طعيمة داود، مترجم] (الطبعة الاولى)، دار الحامد.

زعطوط، رمضان. (2013). *نوعية الحياة لدى المرضى المزمنين وعلاقتها ببعض المتغيرات* [رسالة دكتوراه غير منشورة]. جامعة قاصدي مرباح.

سائل حدة وحيدة ، وقلاتي لمياء. (2021). *نوعية الحياة المرتبطة بالصحة لدى مرضى القلب والأوعية. دراسات نفسية 12* (1)، 8-29.

شويعل، يزيد. (2017). *العلاقة بين الأنماط السلوكية وأساليب التعامل مع الضغط النفسي ونوعية الحياة لدى المرضى المزمنين* [رسالة دكتوراه غير منشورة]. جامعة الجزائر 2 أبو القاسم سعد الله.

Agence nationale de l'évaluation et de la qualité des établissements et services sociaux et médicaux-sociaux (Anesm). (2012, Novembre). *Qualité de vie en Ehpad (volet 4) -L'accompagnement personnalisé de la santé du résident*. <http://www.anesm.sante.gouv.fr/>

Baumann, C., & Briançon, S. (2010, septembre). *Maladie chronique et qualité de vie : enjeux, définition et mesure*. *Adsp* (72), 19-21.



- Brousse, C., & Boisaubert, B. (2007, juillet). La qualité de vie et ses mesures. *La revue de médecine interne*, 28 (7), 458-462. Doi : 10. 1016/j .revmed .2007 .02.010
- Centers for Disease Control and Prevention. (2000, November). *Measuring Healthy Days*. CDC.
- Ferron, M. (2011). *La relation entre qualité de vie et santé : une question épistémologique*. [Thèse de maîtrise non publié]. Université de Montréal.
- Gagne, M-E. (2010). *Signification et déterminants de la qualité de vie selon la personne atteinte de cancer suivie en ergothérapie et selon son réseau évoluant en soins palliatifs* [thèse de maîtrise non publié]. Université Laval.
- Land, C. K., Michalos, A.C., & Sirgy, M. J. (2012). *Handbook of Social Indicators and Quality of Life Research*. Springer. DOI 10.1007/978-94-007-2421-1
- Martine Gayral-Taminh, C. Bravi, M. Depond, F. Pourre, T. Maffre, J-P. R., & Grandjean, H. (2005, janvier). Auto-évaluation de la qualité de vie d'enfants de 6 à 12 ans : analyse du concept et élaboration d'un outil prototype. *Santé Publique*, 17, 35-45. DOI 10.3917/ spub.051.0035
- Rotonda, C. (2011). *Qualité de vie et fatigue en cancérologie : cancer colorectal et cancer du sein* [thèse de doctorat non publié]. Université Henri Poincare - Nancy1.
- Sadal'skaia, E.V., & Enikolopov, S.N. (2002). Psychological Aspects of Quality - of-Life Assessment in Patients with a Psychosomatic Disorder. *International Journal of Mental Health* , 31(2), 77-89.
- St-Cyr, L. (1997). *Le concept de la qualité de vie chez les personnes atteintes de sclérose latérale amyotrophique : étude phénoménologique* [thèse de maîtrise non publié]. Université de Sherbrooke.