University of Kerbala/College of Nursing

Impact of Anxiety and Depression Illnesses Upon Quality of Life of Patients in Holy Kerbala City

A Thesis submitted

By

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To the Council College of Nursing/University of Kerbala, in Partial Fulfillment of the Requirements for the Master degree of Sciences in Nursing

Supervised

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{وقل رب زدني علما}

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Supervisor Certification

I certify that this thesis, which entitled (**Impact of Anxiety and Depression Illnesses Upon Quality of Life of Patients in Holy Kerbala City**), submitted by **Ali Sabry Naser**, was prepared under our supervision at the college of nursing, university of kerbala in partial fulfillment of the requirements for the degree of master in nursing sciences.

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Dedication

I dedicate my effort and work to:

Allah *who inspired me with knowledge and the ability to work*

The sun and moon in my life ***my father*** *and* ***my mother*** *with respect*

My brother and sisters.

the lady who looks like all the beauty of the planet with my love... ***My wife.***

My dear friends, with my love and respect.

Ali Sabry 2022

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Table of Abbreviations and Acronyms

Items	**Meaning**
AIDS	Acquired Immune Deficiency Syndrome
BDI	Beck Depression Inventory
BDI-1A	Beck Depression Inventory-1A
BDI-II	Beck Depression Inventory-Second Edition

DSM-5	The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
GABA	Gamma-aminobutyric acid
GAD	The Generalized Anxiety Disorder
HADS	Hospital Anxiety and Depression Scale
HADS-A	Hospital Anxiety and Depression Scale-A
HRQOL	Health-Related Quality Of Life
ICD-10	International Classification Of Diseases
KDQOL	Kidney Diseases Quality Of Life
LS	Lifestyles Satisfaction
MADD	Mixed Anxiety Depressive Disorder
MCS	Mental Health Component Score
MDD	Major Depressive Disorder
MVQOLI	Missoula-VITAS Quality of Life Index Scale
OCD	Obsessive-Compulsive Disorder
PCS	Post-Concussive Symptom
PDQ-39	Parkinson's Disease Quality of Life Measure
PHQ-9	Patient Health Questionnaire
PMDD	Premenstrual Dysphoric Disorder
PTSD	Post-Traumatic Stress Disorder
QOL	Quality of Life
SAD	Social Anxiety Disorder
SF-12	Short Form Health Survey (Sf-12)
SF-36	Short-Form Health Survey Questionnaire (Sf-36)
SPSS	Statistical Package for the Social Sciences
USA	United States of America
USD	United States Dollar

WB	Well-Being
WHO	World Health Organization
WHOQOL-Brief	Quality of Life Scale Developed Through the World Health Organization
ZAS	Zung Anxiety Scale
ZDS	Zung Depression Scale

Abstract

Quality of Life is a concept that is considered broad multidimensional which have subjective evaluations of all life aspects positively and negatively. This study was done to understand the impact of anxiety and depression Illnesses up on quality of life of patients in holy kerbala city. This study was conducted for the purpose of comparing anxiety and depression and their impact on quality of life of such patients.

Quantitative considered, the study was completed with 104 patients, two groups 52 patients with anxiety disorder, 52 patients with depression disorder to find out the impact of anxiety and depression Illnesses up on the quality of life of psychiatric patients. The study was done in Al-Hassan Al-Mujtaba Teaching Hospital at kerbala city, Iraq, from 5 December 2021 to 30 September 2022. This study uses three scales; Taylor for anxiety, Beck Depression Inventory BDI-II, and World Health Organization Quality-of-Life Scale-Brief the Reliability was sequentially 0.837, 0.747, 0.812. Also the instruments are valid; it was forwarded to 11 experts in various specializations and from several colleges in Iraq.

The results showed unacceptable level of quality of life for anxiety group which was 44.04 and for depression group was 35.47. Anxiety and depression groups have a negative impact on quality of life, and there is a difference in quality of life for the two groups according to their demographic characteristics. The study concludes that anxiety, depression and quality of life are affected by demographic factors, and this effect varies according to the disorder.

The study recommended to find out effective solutions to reduce anxiety and depression in patients to improve the quality of life, such as activating the new technology for communication and following up the patients, and also activate the group therapy

Chapter one

Introduction

Chapter One

1.1. Introduction

The definition of anxiety is not clear in previous reviews although the descriptive properties are very restrictive and easy to identify. But the American Psychiatric Association defined anxiety as the expectation of danger or future passive events along with some other symptoms such as dysphonia or physical symptoms of stress. These elements that expose the person to anxiety may be internal or external, as stated in the definition of the Italian Treaty of Psychiatry that anxiety is an emotional situation with a hateful content linked with a state of anxiety and fear that arises within the absence of actual hazard and is disproportionate to the thrilling stimuli (Perrotta, 2019).

Depression is an "emotional mental disorder that is characterized by certain symptoms such as despair and sorrow". In addition, many people with depression suffer from clear physical symptoms, like sleep disturbance, fatigue, and loss of appetite. Depression increases with increased age, but despite this, statistics found that 15% of children have depressive symptoms and that 3% to 5% of them have severe depression symptoms (Guo & Jen, 2019).

According to WHO, globally the depression is the 3^{rd} major disability reason and its most common is in the elderly as well as the oldest individuals who have been inserted into hospitals with diseases or administrative or physical performance. Moreover, depression is closely related to the dangerous increase in death. This means that depression increases health care cost and increases spending towards promotion of health (Sivertsen et al., 2015).

From the quality of life and from their integrative theory and the questions derived from it the philosophy of life seeks to find the level of QOL. The Integrative Global QOL Theory is an overarching theory or metatheory that encompasses 8 other realistic theories in an objective-existential

subjective spectrum. Other philosophies of life may emphasize another side of life, but with this idea of bringing such existential depth into health and social sciences, This study believes that it taken an essential step closer to a brand new humility and a brand new recognize for the richness and complexity of life (Ventegodt et al., 2003a).

In the 1962 Abraham Maslow established the quality of life theory. According to Maslow the good life is fulfillment of needs. Maslow's view was that happiness, health, and the ability to work come when an individual takes responsibility for his or her all own needs. It is easy, but its difficulty lies in the fact that the individual needs to know himself well to understand his true needs to carry out them. (Ventegodt et al., 2003b).

The WHO defines QOL as "individuals' perception of their position in life in the context of the culture and value system in which they live and in relation to their goals, expectations, standards, and concerns". More specifically, Health-related quality of life can be considered a validated indicator of disease burden. It is an important outcome of mental illness because it describes a multidimensional and subjective concept that includes physical, functional, social, and well-being (Hofer et al., 2017).

The quality of life concept depends on the definition provided by the WHO with regard to health, that is, not only the diseases absence, but the ideal social, mental and physical well-being. The responsibility to provide a high level of well-being is a shared responsibility, including society and government. In general, the quality of life globally has decreased due to the spread of epidemics and some demographic changes that led to some changes in health standards (Siboni et al., 2019).

Quality of life refers to subjective well-being, perceptions of social relationships, life satisfaction, physical health and carrying out daily activities, economic status, perceptions of mental and physical health, social and family relationships, and finally, functioning at work and at home. The quality of life has great difference in the same person at two different times or

between two different persons because it depends on the perceptions of the individual. Regulatory agencies may not place much value on the measures of quality of life because they are not primary outcome measures in clinical trials (Hofmann et al., 2017).

1.2. Problem Statement:

In psychiatric disorders quality of life is one of the most important indicators of outcomes for health in addition to recovery from symptoms of mental disorders, so there is a consensus that objective assessments should be integrated and that assessment of quality of life should be the gold standard (Cohen et al., 2017).

In the field of mental and psychological health, QOL as a concept was of little interest and slow to develop, and there was little reported work on the of quality of life and its affect by mental disorders and their treatment. until soon, features of the mental state such as severity of symptom were used as the major clinical outcome indicators for mental disorders. examining quality of life issues provides a more comprehensive view to find out the impact of mental illness on the patient's life, in contrast to the previous narrow view that neglected QOL (Jonsson et al., 2017).

The term quality of life originated in the beginning with sociology, but the matter evolved to include health and become a global indicator of the welfare of the individual and part of its therapeutic progress through the view of the people in the positive and negative aspects of life, where the World Health Organization began to pay attention to this matter in addition to many other international organizations (Irtelli & Durbano, 2020).

Mental disorders and quality of life relationship can appear as opposing phenomena and largely represent all aspects of well-being, both negative and positive. Poor quality of life is seen as a result of psychological disorder, and sometimes poor quality of life is a precursor to mental disorders, whatever the nature of the mutual relationship between them. There has

been a few number of research or theoretical interest to understand the relationship between mental disorders and quality of life (Boralingaiah et al., 2021).

Depression has long been associated with a lower QOL in adults with mental disorders. However, the effect of anxiety has rarely been explored if it impacts on quality of life or compared between the two disorders. Psychological disorders (anxiety, depression) often lead to poor functional and social life and other physical symptoms. Anxiety and depression impact different aspects of quality of life across age groups (Sarma & Byrne, 2014).

From the researcher's point of view, the QOL for patients with anxiety and depression with these two disorders is much worse than the quality of life for healthy people. It was found that there have been fewer studies dealing with psychiatric patients with these two disorders, and there is few information about the impact of anxiety upon QOL for mental health patients in our society. Therefore, the aim of the current study is to find out the impact of anxiety and depression on quality of life and compare them. so finding appropriate solutions and appropriate managements would improve the QOL if applied.

1.3. Important of study:

The importance of this topic lies in the following: According to (WHO) the health definition is “A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (Hinkle & Cheever, 2018). This study assumes decrease quality of life (QOL) level in severe mental illnesses patients, so the Awareness of the subject in research of psychiatric specialty is rising as increase using quality of life in research as a patient-related outcome, to identity the impact of factors influencing QOL have special interest in these patients (Berghöfer et al., 2020).

According to evidence the poor quality of life is associated anxiety and emotional disorder, Also, bodily functions are affected, such as the quality of life. The previous Studies comparing quality of life dysfunctions for

major depressive disorder and anxiety disorders have produced equivocal results. For major depressive disorder, many studies report a higher deterioration in quality of life. while others report comparable quality of life deficits for anxiety disorders. So the current study will be comparative between the impact of the anxiety and the impact of depression (Hyman Rapaport et al., 2005).

In the past 30 years, Healthcare has paid great attention to the quality of life assessment. Research on quality of life has increased in terms of methodological rigor and sophistication. However, progress has lost the fact that quality of life can be used to a variety of different things, like health status, physical functioning, symptoms, psychosocial modification, well-being, life satisfaction, and happiness. The urgent need to study the quality of life, and the factor that has an effect on it so the quality of life is an important topic (Ferrans et al., 2005).

1.4. Objectives:

1. Assessing the anxiety and depressions levels among anxiety and depression patients.
2. Assessing the level of quality of life of anxiety and depression patients.
3. Identifying the impact of anxiety and depression Upon patients' quality of life.
4. Finding out the difference in the level of quality of life of anxiety and depression patients with regard to their demographic characteristics of educational level, age, economic status, gender, and marital status.

1.5. Research Question:

Is quality of life of psychiatric patients affected negatively by anxiety and depression illnesses?

1.6. Hypotheses:

1.6.1. Null Hypothesis (H0): There is no impact for anxiety and depression illnesses upon quality of life of psychiatric patients.

1.6.2. Alternative Hypothesis (H1): Anxiety and depression have a significant negative impact upon quality of life of psychiatric patients.

1.7. Definition of the Terms:

1.7.1. Anxiety

1.7.1.a. Theoretical Definition:

Anxiety is an indistinct feeling of dread or apprehension; it's miles a reaction to outside or inner stimuli that could have behavioral, emotional, cognitive, and bodily symptoms (Videbeck, 2020).

1.7.1.b. Operational Definition:

It is unusual, uncomfortable feelings or overstated fear as measured by the Taylor scale. It affects the quality of life of psychiatric patients, and is divided into several levels and has several types.

1.7.2. Depression:

1.7.2.a. Theoretical Definition:

Depression is an emotional disorder characterized by low mood, lack of interest and pleasure, and there is a group of emotional and physical problems caused by depression, which reduces the ability to work and perform household duties for the individual (Guo & Jen, 2019).

1.7.2.b. Operational Definition:

Depression is a mood or emotional state that is characterized by psychological disturbance and can measure by Beck Depression Inventory (BDI-II) and it is classified into several levels based on the mentioned scale; it is used to find the most common depression level and its impact on the QOL.

1.7.3. Quality of Life:

1.7.3.a. Theoretical Definition:

Quality of life (QOL) is a broad, multidimensional construct defined by the (WHO) Group as the subjective perception of one's life and well-being, assessing both positive and negative dimensions of functioning (Adams et al., 2020)

1. 7.3.b. Operational Definition:

It is the measure of all the aspects of life functioning (Social, physical, Psychological, Environment) in psychiatric patients in holy kerbala city by using the WHOQOF-Brief scale.

Chapter two Review of Literature

Chapter two Review of Literature

2.1. Quality of life:

The quality of life concept is very important and remarkable today and its definition is surely complex; as a matter of fact, it has advanced through the years and end up a more and more articulated idea (i.e., It is determined by the perception of each individual's health in all aspects emotional, physical and psychological aspects, how independent and what is the degree of independence., via way of means of social relations, and via the way of interaction with one's context (Irtelli & Durbano, 2020).

Quality of life (QOL) has emerged as a crucial endpoint in lots of research of scientific and surgical interventions. When first developed, QOL measures have been maximum normally utilized in research of persistent illnesses with excessive mortality rates, along with most cancers and AIDS. More recently, the quality of life has expanded to include non-fatal medical cases and mental disorders (Smith & Larson, 2003).

The concept of quality of life (QOL) is multidimensional and multilevel idea. The QOL idea is frequently divided into 3 levels, in which international QOL is at the top hierarchy, followed by generic health-related QOL (HRQOL) at the following level, and at lowest hierarchy is the disease-specific health quality of life Global QOL can also additionally encompass lifestyles satisfaction (LS) and covers emotions of well-being (WB) and different elements consisting of financial situation, health, social and/or spiritual aspects of life. Generic HQOL generally consists of domain such as physical aspect, psychological aspect, social aspect, and environmental evaluations of life, with both positively and negatively (Sivertsen et al., 2015).

The first existence idea of quality of life is born at Nineteen Seventies in the social sciences and shortly it arrived with inside the medical and health fields, wherein this perception has been taken into consideration as a

criterion to assess fitness interventions. The World Health Organization defines quality of life "as the subjective perception that individuals have of their life position, in their cultural context and value system, when it comes to their objectives, expectations, standards, and worries". It is a completely complicated and articulated conception (Irtelli & Durbano, 2020).

2.1.1. Theoretical framework:

A quality-of-life (QOL) theory advanced by Abraham Maslow's from human development and their concept and its angles. Developed societies contain contributors who're commonly preoccupied in enjoyable better-order needs (social, esteem, and self-actualization needs), it's said, while less-advanced societies contain contributors who're commonly preoccupied in the lower-order needs (organic and safety or Security and associated needs). QOL is describe in phrases of the hierarchical that need to achieve the satisfaction level all maximum of the contributors of a given society. The quality of life increased in any society who achieved a high level of the satisfaction (Sirgy, 1986).

In 1962, Abraham Maslow posted his e-e book Towards a Psychology of Being, and created a term quality of life, which nonetheless is taken into consideration a regular principle of pleasant of life. Maslow primarily based totally his principle for improvement toward happiness and true being at the idea of human needs. He defined his method as an existentialistic psychology of self-actualization, primarily based totally on human being growth (Ventegodt et al., 2003b).

2.1.2. Quality of life domains:

Many studies have investigated the domains of quality of life that are of high importance for adults and the results determined the domains of quality of life according to health, sensory abilities, daily activities, living environment, social and financial status, family, energy. There is a wide range of quality of life domains and no particular order of importance (Henchoz et al., 2015).

2.2. Anxiety:

Anxiety is "a vague feeling of dread or apprehension"; it is a response to outside or inside stimuli that can have various symptoms behavioral, emotional, cognitive, and physical. It can differentiate between anxiety and fear, that is feeling afraid or threatened by a clearly identifiable outside stimulus that represents danger to the person. Anxiety disorders include a set of situations that percentage a key characteristic of immoderate tension with resulting behavioral, emotional, cognitive, and physiological responses (Videbeck, 2020).

For all ages the highest prevalence mental disorders since 2005 to the day is anxiety disorders. The anxiety rate increased about 14.9% as a result of growth of population. The people with anxiety disorders are estimated in the world about 264 million. The represents a percentage 3.6% from the total world population. The rate of prevalence does not vary greatly between age groups, but like depression the anxiety has higher prevalence in women than in men, this percentage is estimated to be about 2 percent more than men. (Depression and Other Common Mental Disorders Global Health Estimates, 2017) .Globally, as a result of increasing the population and the factors that contribute to anxiety, such as epidemics. This rate increased before the epidemic; the number of people suffering from anxiety disorders was about 298 million, but after Covid 19, there was a noticeable increase in the number of patients, as the total number of patients reached 374 million, with an increase of 25% globally. The increase was about double for females, with a total of 51.8 million, while the increase for males is 27.4 million (Santomauro et al., 2021).

Anxiety is one of the most common mental health problems that young people suffer from, and even mild anxiety may reduce social, emotional and cognitive development in adulthood. Therefore, anxiety must be treated very effectively to get rid of the problems caused by it, but many young people do not seek psychological treatment for several reasons, so

their health condition worsens and their social relationships weaken, as well as a lack of self-esteem (Rickwood & Bradford, 2012).

2.2.1. levels of Anxiety:

According to degree and duration of disorder the anxiety has two aspects healthy and harmful. There are four anxiety levels: From highest anxiety to least panic, severe, moderate, mild. Each level causes both physiological and emotional changes for the person, and these levels are different from positive to negative motivation according to degree of anxiety. The level of anxiety, has positive motivation when the anxiety is less, and vice versa, the higher level of the anxiety, has negative motivation (Videbeck, 2020).

Mild anxiety is related to stress in response to everyday events and is rarely a problem for the individual. On the contrary, it pushes people to work, increases productivity, increases the cognitive field, in addition to increasing awareness of the environment and through it the individual is able to work at his optimum level, at mild anxiety level people employ a number of coping behaviors that by which received their comfort from these mechanisms the following: Sleeping, Cursing, Pacing, Eating, Foot swinging, Finger tapping, Daydreaming, Fidgeting, Smoking, Talking to someone, Crying (Townsend, 2015).

Moderate anxiety is the unpleasant feeling that something is definitely wrong. So the person becomes nervous and restless, but in this case the anxious person is still able to diagnose and solve problems and learn new things with the help of others. The patient finds it difficult to focus, but help can be directed to refocus on the topic. there is some sign and symptoms for moderate anxiety muscle tension, Diaphoresis, Pounding pulse, Headache, Dry mouth, High voice pitch, Faster rate of speech, GI upset, and Frequent urination (Videbeck, 2020).

Severe anxiety is characterized by a decrease in the perceptual field of a person who has severe anxiety to the extent that the focus is centered on one particular thing or only on external details. Also, the attention span is limited and people with this disorder face great difficulty even in completing the simplest tasks. For severe anxiety disorder many of the symptoms, include headaches, dizziness, nausea, trembling, insomnia, palpitations, tachycardia, hyperventilation, urinary frequency, and diarrhea. and that the great feeling of discomfort leads to targeting all public behaviors (Townsend, 2015).

Panic anxiety is the fourth and highest level of anxiety and is characterized by the fact that the person does not realize the potential harm and does not have the ability to think rationally, the safety of the person is the main concern here. So the nurse must continue to talk to the person in a comfortable way even though he or she cannot process what you are saying. Going in places that are comfortable and not stimulating may help reduce anxiety. An anxiety attack may last from 5-30 minutes; its risk is that it can lead to suicide, so calm and control are essential if the nurse is working with someone who has this disorder (Videbeck, 2020).

2.2.2. Types of anxiety:

In line with the International Classification of Diseases (ICD-10) the anxiety disorders, as categorized in the phobic disorders, including agoraphobia with or without panic disorder, social phobia, and the specific phobias, as well as other anxiety disorders, including panic disorder, generalized anxiety disorder, and mixed anxiety and depression. according to Diagnostic and Statistical Manual of Mental Disorders (DSM-5), separation anxiety disorder and selective mutism are newly classified as anxiety disorders, in the past these illnesses considered were restricted to child- hood and adolescence, but now it is applicable to the adulthood (Ströhle et al., 2018).

2.2.2.1. The phobic disorders:

Phobias are immoderate anxiety approximately being in public or open places (agoraphobia), a particular object, or social situations (Videbeck, 2020). According to many studies, phobias are the more common anxiety disorders among older people; the past studies considered according to the data phobias as less common than general anxiety disorder. The latest studies report that the phobias are maximum; the most common disorder among the elderly is anxiety, and the latest studies indicate that the prevalence of anxiety is 21% of the elderly and that 11% of them suffer from phobias, in contrast, 10.8% is the percentage of general anxiety (Pachana et al., 2007).

2.2.2.1.a. Social phobia:

Additionally, recognized social anxiety disorder SAD consists of a spectrum of phenomena that can vary from shyness to social isolation fears which may decrease or increase as much as the clinically applicable diagnostic prototype of SAD. every now and then additionally extending to avoidant or anxious personality disorder. Social fears can also additionally arise in one or two conditions; however, they will also be greater pervasive in a much wider variety of conditions. They encompass overall performance fears consisting of worry of public speaking or speaking in the front of others or taking checks and fears of being found with the aid of using others whilst writing in public, reading aloud, or ingesting and/or drinking in public (Creswell & Sasagawa, 2015).

2.2.2.1.b. Specific phobias:

Specific phobias have a subcategory and have not been well studied. Phobias consist of avoidance and fear. These phobias are fundamental because of their early onset and strong persistence over time. Studies imply the lifetime prevalence rate of specific phobias worldwide about 3% to 15%, fears and phobias regarding heights and animals being the most common; the peaks of Phobias during the midlife and old age, although it starts in

childhood. Phobias may persist for many years or even decades (Eaton et al., 2018).

A specific phobia is an unreasonable fear associated with a person, thing, or situation, and the continued avoidance of that situation or thing for a long period of time that may last for months or years. Having a condition that a person recognizes his or her phobia is unreasonable, but having insight is important. Phobias are diagnosed through short questions related to symptoms. The questions are a series in which the first question is about the fear itself, and then the duration and accompanying events, as well as your visits to the psychiatrist or taking medications (Eaton et al., 2018).

Phobias may appear at any age, and those that start in childhood often end without any treatment, but those who have a phobia begin in adulthood or continue into adulthood, those need help. Phobias are less common in men than in women. People rarely seek treatment for this disorder, despite its prevalence, unless it interferes with the ability to work. Specific phobias are classified according to the trigger of the phobia and include about 27 types, but this number is not comprehensive, from this type (Acrophobia, Ailurophobia, Algophobia, Anthophobia, Anthropophobia, Aquaphobia) (Townsend, 2015).

2.2.2.2. Panic disorder:

The first appearance of panic disorder was in the year 1980, and as a diagnostic entity, it has gained scientific, clinical and public health interest. Panic definition appear in the form of repeated, unexpected and uncontrollable attacks to situations that are natural or can be mildly stressful, in addition to the development of avoidance of phobias, which mean changing the general behavior for the purpose of avoiding things that cause panic (Chen & Tsai, 2016).

Anxiety occurs as a result of the restrictions that we impose on ourselves in any form of fear. As a result of long-term anxiety, a panic attack is formed or produced; the main symptoms for panic attack are mentioned

by DSM-5 it Include tachycardia, dyspnea, sweating, chest pain, abdominal discomfort, unstable, body chills or hot, going crazy or fear of loss control, afraid from dying and a lot of other symptoms. a distinction must be made between real panic and recurrent, stimulated and unexplained panic attacks, at least it was preceded by a long period of anxiety (Perrotta, 2019).

Despite the prevalence of panic disorder among the population, clinical therapeutic practices are still less than what is imagined. In dealing with panic, it is necessary to focus on the fact that panic is a relapsing or chronic disorder. It must be remembered that a third of patients are resistant to treatment, so antidepressant treatments and cognitive behavioral therapy must be combined if there is resistance to treatment. The diagnosis of panic was built an two domains, unexpected panic attacks presented by different autonomic and somatic symptoms, the absence of symptoms after treatment does not mean a complete recovery from the disease (Chen & Tsai, 2016).

2.2.2.3. The generalized anxiety disorder (GAD):

It is defined as “excessive and uncontrollable worry” that often interferes with daily functions and effects on the individual’s mental ability to make a suitable decision. GAD is a long term disorder and is and there is difficult to diagnose. GAD is associated with a number of symptoms, such as irritability, muscle tension, and somatic symptoms relatively rarely such as rapid heart rate (Alharthy et al., 2017).

Generalized anxiety disorder may start in childhood or adolescence, but its appearance is not rare after the 20 years of age. This type of anxiety is characterized by persistent and unrealistic anxiety for more than 6 months without any organic cause such as caffeine intoxication or hyperthyroidism, and often from people avoiding activities that lead to negative outcomes or spend significant time and effort preparing for these activities. Anxiety often causes procrastination in behavior or decision-making. General anxiety is often accompanied by muscle spasms, insomnia and malaise,

and its symptoms cause poor social and professional relationships and all other areas of life (Townsend, 2015).

2.2.2.4 Mixed anxiety and depression:

Mixed anxiety depressive disorder MADD is suffer from anxiety and depression it is a new diagnostic category. Anxiety and depressive symptoms of limited intensity and equal intensity are accompanied by at least some autonomic features. Patients do not independently obtain criteria for specific anxiety or depressive disorders. The onset of symptoms is independent of life stressors (Kara et al., 2000).

Health care providers, especially primary care providers, often face many patients who suffer from anxiety and depression but do not meet the full criteria for either disorder. The symptoms of one of them are not clearly prevalent. For example, we see that generalized anxiety disorder or a major depressive episode can cause significant distress or disability if compared with a syndromic diagnosis therefore requires appropriate treatment and recognition of the disorder. This is the reason why the WHO included the disorder in ICD10, but the DSM5 did not include it because the proposed criteria were not reliable enough according to the opinion of the American Psychiatric Association (Kasper et al., 2016).

According to ICD-10 criteria, mixed anxiety and depressive disorder (MADD) symptoms are secondary to anxiety and depression, and are of sufficient severity to warrant a psychiatric diagnosis in either of them for the prevalence of this disorder. However, MADD is the opposite; it is more prevalence. MADD prognosis depends on several factors such as apparent distress, impairment of daily living skills, comorbid anxiety and depression and their relationship to poor quality of life. As a diagnostic category, the validity and usefulness of MADD are still under discussion (Möller et al., 2016).

2.2.2.5. Separation anxiety disorder:

Separation anxiety disorder is characterized via way of means of persistent, excessive, and from the evolutionary point of view, in addition to

the point, the concern to separate from the main attachment figures, typically the parents, is one of the most commonly diagnosed anxiety disorders in children. Some studies have reported that separation anxiety disorder leads to panic disorder in adulthood, and some researchers have argued that it leads to generalized anxiety disorder, but in general, it effects on the children psychology in future are unclear (Kossowsky et al., 2013).

The most common symptoms of separation anxiety disorders in children were the distress associated with separation, such as not being alone without an adult, as well as avoiding sleeping far from parents or their representative, as a child caregiver, and the possibility of recurring nightmares for children. There is no difference in the prevalence rate for both gender or age, although there are a number of reports that indicate that females are more afraid than males about attending schools, as well as children who are less than 8 years old (Allen et al., 2010).

In the DSM5, separation anxiety disorder has become part of a broad spectrum of anxiety disorders, and its diagnosis was not based on the necessity of its appearance during infancy, childhood or adolescence, as it was in the past; in adult's symptoms could resave retrospective diagnosis. Separation anxiety disorder is divided into two parts: adults Separation anxiety disorder (adulthood onset), in this type Symptoms are onset in adults and begin without a history of childhood separation anxiety; the other type is adults Separation anxiety disorder (childhood onset); symptoms in this type appear in the child period and persists through puberty (Baldwin et al., 2016).

2.2.2.6. Selective mutism:

Through the development of psychiatric branch; the selective mutism specified as an independent anxiety disorder in infant, adolescence and likewise adulthood in DSM5. It frequently starts of evolving in early formative years with a form of speechlessness in specific situations. Very often comorbid anxiety disorders, especially social phobia and depression also occur. The course is very variable and with some affected person's regression

of the pathology occurs suddenly and completely and with others there is a slow regression of the symptoms. This disorder can be persisting until adulthood (Rogoll et al., 2018).

Selective mutism is a rare anxiety disorder that appears in adolescence or childhood and is discovered when a child enters school. The prevalence of this disorder is about 0.03% to 1%, but there is no accurate data on the exact percentage, so these estimates are due to the diversity of the sample locations such as schools, hospitals and public places. It is characterized by the inability to speak in certain situations despite talking with close people, such as family, for example. If the person in question cannot speak or make any sound like laughing, crying, coughing, etc. at all anyway, then it is called total silence (Ströhle et al., 2018).

The first designation for selective silence appeared in the year 1877, and it was called aphasia voluntaria at the time. Then it was renamed dsm3 with elective mutism silence and finally its name has now settled in the dsm5 with selective mutism. This disorder is the result of the interaction of genetic, environmental, developmental and temperamental factors together. Studies have shown a strong relationship between anxiety and muteness, in addition to the lack of other factors that have been implicated, such as communication delays, immigration and bilingualism, all of which have contributed to the development of mutism. The best treatment is psychotherapy and gradual exposure to situations that require verbal communication (Hua & Major, 2016).

2.2.3 Theories of anxiety:

2.2.3.1. Genetic Theories:

Genetics greatly contributes to anxiety symptoms, but other factors, such as the interaction of genes with environmental factors, have a greater impact than genes alone. Researchers found the serotonin transporter gene (5-HTTLPR) after hard work to identify the genes responsible for anxiety. Through this gene, a genetic mutation 5-HTTLPR has been identified

that is responsible for decreased serotonin activity and increased anxiety in people (Bridley & Jr., 2018).

2.2.3.2. Neurochemical Theories:

Gamma-aminobutyric acid (GABA) is the amino acid neurotransmitter believed to be dysfunctional in anxiety disorders. Researchers believe that a problem with the regulation of these neurotransmitters occurs in anxiety disorders. Serotonin, the indamine neurotransmitter is usually implicated in psychosis and mood disorders. Serotonin is believed to play a distinct role in OCD, panic disorder, and GAD. An excess of norepinephrine is suspected in panic disorder, GAD, and PTSD (Videbeck, 2020).

2.2.3.3. Psychodynamic Theories:

The function of anxiety is to warn the person of impending danger. Anxiety motivates the person to do something; thus, a behavior is seen. As a result of increased tension or anxiety, an individual is forced to learn new methods of reducing the tension. these new methods are called ego defense mechanisms “All defense mechanisms have two characteristics in common: (1) They deny, falsify, or distort reality and (2) they operate unconsciously”. the id is the original system of the personality. The id is unable to tolerate an increase in energy, which is experienced as an uncomfortable state of tension and lead to anxiety (Indd, 2014).

2.2.3.4. Interpersonal Theory:

Sullivan made use of the concept of anxiety as the chief disruptive force in interpersonal relations and the main factor in the development of serious difficulties in living. Anxiety too has been defined operationally. Sullivan has made no attempt to say what is anxiety; he describes it in terms of its effects. Certainly it has its origins in the conditions of prolonged and complete human dependency in infancy: the urgency of the biological needs, and the fact that the efforts of a mothering person are necessary for their satisfaction (harry stack sullivan, 1955).

2.2.3.5. Behavioral Theory:

Behavioral theorists view anxiety as being learned through experiences. Conversely, people can change or "unlearn" behaviors through new experiences. Behaviorists believe that people can modify maladaptive behaviors without gaining insight into their causes. They contend that disturbing behaviors that develop and interfere with a person's life can be extinguished or unlearned by repeated experiences guided by a trained therapist (Videbeck, 2020).

2.3. Impact of anxiety on quality of life:

The quality of life is affected by many environmental variables, social and physical variables, and it is affected by fixed and unmodifiable variables such as gender, age, race, skin color, etc. From demographic variables that are not adjustable, on the other hand, they are greatly affected and with statistically significant results by psychological variables, including anxiety, and the last variable is easy to treat if it is noticed health care providers (J. Kelly Graves et al., 2016).

Patients with severe mental illnesses suffer from low quality of life. Recently increase the interest of the research is rising in psychiatric topics. Due to patient-related outcomes, it is possible to use more and more quality of life, the identification of factors and their impact on quality of life is of particular importance. In addition to the diagnosis, socio-demographic and medical factors had been mentioned as applicable elements in preceding studies for particular sickness groups (Berghöfer et al., 2020).

Generally, people with anxiety suffer from poor quality of life. However, the limited number of studies does not allow for complete solidity. Some researchers reported some negative relationships between anxiety and quality of life for adults, and it was statistically found that there is a strong relationship between anxiety and quality of life for younger adults. The chance of developing an anxiety disorder is very high for the elderly, about

40% of people are exposed to anxiety after the age of 70 (Canuto et al., 2018).

2.4. Depression:

All the disruptive mood dysregulation disorder, major depressive disorder (including major depressive episode), persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder are under the tent of depressive disorders (David J. Kupfer, 2013).

2.4.1. Types of depression:

The primary mood disorders are major depressive disorder and bipolar disorder and also there is other related disorders to depression (Persistent depressive (dysthymic) disorder, Disruptive mood dysregulation disorder, Cyclothymic disorder, Substance-induced depressive, Seasonal affective disorder (SAD), Postpartum or “maternity” blues is a mild, Postpartum depression, Postpartum psychosis, Premenstrual dysphoric disorder, Non suicidal self-injury (Videbeck, 2020).

2.4.1.1. Major depressive disorder:

Major depressive disorder (MDD) is a debilitating disorder that is characterized by depressed mood, lack of interests, low cognitive function and vegetative symptoms, such as sleep and appetite disturbance. This disorder is occurring in the adults and affect one from six in their life, and men affected, is the half number of affected women. caused by multifactorial and the main factor is genetic factor about 35% from total causes. In addition, environmental factors, such as childhood abuse whether sexual, physical or emotional, this factor are strong association by MDD (Otte et al., 2016).

2.4.1.2. Bipolar disorder:

When the mood is oscillating between extremes of mania and/or depression, this is the criteria of bipolar disorder. Mania is "a distinct period

during which mood is abnormally and persistently elevated, expansive, or irritable"; this period continues at lasts about 1 week (unless the person takes a medical intervention), but it may be longer for some person. Bipolar disorders have two type: (Bipolar I disorder: one or more manic or mixed episodes usually accompanied by major depressive episodes), (Bipolar II disorder: one or more major depressive episodes accompanied by at least one hypomanic episode (Videbeck, 2020).

2.4.1.3. Persistent depressive (dysthymic) disorder:

Persistent depressive disorder is a chronic and frequent mood disorder, recognized from episodes of major depression that are often the persistent depressive disorder more disabling than major depression. The term consists of several chronic depressive presentations, including dysthymia with or without superimposed major depressive episodes, chronic major depression, and recurrent major depression without recovery between episodes. In the psychiatric primary care unit cannot detect the dysthymia until it intensifies to reach to major depressive (Schramm et al., 2020).

2.4.1.4. Disruptive mood dysregulation disorder:

Disruptive mood disorder is a constant anger or mood disorder characterized by outbursts of anger that are not commensurate with the size of the situation, beginning before age 10 (Videbeck, 2020). This disorder is comparatively uncommon after early childhood; it is often associated with other psychiatric disorders, and meets common standards for psychiatric “caseness. “Children with severe levels of emotional and behavioral dysregulation may identify with this disorder, disruptive mood dysregulation disorder (briefly called mood dysregulation disorder with dysphoria) (Copeland et al., 2013).

2.4.1.5. Cyclothymic disorder:

It is a primary mood disorder characterized by many ambiguities and controversies, it is characterized by episodes consisting of hypomanic

and depressive symptoms that do not meet all criteria for bipolar or major depressive disorder. This disorder has diagnostic features shared by other disorders, so it is unclear. It falls into the category of bipolar mood disorder. Cyclothymic is sometimes like a personality disorder because its onset is early, chronic, and pervasive (Van Meter & Youngstrom, 2020).

2.4.1.6. Substance-induced depressive:

Substance-induced depressive or bipolar disorder is characterized by a significant disturbance in mood that is a direct physiological consequence of ingested substances such as alcohol, other drugs, or toxins. (Videbeck, 2020).

Instead of the prosaic euphoria experienced while inebriated or the "hangover" the next day, some people will become manic or go into a state of depression. Mood disorders that occur only in association with substance use are specified as "substance-induced". Affective disorders that can precipitate in the context of substance use include both bipolar and related disorders and depressive disorders. Depression and bipolar disorder commonly occur with substance use disorders (N & V, 2020).

2.4.1.7. Seasonal affective disorder (SAD):

Seasonal affective disorder (SAD) is a seasonal pattern of recurrent major depressive episodes that most often occur in the fall or winter and resolve in the spring. The prevalence of SAD ranges from 1.5% to 9%. Phototherapy is a non-drug treatment that exposes people to artificial light. Delivery method and shape of light vary (Nussbaumer-Streit et al., 2019).

There are two types of Seasonal Affective Disorder (SAD). In one, more commonly referred to as winter blues or fall SAD, people suffer from increasing in appetite, sleep, and carbohydrate cravings, overweight, interpersonal conflict, heaviness in the limb beginning in late autumn and decrease in spring and summer and irritability. The second type, and it is less common called Spring onset SAD, with symptoms of weight loss, insomnia,

and lack of appetite that lasts from late spring or early summer to early fall (Videbeck, 2020).

2.4.1.8. Postpartum or "maternity" blues:

"The postpartum blues" is defined as "low mood and mild depressive symptoms that are transient and self-limiting and are extremely common during the perinatal period". Symptoms usually develop within two to three days of giving birth, peak the following days, and resolve on their own within two weeks of onset. Postpartum blues are extremely common and are estimated to occur in around 50% or more of women in the first few weeks after giving birth. Major postpartum depression is about 4 to 11 times more common in women who experience postpartum blues (Chasanah et al., 2019).

2.4.1.9. Postpartum depression:

Postpartum depression is a debilitating but treatable mental disorder that is one of the most common complications of pregnancy. Postpartum depression is included in the (DSM-5), as a major depressive episode "with per partum onset if onset of mood symptoms occurs during pregnancy or within 4 weeks of delivery. However, the depression starts after 4 weeks' delivery or does not meet the full criteria for a major depressive episode may still cause harm and require treatment (Stewart & Vigod, 2016).

2.4.1.10. Postpartum psychosis:

This disorder appears a few weeks after birth and is in the form of episodes; these episodes are in the form of severe mania or depression accompanied by psychosis, which they consider a life-threatening emergency, can have a significant negative effect on the mother, the baby and the which family. The postpartum psychosis is stall Controversial; however, evidence indicates most episodes to be manifestations of bipolar disorder and vulnerability to a puerperal trigger (Perry et al., 2021).

2.4.1.11. Premenstrual dysphoric disorder PMDD:

PMDD includes psychological and somatic symptoms and functional impairment that are at the severe end of the Premenstrual symptoms

continuum. This disorder results from hormonal change. Symptoms must be present during the last week before the onset of menstruation, and the symptoms begin to be better within some days after menstruation; it should decrease or disappear in the weeks following menstruation and should be present in most cycles for the past year. At least 5 symptoms must be present, including one "core" symptom (marked affective lability, irritability, depressed mood or anxiety) (Lanza di Scalea & Pearlstein, 2017).

2.4.1.12. Non suicidal self-injury:

Non-suicidal self-injury includes a person who harms his body such as cutting or burning deliberate, abrasion, hitting, or any other physical method or interference with wound healing resulting from self-harm urges or thoughts; injury is not an attempt at suicide. The persons with self-injury (that may have called self-mutilation) report reasons of relieving negative emotions, punishing oneself, seeking attention, or escaping a situation or responsibility. Others report the influence of peers or the need to “fit in” as contributing factors (Videbeck, 2020).

2.4.2. Causes of depression:

These may be Genetic causes, Biological causes, Social factors and lifestyle, Influence of family, Sociocultural factors, The school environment, and other factors (Bembnowska & Jośko-Ochojska, 2015). Also there are many theories about the depression arising; these theories are Psychoanalytic theories of depression, Attachment theory, Behavioral theories of depression, Cognitive theories of depression, and interpersonal theories (Gilbert, 2017).

2.4.2.1. Psychoanalytic theories:

In 1917 Freud established the exploration of depression and its link to aggression in “Mourning and Melancholia” and internally directed aggression. He conceptualized that in response to the loss experience, according to Freud, superego is the result of an internal set of standards and values by which one judges him-or herself, by unconscious method individuals may

inhibit their hostility or aggression to avoid the negative consequences of expressing it externally; this way, they maintain their position in the family or society, in this process results in internalized hostility that makes a person more prone to depressive symptoms. Freud proposed superego is mediated the association between the depression and internally directed aggression (Haddad et al., 2008).

2.4.2.2. Attachment theory:

Attachment theory aims to discover the relationship between parents, children and adults in terms of personal and intimate relationships. Some researchers believe that depression is association to insecure attachment, whether it is with children, adolescents or adults. They also believe that attachment occurs not only between the mother and the child, but can occur between partners and friends. They showed similar characteristics to the mother-child relationship. It was found that bad experiences that children go through, such as parental separation, neglect or mistreatment, are the origin of insecure attachment, which has a strong association with severe depression. In conclusion, individuals who suffer from insecure attachment are more prone to depression (Guo & Jen, 2019).

2.4.2.3. Behavioral theories of depression:

Ferster posits that the primary aspect of depression is the reduced frequency of behaviors and suggests that depressive behavior is primarily functional. If depression is assumed to be a behavioral deficit, Ferster finds that the frequency of the behavior decreases when the dominant stimulus or discriminatory stimulus is removed. Ferster stresses the importance of this factor in precipitation in depression. For example, the loss of a spouse or job constitutes the loss of a discriminatory stimulus and thus interrupts and puts an end to many behaviors. So the primary feature of depression is a "lower rate of emitting positively reinforced behaviors (Mathews, 1977) .

2.4.2.4. Cognitive theories of depression:

(Pössel & Smith, 2020); Townsend (2015); and Aaron Beck's suggest that the primary disturbance in depression is cognitive rather than affective; cognitive theory of depression consists of the following components: dysfunctional attitudes, cognitive errors, and Beck's cognitive triad or negative cognitive triad consisting of a negative view of self, the world, the future, and negative automatic thoughts. This dysfunctional attitude is relatively enduring, organizing structures that guide situational information processing (e.g., "People will probably think less of me if I make a mistake"). When these elements are activated by stress, dysfunctional situations lead to cognitive errors that distort perception and thinking and make it extreme. Finally, the results that have been reached indicate that negative thoughts represent a perceptual symptom of depression. Figure 2-1 represents an illustration of Beck's theory of depression.

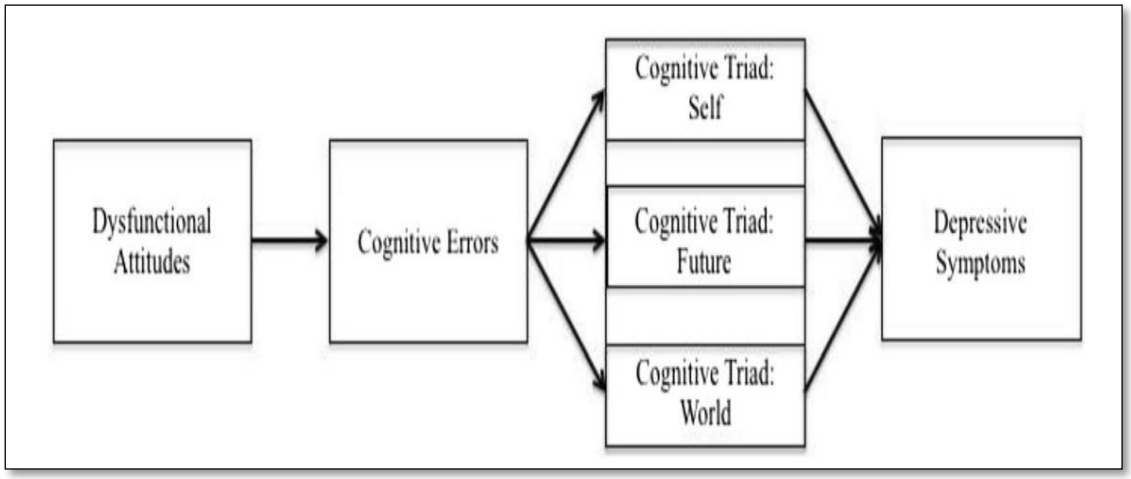

Figure (2-1) Explanation of Beck's theory (Pössel & Smith, 2020)

2.4.2.5. Interpersonal theory:

Interpersonal theory for Coyne's (1976a, 1976b), assumed that the combination of depressive symptoms and excessive search for reassurance lead to interpersonal problems. People with depression can inadvertently reverse the positive effect of social support. Coyne's theory is one of the first to state that personal behaviors can affect people's emotional well-being. As

an example for this theory, some people can become more depressed just because of a phone call (Pritchard, 2013).

2.5. Impact of depression on quality of life:

The quality of life is negatively affected by depression; also the prevalence of depression increases the disability and risk for mortality. Compared to healthy people, people with a depression suffer from lower of quality of life in world wide. A decrease in health-related quality of life is associated with high depression. The associations appeared to be stable over time and independent of how quality of life was assessed. This review found strong association between the lack of quality of life and the degree of depression; this association is stable all the time, regardless of the instruments applied to measure the quality of life (Sivertsen et al., 2015).

The quality of life in patients is affected by depression negatively, especially those who suffer from chronic physical diseases such as cancer, stroke, and others. It also leads to a high rate of functional disability and an increase in the death rate and also contributes to adding a negative impact on the paths of diseases, so reducing and controlling depression and the factors that contribute to increasing this disorder that will increase the quality of life (Kang et al., 2015).

2.6. Previous Studies:

First study:

(Rapaport et al., 2005) conducted a study "Quality-of-Life Impairment in Depressive and Anxiety Disorders". Several studies and previous reports have shown poor quality of life for patients suffering from anxiety and emotional disorders, whether the survey was for epidemiological or relatively small samples. This study aims to study the impact of anxiety and depression disorders on the quality of life of people who suffer from these disorders and compare them, through the management of the measure of quality of life and enjoyment of life and measurement of satisfaction. Quality of life and life satisfaction scales were taken for 11 treatment trials including

studies of major depression, chronic/dual depression, chronic depressive disorder, panic disorder, obsessive-compulsive disorder (OCD), social phobia, premenstrual dysphoric disorder and post-traumatic stress disorder (PTSD). The results showed quality of life impairment and its major depression were (63%), chronic/double depression (85%), dysthymic disorder (56%), panic disorder (20%), OCD (26%), social phobia (21%), pre- menstrual dysphoric disorder (31%), and PTSD (59%). Finally, the study concluded that there is a severe impairment in the quality of life for people who enter into emotional disorders or anxiety. The individual's perception of quality of life should be part of the final assessment because the measures of the specific symptoms of each disorder did not show significant variation in quality of life among themselves.

Second study:

Lv et al., (2009) performed a study "Depression, anxiety and quality of life in parents of children with epilepsy" This study was submitted to the Department of Neurology, Peking Union College of Medicine Hospital, Peking Union College of Medicine, Beijing, People's Republic of China in 2009. The study aimed at evaluating the quality of life and mental health of parents of children with epilepsy, as well as measuring the correlation between anxiety and depression on the one hand and quality of life on the other. Two groups of children were taken, the first was from healthy children and their number was 270 children, and the other group was from children with epilepsy and their number was 263 children and this group was divided into two part newly diagnosis in epilepsy and follow up visit group. The following scales were used after making sure of the balance of the two groups in relation to the background of variables Short-Form Health Survey (SF-36) Questionnaire, Zung Depression Scale (ZDS) and Zung Anxiety Scale (ZAS) were applied to all parents. The study showed that the parents of a child with epilepsy had high levels of anxiety and depression in addition to a significant decrease in the quality of life compared to the other group of

parents of healthy children. The study concluded that children's illness leads to a deterioration in the mental health of parents and thus a decrease in the quality of life. In addition, distinguishing the associations between study variables would improve the quality of life.

Third study:

Hanna & Cronin-Golomb (2012) conducted a study of "Impact of Anxiety on Quality of Life in Parkinson's Disease" This study was presented in Boston, United States of America. This study investigates the impact of anxiety and depression on quality of life in Parkinson's disease. This is because previous studies examining the impact of depression and disabilities on quality of life and anxiety are ignored. The Parkinson's Disease Quality of Life measure (PDQ-39) was used. The sample size was 38 samples of people with the disease, and the study revealed that the effect of anxiety is greater than the impact of depression on the quality of life of patients, where the sample variance for anxiety was 29%, while depression was 10% of the total quality of life measure for Parkinson's disease by using progressive regression analysis. Proper and early treatment of anxiety and depression is extremely important in improving the quality of life for Parkinson's patients.

Fourth study:

(Vasilopoulou et al., 2016) conducted a study of "The Impact of Anxiety and Depression on the Quality of Life of Hemodialysis Patients". The purpose of this study is to find out how quality of life is affected by anxiety and depressive disorders. The sample consisted of 395 people suffering from renal failure and continuous dialysis, and the data were collected through special procedures for this purpose. The scale was HADS scale for assessing the level of anxiety and depression and the Missoula-VITAS Quality of Life Index (MVQOLI) scale for assessing patients' quality of life. The results of the study were as follows: 47.8 had high levels of anxiety and 38.2 had high levels of depression. finally, the average of quality of life level was

17.14 and showed statistical evidence of the relationship with the family situation, the number of children, adherence to the doctor's orders, adherence to a diet, in addition to the patient's relationship with the medical staff. Using multiple linear regression, it was found that the quality of life was associated with level of depression, where the overall quality of life score was 2.5 to 4.4 lower for people with moderate and high levels of depression compared to people with low level of depression. The study concluded that the evaluation of anxiety and depression in addition to the quality of life is an important part of the treatment regimen and the dialysis process and they cannot be neglected.

Fifth study:

(Fan et al., 2016) performed a study of "Relationships among Depression, Anxiety, Sleep, and Quality of Life in Patients with Parkinson's Disease in Taiwan". The study was presented in Taiwan in 2016. The study aims to examine the correlation between anxiety, depression, sleep disorders, Parkinson's disease and its medications and their impact on quality of life. A range of scales and questionnaires were administered and validated, including Unified Parkinson's Disease Rating Scale, Beck Anxiety Scale, Beck Depression Scale, Parkinson's Disease Questionnaire (39 items), and Parkinson's Disease Sleep Scale-2. The sample consisted of 134 people with the disease, for whom the quality of life was measured, and it was found that a decrease in the quality of life was positively associated with a higher rate of anxiety and depression, prolonged period of disease, as well as sleep disturbances. Independent factors including cognitive status, anxiety, depression, and activities of daily living were identified as predictors of quality of life. The knowledge of caregivers of psychological treatment methods to control disorders can raise the quality of life for patients

Sixth study:

Kousha et al. (2016) performed a study under the title of "Anxiety, depression, and quality of life in Iranian mothers of children with autism

spectrum disorder". A descriptive study in Iran, aims to know the frequency of anxiety, depression and quality of life of Iranian mothers who have a child with autism, due to the prevalence of autism spectrum in all developing countries as well as developed countries. 127 outpatient mothers of a child with autism were taken for the purpose of studying demographic data and mental health characteristics. Mothers suffer from high rates of anxiety (72.4), in addition to depression, which is estimated at 49.6, and low levels of quality of life for mothers. The study found that maternal depression is strongly correlated with the age of the child, in addition to positive correlations with the length of the illness. Providing support to families will improve their mental and psychological health.

Seventh study:

Prisnie et al., (2018) performed a study "Effects of depression and anxiety on quality of life in five common neurological disorders" As a result of previous studies, it is not clear that anxiety and depression affect quality of life equally across neurological disorders. This study investigates the relationship between neurological disorders, anxiety, depression and quality of life. Data were collected using a number of scales and they were the Short Form Health Survey (SF-12) in Neurology Patients, Patient Health Questionnaire (PHQ-9) and Hospital Anxiety and Depression Scale (HADS-A). The sample size consisted of 279 samples for patients with epilepsy, migraine 268, multiple sclerosis 222, stroke 204, and Parkinson's disease 224. The statistical analysis used was multiple linear regression to assess the variables associated with the mental health component and physical health component scores. Anxiety and depression have a significant contribution to PCS in migraine, stroke, and multiple sclerosis. But the greatest contribution was to MCS. This study found that anxiety and depression have varying effects on quality of life.

Eighth study:

Adams et al. (2020) performed a study "The Relationship Between Child Anxiety and the Quality of Life of Children, and Parents of Children, on the Autism Spectrum" This study aimed to find out the correlation between anxiety, quality of life and characteristics of autism in children and their parents alike. Children with autism suffer from high rates of anxiety, but the effect of this anxiety on the quality of life cannot be known so this study was about this affect. The Children's Quality of Life Scale and the World Health Organization Scale were used to measure the quality of life of parents, in addition to the Children's Anxiety Scale-Autism Spectrum Disorder of the parent. The final result was quality of life was poor for parents and children with high anxiety level. This study found that anxiety is one of the important factors that can help improve the quality of life if it is treated.

Ninth study:

Khalil et al., (2021) performed a study "Depressive Symptoms, Anxiety, and Quality of Life in Hemodialysis Patients and their Caregivers: A Dyadic Analysis" A cross-sectional descriptive study; aims to identify the effect of anxiety and depression on the physical and psychological quality of life of patients with end stage kidney failure who are continuing on dialysis and health caregiver dyad in Jordan, using the interdependence model between the representative and the husband. 120 samples were taken and anxiety and depression were measured for them, with the quality of life measured by the WHOQOL-Bref. The depression scores of the patients were higher than that of the health care providers (8.74 ± 5.23 vs. 6.9 ± 3.9, $p = .001$), and the patients also had lower scores on the physical aspect of quality of life (47.37 ± 22.9 vs. 64.1 ± 17.49, $p < .001$). The results showed that anxiety and depression affect the husband's quality of life while for patients, the quality of life is affected by symptoms of depression only. In conclusion, this study concluded that anxiety and depression are equally important in managing quality of life.

Tenth study:

Al-Nashri & Almutary (2022) conducted a study " Impact of anxiety and depression on the quality of life of hemodialysis patients" The study aimed to investigate the impact of depression and anxiety on quality of life in patients with renal failure who are on dialysis. Although it is known that hemodialysis affects the quality of life, anxiety and depression do not take serious steps to treat it. The study design was correlational a cross-sectional design. The sample size was 114 patients undergoing hemodialysis treatment. The Kidney Disease and Quality of Life Survey 36 and the Anxiety and Depression Scale were used within hospitals for the purpose of sample collection. The statistics were descriptive and inferential using the t-test for the purpose of finding the correlation between the quality of life of patients with renal failure and dialysis and anxiety and depression on the other hand. The result of this study was that 50% of the sample size suffers from anxiety and 44.7 suffer from depression, and there was a strong negative correlation with statistical significance between anxiety and depression on the one hand and quality of life on the other. This study concluded that early detection and finding solutions for anxiety and depression disorders can have a positive benefit on renal failure patients. Also, the two disorders mentioned are among the most common symptoms in patients with kidney failure.

Chapter Three

Methodology

Chapter Three

Methodology

3.1. Design of the Study:

A quantitative descriptive study was conducted to find out the impact of anxiety and depression illnesses upon quality of life of patients in holy kerbala city, during the period of the study from 5 December 2021 to 30 September 2022.

3.2. Administrative Arrangement:

Official Permissions are obtained from Ministry of Health/ Holy Karbala Health directorate / Training and Human Development Center, and Al-Hassan Al-Mujtaba Teaching Hospital to carry out the study (appendix A, AI).

3.3. Ethical Consideration:

Ethical approval was taken from the Ethical Committee of Research in the nursing college/University of kerbala concerning confidentiality and participants' anonymity (Appendix B). Also, the participants had full information about the current study and its aims and before taking the information of any participant, his or her oral consent was obtained in order to participate in the research; there is a note also on the questions stating the following: dear if you agree to participate in this research, with respect you can fill out questionnaire at your disposal. Besides, the confidentiality of information obtained from patients who participated in the present study was taken into consideration.

3.4. Setting of the Study:

An accessible sample of adult people with anxiety or depression illnesses is selected from the outpatient at Imam Al-Hassan Al-Mujtaba Teaching Hospital in the holy Kerbala city.

3.5. Instrument of the Study:

The questionnaire consisted of 4 parts which are used to achieve the objectives of the study as in the following:

Part I:

Part I was built in accordance with the requirements of the study, it consists of demographic characteristics for patients. It contains 5 variables (age, gender, marital status, educational level and monthly income) (Appendix G).

Part II:

Beck Depression Inventory BDI-II was used to assess the depressive illness; it is a global scale. It was developed by Aron Beck in 1996 and is an upgraded version of BDI and BDI-1A. It consists of 21 axes; each axis includes a set of questions; the answers range from 0-3. According the value of degree that patients are taking the level of depression is determined: 0-11=Absence of depression, 12-19=Mild depression, 20-27=Moderate depression, 28-63=Severe depression (Appendix H).

Part III:

It is the standard scale (Taylor anxiety scale) to assess the anxiety level in patients; this scale measures, to a large degree of objectivity, the anxiety of how the patient feels, developed by Janet Allison Taylor; it consists of 50 questions to measure the anxiety; it is used for both child and adult patients. The scale has two answers ‘yes take 1 score’ and ‘no take 0’ but there are some reverse questions (3, 13, 17, 20, 22, 29, 32, 38, 48, 50); in this questions the answer yes takes 0 and the answer no takes 1. So according to degree from 50 the anxiety level is determined: 0-16=Very low anxiety, 17-19=Low anxiety, 20-24=Average anxiety, 25-29=Above average anxiety, 30-50=High anxiety (Appendix I).

Part IV:

The third scale is the World Health Organization Quality of Life-Brief (WHOQOL-Brief). This scale consists of 26 question each question has answers ranging from 1-5 used to assess quality of life. These questions are divided into 4 domains: Physical Health (7 items), Psychological Health (6 items), Social Relationship (3 items), Environment (8 items) and two items without domains; the closer the answer is to zero, the quality of life becomes worse (Appendix J)

3.6. Validity:

Although the scales are valid, the questionnaire was forwarded to 11 experts in various specializations and from several colleges in Iraq to make it more valid by using content validity. (Appendix F)

(3) Faculty members from the College of Nurse, University of Baghdad

(3) Faculty members from the College of Nurse, University of Kerbela.

(3) Faculty members from the College of Nurse, University of Babylon.

(1) Faculty members from the College of medicine, University of Kufa.

(1) Faculty members from the College of Nurse, University of Kufa.

By the face validity the researcher asks the expert to review the contents of the study instruments and to investigate the clarity, relevancy, and adequacy of the questionnaire.

The result of the validity by experts indicated that the questionnaire was clear, easy to understand by any patient, adequate, and relevant, and valid after some change on questionnaire according to their suggestions.

3.7. Pilot Study:

A pilot study was carried out by the researcher from 5 - 7 April. The sample of the pilot study consisted of 20 participants selected by a convenience method, 10 of whom studied the anxiety and quality of life, and the

remaining 10 examined the depression and quality of life. This sample was excluded from the total sample allocated to the study.

The purposes of the pilot sample study were:

1. To know the time taken by the participants of filling out the study instruments.
2. To know the nature of the difficulties facing the participants of the study and following the best approach for the purpose of solving them.
3. To verify the content of the study instruments, and to modify the points that need to be modified.
4. To identify the reliability of the study instruments.

After conducting the pilot study, all these purposes have been achieved.

3.8. Reliability of the Questionnaire:

Reliability refers to the stability or internal consistency of an instrument that means the instrument good reliability the respondent for a given condition under constant conditions will take the same degree. It is rare for two repeated tests to get exactly the same score because it is affected by errors of chance, but the score is close. The goal of reliability is to avoid chance errors and to prove that the scale is as error-free as possible and reliable. Reliability is very important because it is the first step to accepting scientific research and the usefulness of the test; the extent to which the test accurately measures the structure it wants to measure (Segal & Coolidge, 2018).

For measuring the reliability and internal consistency, Split-Half test is used to measure the Reliability for the study instrument. The reliability result of (Taylor scale for anxiety) was 0.837, the reliability result of the (beck scale for depression) was 0.747, and the reliability result of (WHOQOF-Brief scale) was 0.812; the acceptable value of reliability is 0.7 (Barton & Peat, 2014) which means that the study instrument is reliable in measuring the study phenomenon (Appendix C, D, E).

3.9. Sample of the study:

A non-probability sample was selected by using the convenience method; it consists of 104 patients: 52 patients with anxiety illnesses and the others are patients with depression illnesses. The sample is collected at Al-Hassan Al-Mujtaba Teaching hospital for the period from 16 April to 27 may 2022, for five days a week from 8:30 AM to 2:00 PM.

3.10. Inclusion criteria:

Adult patients who have diagnosis with anxiety or depression disorders by consultant psychiatrists were studied.

3.11. Exclusion criteria:

the following were excluded:

1-Patients who have more than one disorder or mixed disorders such as depression or anxiety with schizophrenia.

2-Child patients.

3.12. Data Collection Methods:

The participants were patients with anxiety and patients with depression visiting Al-Hassan Al-Mujtaba Teaching Hospital and agreeing to participants in the present study. The study sample was collected by the convenience sampling by visiting the psychiatric clinic for five days a week from 8:30a.m to 2:00 p.m. from the period of 16 April to 27 May 2022. The researcher attendance starts daily with the physicians' attendance and ends with their leaving. This study depends on a psychiatrist for diagnosis, so after the diagnosis of patient by the physician by one of the study variables (anxiety and depression) and after taking patient's permission, the subjects are taken by two methods either self-report for patient who can read and write or by semi structured interview for patients who cannot read and write the questionnaire or cannot answer for any reason.

3.13. Statistical Data Analysis:

SPSS V. 26 software is used to manage and to analyze the data. Descriptive statistics including number and frequencies, percentages, means and standard deviations, and inferential statistics in proportion to the distribution of data is used in terms of normality.

- Split half test for measuring the internal consistency reliability for the study instruments.
- Descriptive analysis (Frequencies, and Percentages, Means and standard deviations) for describing the demographic characteristics and finding out the level of the anxiety, depression and quality of life.
- Kolmogorov-Smirnov test to determine the distribution of the sample if normal disruption or abnormal so this test leads to the other statistical tests used in this study.
- Independent sample t-test to show the significant difference between the categories of gender with regard to the quality of life.
- Pearson correlation coefficient test is used to find out the correlation between the anxiety, depression and the quality of life domains.
- ANOVA this test is used to show the difference in the level of quality of life of patients with regard to their demographic characteristics.
- Scheffe multiple comparison test to distinguish the significant difference in the levels of quality of life for patients with their demographic variables subcategories. It is done for the demographic variables that showed a significant difference in the ANOVA test.

3.14. Limitations of the study:

1. The nonrandomized and small size of sample limiting the generalizability of the study results.
2. The study looked at the quality of life for anxiety and depression patients but did not compare it with the quality of life of healthy people.
3. The setting of the study was in one center for getting sample.

Chapter Four

The Results

Chapter Four

The Results

Table (4-1): Distribution of the Participants According to their socio demographic data Characteristics:

Demographic characteristics	Subgroup	f.	%
Age group	Less than 20 years	20	19.2
	20-29 years	28	26.9
	30-39 years	26	25.0
	40-49 years	14	13.5
	50 years and above	16	15.4
	Total	104	100.0
Gender	Male	46	44.2
	Female	58	55.8
	Total	104	100.0
Education level	Do not read and write	8	7.7
	Read and write	10	9.6
	Primary school	34	32.7
	Secondary school	30	28.8
	Diploma degree	12	11.5
	Bachelor's degree	10	9.6
	Total	104	100.0
Marital status	Single	32	30.8
	Married	52	50.0
	Widow	10	9.6
	Divorced	10	9.6
	Total	104	100.0
Monthly income	Enough	18	17.3
	Somewhat enough	26	25.0
	Not enough	60	57.7
	Total	104	100.0

f= frequencies, %=Percentages, N= number

In table 1 the results showed the ages of participants (N=104) in the current study were at most (26.9%) from 25 to 34 years and followed by 35 to 44 years (25%), and regarding the genders (55.8%) were women. According to the education levels the higher percentage (32.7%) had primary school

and followed by secondary school (28.8%). Regarding marital status, the results showed 50% were married and the results also showed the most of participants (57.7%) were not had enough monthly income.

Table (4-2): Distribution of the participants in anxiety and depression groups according to their socio demographic data characteristics:

Demographic Characteristics	Subgroup	Anxiety group N=52		Depression group N=52	
Age group	Less than 20 years	12	23.1	8	15.4
	20-29 years	14	26.9	14	26.9
	30-39 years	8	15.4	18	34.6
	40-49 years	12	23.1	2	3.8
	50 years and above	6	11.5	10	19.2
	Total	52	100.0	52	100.0
Gender	Male	22	42.3	24	46.2
	Female	30	57.7	28	53.8
	Total	52	100.0	52	100.0
Education level	Do not read and write	2	3.8	6	11.5
	Read and write	6	11.5	4	7.7
	Primary school	16	30.8	18	34.6
	Secondary school	16	30.8	14	26.9
	Diploma degree	4	7.7	8	15.4
	Bachelor's degree	8	15.4	2	3.8
	Total	52	100.0	52	100.0
Marital status	Single	16	30.8	16	30.8
	Married	26	50.0	26	50.0
	Widow	6	11.5	4	7.7
	Divorced	4	7.7	6	11.5
	Total	52	100.0	52	100.0
Monthly income	Enough	10	19.2	8	15.4
	Somewhat enough	16	30.8	10	19.2
	Not enough	26	50.0	34	65.4
	Total	52	100.0	52	100.0

f= frequencies, %=Percentages, N= number

In Table 2 the results showed the ages of participants (N=52 in anxiety group and N=52 in depression group) in the current study were at most (26.9%) from 20 to 29 years in anxiety group, while in depression group at

most (34.6%) from 30 to 39 years, the female was more than the male in two groups (57.7% in anxiety group and 53.8% in depression group). According to the education levels the higher percentage (30.8%) was in the primary school and the same percentage in secondary school for anxiety group and 34.6% were the high percentage in primary school for depression group. Regarding marital status, the results showed that 50% were married in the two groups and the results also showed that most of the participants 50% had not enough monthly income in anxiety group and 65.4% in depression group (Figures see appendix K, L, M, N, O)

Table (4-3) The level of anxiety among patients with anxiety illness for each item:

Items	No		Yes		Mean	S.D	level of anxiety
	f.	%	f.	%			
1. My sleep is fitful and disturbed.	12	23.1	40	76.9	.77	.425	H
2. I have had periods in which I lost sleep over worry.	14	26.9	38	73.1	.73	.448	H
3. I have very few fears compared to my friends.	20	38.5	32	61.5	.38	.491	L
4. I believe I am more nervous than most others.	22	42.3	30	57.7	.58	.499	H
5. I have nightmares every few nights.	10	19.2	42	80.8	.81	.398	H
6. I have a great deal of stomach trouble.	2	3.8	50	96.2	.96	.194	H
7. I frequently notice my hand shakes when I try to do something.	24	46.2	28	53.8	.54	.503	H
8. I have diarrhea without medical causes	22	42.3	30	57.7	.58	.499	H
9. I worry over money, business, and my job	16	30.8	36	69.2	.69	.466	H
10. I have attacks of nausea.	18	34.6	34	65.4	.65	.480	H
11. I am often afraid that I am going to blush.	22	42.3	30	57.7	.58	.499	H
12. I feel hungry almost all the time.	32	61.5	20	38.5	.38	.491	L
13. I trust myself so much	30	57.7	22	42.3	.58	.499	L
14. I tire quickly.	0	0	52	100.0	1.00	.000	H
15. It makes me nervous to have to wait.	8	15.4	44	84.6	.85	.364	H

16. I feel so nervous I can't sleep	18	34.6	34	65.4	.65	.480	H
17. I am usually calm	36	69.2	16	30.8	.69	.466	H
18. I have periods of such great restlessness that I cannot sit long in a chair.	18	34.6	34	65.4	.65	.480	H
19. I am do not happy most of the time.	8	15.4	44	84.6	.85	.364	H
20. It's easy to focus my mind on something	12	23.1	40	76.9	.23	.425	L
21. I feel anxiety about something or someone almost all the time.	10	19.2	42	80.8	.81	.398	H
22. I do not worry quite a bit over possible misfortunes.	22	42.3	30	57.7	.42	.499	L
23. I wish I could be as happy as others seem to be.	4	7.7	48	92.3	.92	.269	H
24. I frequently find myself worrying about something.	4	7.7	48	92.3	.92	.269	H
25. I certainly feel I am useless at times.	34	65.4	18	34.6	.35	.480	L
26. I sometimes feel that I am about to go to pieces.	16	30.8	36	69.2	.69	.466	H
27. I sweat very easily even on cool days.	22	42.3	30	57.7	.58	.499	H
28. Life is difficult for me.	10	19.2	42	80.8	.81	.398	H
29. I don't worry and I don't care about my bad luck	24	46.2	28	53.8	.46	.503	L
30. I am extraordinarily sensitive	12	23.1	40	76.9	.77	.425	H
31. I notice my heart beating so hard	16	30.8	36	69.2	.69	.466	H
32. I do not cry easily.	18	34.6	34	65.4	.35	.480	L
33. I have been afraid of things or people that I know could not hurt me.	28	53.8	24	46.2	.46	.503	L
34. I am deeply affected by the events	4	7.7	48	92.3	.92	.269	H
35. Frequently I have headaches.	12	23.1	40	76.9	.77	.425	H
36. I was worried about things of no value	18	34.6	34	65.4	.65	.480	H
37. I cannot keep my mind on one thing.	22	42.3	30	57.7	.58	.499	H
38. I don't get confused easily	20	38.5	32	61.5	.38	.491	L
39. Sometimes I think I'm weak and useless	22	42.3	30	57.7	.58	.499	H
40. I am a high-strung person.	8	15.4	44	84.6	.85	.364	H
41. Sometimes when embarrassed, I break out in a sweat.	16	30.8	36	69.2	.69	.466	H
42. I blush excessively when I talk to others	28	53.8	24	46.2	.46	.503	L

43. I am more sensitive than most other people.	16	30.8	36	69.2	.69	.466	H
44. I have sometimes felt that difficulties were piling up so high that I could not overcome them.	10	19.2	42	80.8	.81	.398	H
45. I get very nervous while doing something	14	26.9	38	73.1	.73	.448	H
46. My hands and feet are usually cold.	32	61.5	20	38.5	.38	.491	L
47. I dream frequently about things that are best kept to me.	10	19.2	42	80.8	.81	.398	H
48. I have high confidence in myself	34	65.4	18	34.6	.65	.480	H
49. I sometimes suffer from constipation	28	53.8	24	46.2	.46	.503	L
50. I never blush from shyness	16	30.8	36	69.2	.31	.466	L
Total					**.64**	**.092**	**H**

f= frequencies, %=Percentages, M = Mean of score, S.D = Standard Deviation, levels (Very low= 0- .32, Low= 0.33-0.38, Average= 0.39- 0.48, Above average= 0.49- 0.58, High= 0.59- 1)

In Table 3 the results showed the level of anxiety for participants with anxiety illness were high with Mean ± SD 0.60 ± 0.092 and the higher percentage in item number 14 with Mean ± SD 1.00 ± 0.000 (high) and the lower percentage in item number 20 with Mean ± SD 0.23 ± .425 (very low).

Table (4- 4): Levels of anxiety among each participant with anxiety illness:

Levels of anxiety	Scores	f.	%	Mean± S.D
Very low anxiety	0- 16	0	0	
Low anxiety (normal)	17- 19	0	0	
Average anxiety	20- 24	0	0	
Above average anxiety	25- 29	22	42.3	**32.12 ± 4.605** Min 25- Max 40
High anxiety	30- 50	30	57.7	
Total score	**0- 50**	**52**	**100.0**	

f= frequencies, %=Percentages, M = Mean of score, S.D = Standard Deviation

The results in table 4 showed the most of participants (57.7%) with anxiety illness had high levels of anxiety with Mean ± SD 32.12 ± 4.605 (Figure Appendix p).

Table (4-5): The level of depression among patients with depression illness for each item:

NO.	Items	Mean	S.D
1	Sadness	2.08	1.007
2	Pessimism	1.96	1.267
3	Past failure	1.73	1.140
4	Loss of pleasure	2.46	.803
5	Guilty feelings	1.42	1.126
6	Punishment feelings	.96	1.204
7	Self-dislike	1.46	1.228
8	Self-criticalness	2.12	.983
9	Suicidal thoughts or wishes	1.00	1.048
10	Crying	1.54	1.093
11	Agitation	1.73	.819
12	Loss of interest	1.81	1.155
13	Indecisiveness	1.50	1.094
14	Worthlessness	1.12	1.231
15	Loss of energy	2.23	.983
16	Changes in sleeping pattern	1.46	.803
17	Irritability	1.50	.897
18	Change in appetite	1.38	.932
19	Concentration difficulty	1.85	.916
20	Tiredness or fatigue	1.88	1.022
21	Loss of interest in sex	1.46	1.290
	Total	1.65	.527

f= frequencies, %=Percentages, M = Mean of score, S.D = Standard Deviation, levels (Absence = 0- .52, Mild= 0.53-0.90, Moderate= 0.91- 1.28, Sever= 1.29- 3).

In Table 5 the results showed the level of depression for participants with depression illness was severe with Mean ± SD 1.65 ± 0.527 and the higher percentage in item number 15 with Mean ± SD 2.23 ±.983 (sever) and the lower percentage in item number 6 with Mean ± SD 0.96 ± 1.204 (moderate).

Table (4-6): Total levels of depression among each participant with depression illness:

Levels of depression	Scores	f.	%	Mean± S.D
Absence of depression	0- 11	0	0	
Mild depression	12- 19	4	7.7	
Moderate depression	20- 27	12	23.1	
Severe depression	28- 63	36	69.2	**34.65 ± 11.075**
Total score	**0- 63**	**52**	**100.0**	Min 17- Max 54

f= frequencies, %=Percentages, M = Mean of score, S.D = Standard Deviation

The results in table 6 showed the most of participants (69.2%) with depression illness had severe depression with Mean ± SD 34.65 ± 11.075 (Figure Appendix Q).

Table (4-7): The level of quality of life for patients with (anxiety and depression) illness in mean scores for each item:

Domain	Items	Anxiety G		Depression G	
		Mean score	S.D	Mean score	S.D
	1. How would you rate your quality of life?	2.81	1.221	2.15	1.334
	2. How satisfied are you with your health?	2.88	1.199	2.58	1.460
Physical health	3. How much do you feel that pain prevents you from doing what you need to do?	2.58	1.258	2.73	1.470
	4. How much do you need medical treatment to function in your daily life?	2.42	1.319	2.81	1.373
	10. Do you have enough energy for every-day life?	2.92	1.045	2.38	1.223
	15. How well are you able to get around?	2.62	1.191	2.27	1.173
	16. How satisfied are you with your sleep?	2.50	1.321	1.88	1.132
	17. How satisfied are you with your ability to perform daily living activities?	3.23	1.198	2.54	1.228
	18. How satisfied are you with your capacity for work?	2.77	1.262	2.42	1.289
Psychological health	5. How much do you enjoy life?	2.54	1.056	1.92	1.152
	6. To what extent do you feel life to be meaningful?	2.58	1.054	2.19	1.221
	7. How well are you able to concentrate?	2.58	1.289	2.69	1.276
	11. Are you able to accept your bodily ap-pearance?	3.42	1.161	2.69	1.181
	19. How satisfied are you with yourself?	3.12	1.323	2.42	1.433

	26. How often do you have negative feelings such as blue mood, despair, anxiety, depression?	2.08	1.281	1.62	.932
Social relationship	20. How satisfied are you with your personal relationships?	3.19	1.189	2.65	1.282
	21. How satisfied are you with your sex life?	2.58	1.194	2.38	1.223
	22.How satisfied are you with the support you get from your friends?	2.96	1.236	2.62	1.586
Environment	8. How safe do you feel in your daily life?	2.42	1.126	2.04	.989
	9. How healthy is your physical environment?	2.69	1.213	2.54	1.320
	12. To what extent do you have enough money to meet your needs?	3.15	1.036	2.92	1.186
	13. How available to you is the information that you need in your day-to-day life?	2.73	.992	2.46	1.128
	14. To what extent do you have the opportunity for leisure activities?	2.50	.980	2.04	1.028
	23.How satisfied are you with the conditions of your living place?	3.04	1.267	2.62	1.611
	24.How satisfied are you with your access to health services?	2.96	1.357	2.96	1.267
	25.How satisfied are you with your transport?	2.54	1.196	2.35	1.370
Total		**2.76**	**.536**	**2.42**	**.604**

1 point represent the worst state of health, while 5 points represent the best state of health

The results in Table 7 showed the quality of life for patients with anxiety illness was better from patients with depression illness.

Table (4-8): The level of quality of life for the study groups (anxiety and depression illness) in total scores for each domain:

Domain	Anxiety group				Depression group			
	T	Raw score	Trans-formed score		T	Raw score	Trans-formed score	
			4-20	0-100			4-20	0-100
Physical Health (7 items)	19.04	2.72	10.88	**42.99**	17.04	2.43	9.73	**35.85**
Psychological Health (6 items)	16.30	2.71	10.86	**42.94**	13.54	2.25	9.02	**31.41**
Social Relation-ship (3 items)	8.73	2.91	11.64	**47.76**	7.65	2.55	10.20	**38.78**
Environment (8 items)	22.04	2.75	11.02	**43.87**	19.92	2.49	9.96	**37.26**
Total (26 items)	71.80	2.76	11.04	**44.04**	62.88	2.41	9.67	**35.47**

Zero point represents the worst possible state of health, while 100 points represent the best possible state of health

The results in Table 8 showed the quality of life was unacceptable level for patients with anxiety and depression illness, and showed that the quality of life for patients with anxiety illness was better than patients with depression illness (Figure Appendix R).

Table (4-9): The differences in the level of quality of life for patients with anxiety and depression illness:

Quality of life	Anxiety G	Depression G	t	df	p. value
Physical Health	42.99	35.85	2.133	51	.038
Psychological Health	42.94	31.41	3.295	51	.002
Social Relationship	47.76	38.78	2.554	51	.014
Environment	43.87	37.26	2.273	51	.027
Total	44.04	35.47	3.278	51	.002

Sig.= Significance, N. S=Non Significant at $p>0.05$, S= Significant at $p<0.05$, H.S: High Significant at $p<0.001$.

The results in Table 9 showed there were significant statistical differences in quality of life between patients with anxiety and depression illness at p< 0.05.

Table (4-10): Distribution of the samples by using Kolmogorov-Smirnov test:

	Kolmogorov-Smirnov		
	Statistic	**df**	**Sig.**
Anxiety	1.253	52	.087
Depression	.945	52	.334
QOL for anxiety group	1.088	52	.187
QOL for depression group	.765	52	.602

Normality = p- value > 0.05

In Table 10 the results showed the distribution of the samples were normality at p- value > 0.05.

Table (4-11): The impact of anxiety and depression upon patients' quality of life:

Illness / Quality of life	Anxiety			Depression		
	r	**p. value**	**Result**	**r**	**p. value**	**Result**
Physical Health	**-.065-**	**.645**	**NS**	**-.675-**	**.000**	**HS**
Psychological Health	**-.217-**	**.122**	**NS**	**-.591-**	**.000**	**HS**
Social Relationship	**.025**	**.859**	**NS**	**-.318-**	**.022**	**S**
Environment	**-.179-**	**.205**	**NS**	**-.486-**	**.000**	**HS**
Total	**-.176-**	**.211**	**NS**	**-.652-**	**.000**	**HS**

P=probability value, NS: Non-Significant at P > 0.05, S: Significant at P < 0.05, HS: Highly Significant at P < 0.001.

In Table 11 the results showed there were highly significant statistical correlations between patients with depression illness and their quality of life at p- value P < 0.001, with reverse impact depression illness upon quality of

life. And the results showed there were non-significant statistical correlations between patients with anxiety illness and their quality of life at p- value $P > 0.05$, with reverse impact anxiety illness upon quality of life.

Table (4-12): The difference in the level of quality of life of anxiety and depression patients with regard to their demographic characteristics:

Demographics			Sum of Squares	df	Mean Square	F	Sig.
Age	QOL/ Anxiety	Between Groups	3348.792	4	837.198	6.788	.000
		Within Groups	5796.989	47	123.340		
	QOL/ Depression	Between Groups	928.539	4	232.135	1.018	.408
		Within Groups	10718.380	47	228.051		
Education level	QOL/ Anxiety	Between Groups	1715.046	5	343.009	2.123	.079
		Within Groups	7430.735	46	161.538		
	QOL/ Depression	Between Groups	5540.919	5	1108.184	8.349	.000
		Within Groups	6106.000	46	132.739		
Marital status	QOL/ Anxiety	Between Groups	444.427	3	148.142	.817	.491
		Within Groups	8701.354	48	181.278		
	QOL/ Depression	Between Groups	607.499	3	202.500	.880	.458
		Within Groups	11039.420	48	229.988		
Monthly income	QOL/ Anxiety	Between Groups	2786.716	2	1393.358	10.737	.000
		Within Groups	6359.066	49	129.777		
	QOL/ Depression	Between Groups	124.420	2	62.210	.265	.769
		Within Groups	11522.499	49	235.153		

P=probability value, NS: Non-Significant at $P > 0.05$, S: Significant at $P < 0.05$, HS: Highly Significant at $P < 0.001$.

In Table 12 the results showed there were highly significant differences between the levels of quality of life of anxiety patients with their age and monthly income at P < 0.001.

Also the results showed there were highly significant differences between the levels of quality of life of depression patients with their educational level at P < 0.001 (Figure Appendix S, T, U)

Table (4-13): Scheffes' multiple comparisons test for significant differences with respects to quality of life of patients and their monthly income:

Variable	/ QOL in anxiety group		Mean difference	p. value	Sig
Monthly income	I	J	(I-J)		
	Enough	Somewhat Enough	** 20.03	.000	HS
		Not Enough	* 17.28	.001	S
	Somewhat enough	Enough	** -20.03	.000	HS
		Not Enough	-2.75	.751	NS
	Not enough	Enough	* -17.28	.001	S
		Somewhat Enough	2.75	.751	NS

P=probability value, NS: Non-Significant at P > 0.05, S: Significant at P < 0.05, HS: Highly Significant at P < 0.00

In Table 13 the results showed the highly significant differences in the level of quality of life for anxiety patients with their monthly income between enough and somewhat enough at P < 0.001

Table (4-14): Scheffes' multiple comparisons test for significant differences with respects to quality of life of patients their age:

Variable	QOL in anxiety group		Mean difference	p. value	Sig
	I	J	(I-J)		
Age	**Less than 20 years**	20-29 years	11.17	.181	NS
		30-39 years	-13.87	.132	NS
		40-49 years	4	.940	NS
		50 years and above	5.44	.914	NS
	20-29 years	Less than 20 years	-11.17	.181	NS
		30-39 years	** -25.04	.000	HS
		40-49 years	-7.17	.614	NS
		50 years and above	-5.73	.890	NS
	30-39 years	Less than 20 years	13.87	.132	NS
		20-29 years	** 25.04	.000	HS
		40-49 years	* 17.87	.024	S
		50 years and above	* 19.31	.049	S
	40-49 years	Less than 20 years	-4	.940	NS
		20-29 years	7.17	.614	NS
		30-39 years	* -17.87	.024	S
		50 years and above	1.44	.999	NS
	50 years and above	Less than 20 years	-5.44	.914	NS

		20-29 years	5.73	.890	NS
		30-39 years	* -19.31	.049	S
		40-49 years	-1.44	.999	NS

P=probability value, NS: Non-Significant at P > 0.05, S: Significant at P < 0.05, HS: Highly Significant at P < 0.00

In Table 13 the results showed the highly significant differences in the level of quality of life for anxiety patients with their age between 20-29 years and 30-39 years at P < 0.001.

Table (4-15): Scheffes' multiple comparisons test for significant differences with respects to quality of life of patients and their Educational level:

Variable	QOL in depression group		Mean different	p. value	Sig
	I	J	(I-J)		
Educational level	Do not read and write	Read and write	24.04	.278	NS
		Primary school	0.6	1.000	NS
		Secondary school	3.12	1.000	NS
		Diploma degree	-21.16	.490	NS
		Bachelor's degree	10.81	.921	NS
	Read and write	Do not read and write	-24.04	.278	NS
		Primary school	* -23.44	.008	S
		Secondary school	* -20.92	.024	S
		Diploma degree	** -45.2	.000	HS
		Bachelor's degree	-13.23	.487	NS
	Primary school	Do not Read and write	* -0.6	.008	S

		Read and write	23.44	1.000	NS
		Secondary school	2.52	.995	NS
		Diploma degree	-21.76	.062	NS
		Bachelor's degree	10.21	.529	NS
	Secondary school	Do not Read and write	* -3.12	.024	S
		Read and write	20.92	1.000	NS
		Primary school	-2.52	.995	NS
		Diploma degree	* -24.28	.026	S
		Bachelor's degree	7.69	.793	NS
	Diploma degree	Do not Read and write	** 21.16	.000	HS
		Read and write	45.2	.490	NS
		Primary school	12.76	.062	NS
		Secondary school	* 24.28	.026	S
		Bachelor's degree	*31.97	.004	S
	Bachelor's degree	Do not Read and write	-10.81	.487	NS
		Read and write	13.23	.921	NS
		Primary school	-10.21	.529	NS
		Secondary school	-7.69	.793	NS
		Diploma degree	* -31.97	.004	S

P=probability value, NS: Non-Significant at P > 0.05, S: Significant at P < 0.05, HS: Highly Significant at P < 0.00

In Table 13 the results showed the highly significant differences in the level of quality of life for depression patients with their educational level between read and write and diploma degree at P < 0.001.

Table (4-16): The difference in the level of quality of life for anxiety and depression patients with regard to their gender characteristics:

	Mean	SD	QOL/ Anxiety		Mean	SD	QOL/ Depression	
Gender	43.36	6.914	315	.754	35.49	16.625	.197	.845
	44.55	16.737			35.45	14.194		

P=probability value, NS: Non-Significant at P > 0.05, S: Significant at P < 0.05, HS: Highly Significant at P < 0.001.

The results showed in Table 14 there were non-significant statistical differences between quality of for anxiety and depression patients with regard to their gender categories at P > 0.05.

Chapter five

Discussion of findings

Chapter Five

Discussion of Findings

Part I: Discussion of the demographic characteristics of patients with anxiety and patients with depression illnesses (Table 4-2)

The results of the present study reveal that the highest percentage (26.9%) for anxiety group was in the (20-29) year old, This result is similar to (Kalsoom, 2020) conducted in Pakistan and aimed to examine the gender role in quality of life, depression and anxiety in patient with chronic kidney disease. who found that 25.9% from the total sample are located in 18-30 years' age group.

The current result found that the great categories of age in depression group was 34.6% in the (30-39) years group. This result is supported by (Rapaport et al., 2005) who aim to compare the effects of anxiety and depression disorders on quality of life based on previous reports, they mention that the mean of age was 36.1 ± 5.0 for Premenstrual dysphoric disorder group.

This result agrees with (Ali Altınok et al., 2016) conducted in Turkey that aimed to investigate the quality of life and depression in the patient with type 2 diabetes mellitus and the related factors, They mention that 27% of participants are in the category 23-49 years. The current study agrees also with (Brown & Roose, 2011) in United States who aimed to find if the anxiety and depressive symptomatology moderates the age, and quality of life relationship. that found 34.7% from total participants from (30-59) years age group.

The current study found that the bulk of the study sample, was female for both groups anxiety (57.7%) and depression (53.8%) from the sample size; This finding is similar to (Al-Nashri & Almutary, 2022) in Saudi Arabia, they aimed "to evaluate the impact of anxiety and depression

on quality of life for dialysis patients", They show that the majority of the study participants are females (64%) in comparison with 36% were males.(Khalil et al., 2021) in Jordan found that the gender of two groups of study are consist with the current study (56.7%) of patient sample was females. This result is also similar to (Ali Altınok et al., 2016) conducted in Turkey; they agree with current results; they stated that 58% are females whereas 42% are males.

The current study result found that the bulk of sample of depression group have primary school education level that represent 34.6%, and for anxiety group was equal primary and secondary school education level that represent 30.8% of sample, (Vasilopoulou et al., 2016) in Greece aimed to "explore the impact of anxiety and depression on the quality of life of hemodialysis patients"; they found that the elementary education level was 38.7% and the secondary education was 31.1% from the total percentage.

The current study is similar also to (Soleimani et al., 2016) in Iran that aimed to examine the relationship between the death anxiety and quality of life in cancer patients; they revealed that 27.9% of the total study community was primary school education. The current study is consistent also with (Inal et al., 2010) conducted in Turkey which aimed to assess the quality of life for patients with Sjogren's syndrome, they found that 37.4% of study society have primary school education.

The result of the current study shows that half of the study sample (50%) was married for both anxiety and depression groups; This finding is supported by Al-Nashri & Almutary (2022) in Saudi Arabia. They show that 53.5% of study sample was married. It is also similar to (Vasilopoulou et al., 2016) in Greece who show that 50.1 % from the study community are married. According to (Rapaport et al., 2005), the result is completely identical with the current result; they found that 50% is married from the sample size of patient with major depressive disorders. Likewise the current study agrees with (Villar et al., 2017) in Spain; they aimed to determine the quality of life

and anxiety level for patient with breast cancer and the change after treatment, they found that 64.9% from the participants were married or live with a partner.

The current study shows that 50% of anxiety group sample have insufficient monthly income, and 65.4% of depression group sample also have insufficient monthly income, These results are supported by (Khalil et al., 2021) in Jordan who mention that 46.7% from patients and 44.2% from caregivers their monthly income was less than 350 United States dollars. According to the study, this amount is an insufficient monthly income. The minimum Jordan salary is 578 USD. This results also agrees with (Adewuya et al., 2008) in Nigeria; they found the great number of participants were a low Socioeconomic level; it represent 41.4% from the study sample.

Part II: Discussion of anxiety disorder levels (Table 4.3) and (Table 4.4)

The present findings reveal that 57.7% are with high level of anxiety disorder; this result is supported by the study of (Al-Nashri & Almutary, 2022) which is conducted in Saudi Arabia. They found that 50% of the participants had anxiety disorder (mean of score was 7.7 ± 5.3); the current study is also consistent with (Kousha et al., 2016) in Iran who found that the greater percentage of participants are with high level of anxiety; it was about 72.4% from the total sample. This result agrees also with Villar et al.(2017) in Spain; they mention that 45% have severe anxiety disorders. According to the study of ("Depressive Symptoms, Anxiety, and Quality of Life in Hemodialysis Patients and Their Caregivers: A Dyadic Analysis," 2021) conducted in Jordan; it revealed that the mean of anxiety 7.84 ± 5.23 (the score was from 0 to 20) which agrees with present study findings. The current study disagree with (Inal et al., 2010) which conducted in Turkey; that found 30% of the sample have anxiety and 70% without anxiety.

Part III :Discussion of depression levels (Table 4.5) and (Table 4-6)

The result of the current study shows that 69.2% of total sample of depression group had severe depression; the current result is similar to (Vasilopoulou et al., 2016) in Greece who found that 58.2% of the total sample had moderate to severe depression. The current study is consistent with (Naumann & Byrne, 2004) conducted in Australia who found that the levels of depression are the following: severe 33.3% (n=13); moderate 33.3% (n=13); and mild 28.2% (n=11) from the total sample.

The current result disagrees with (Al-Nashri & Almutary, 2022) conducted in Saudi Arabia who found that 55.3% of sample is not depressive patients. In addition, (Inal et al., 2010) in Turkey who found that 31.1% from the total sample have depression and other 68.9% without depression symptoms therefore, which is also inconsistent with the current study.

Part IV: Discussion of quality of life of patients with anxiety and depression (Table 4-8)

In the current study the result shows that the level of quality of life for anxiety patients was un acceptable (44.04%) of sample size. These study results are similar to Boralingaiah et al. (2021) conducted in India and aimed to understand the relationship between the unipolar depression quality of life and the general anxiety disorder quality of life before and after depression; they found that the mean of quality of life for general anxiety before treatment was 147.76 ± 14.16. the maximum score gathered for quality of life in the above mentioned study was 400. The present study is also consistent with Soleimani et al. (2016) in Iran who mentioned that the total mean score of the quality of life was 106 ± 25.4, and the range of quality of life (7-191). In addition the current study is consistent with the study of Inal et al. (2010) in Turkey; they use WHO quality of life scale. It revealed that the mean and standard deviation for each domain of depression group was as follows:

Physical, Psychological health (50.0± 6.4), (51.0 ± 14.6) respectively; the Social relationship and environment domains (52.9 ± 19.9), (56.8± 24.8) respectively. The current result is also consistent with Liu et al. (2021) who mentioned that the total score of the quality of life was 57.44 ± 9.03; Physical health 15.09 ± 2.43; psychological health 14.58 ± 2.72; social relationships 13.94 ± 2.60; and environment 13.82 ± 2.63 which agree with the current findings.

The current study found unacceptable quality of life for depressive patients; the total quality of life was 35.47%. These study results are similar to (Boralingaiah et al., 2021) in India who found that the mean of quality of life for general anxiety before treatment was (163.53 ± 15.04). Which are consistet with the current study the mean of kidney diseases quality of life (KDQOL) was Physical component score 44.5 ± 25.9; Mental component score 53.9 ± 20.7; Burden of disease 42.5 ± 25.4; Symptoms problem list 60.1 ± 19.8; Effect of kidney disease 59.1 ± 18.8; and total score KDQOF 49.1 ± 18.7. The present study agree also with (Adewuya et al., 2008) in Nigeria; who mentioned that the level of quality of life was: Physical health 23.20 ± 8.68; Psychological health 20.91 ±6.95; Social relationship 8.87 ±3.39; Environmental 24.36 ±7.11; and total quality of life 77.33 ± 3.14. In addition, this study is consistent with (Inal et al., 2010) in Turkey; they use WHO quality of life scale, they found that the quality of life for anxiety patient was the following: mean and standard deviation for each domain is as follows Physical health = 48.7± 6.3; Psychological health = 51.6± 11.2; Social relationship = 55.6± 17.1; Environment = 66.5± 16.8.

The researcher concluded that the depression had more impact on the quality of life than anxiety because depression has more severe impact on aspects of life, such as self-neglect and inability to work, in addition to other psychological symptoms such as sadness and isolation.

Part V: The impact of anxiety and depression with the quality of life (Table 4-11)

The results of the current study found a significant statistical correlation between depression illness and the quality of life. The current results are similar to (Al-Nashri & Almutary, 2022) which showed a strong negative correlation between depression and quality of life by using Pearson's correlation coefficients (r=.454, p < .0001). The findings are also consistent with the study of (Kousha et al., 2016) conducted in Iran; the results indicated that there is a positive correlation between depression, anxiety and low score of mothers' quality of life.

The current result is similar to (Khalil et al., 2021)) who revealed that there is a significant negative correlation between depression and the quality of life in all aspects in their study (physical and psychological aspects). That mean when the depression was high there is a poor quality of life. (Lv et al., 2009) also mentioned that there is a negative significant relationship between the quality of life and the diagnosis of depression. According to study of (Adewuya et al., 2008) conducted in Nigeria; they show that there is a negative relationship between the depression and quality of life.

The findings of the current study show that there is no significant relationship between the anxiety and the quality of life; this result is similar to (Shafaii et al., 2017) who found non-significant relationship between the death anxiety and quality of life.This result disagrees with (Kousha et al., 2016) conducted in Iran; they found high significant negative correlation between the anxiety and quality of life for patient (r= -.454, p<.0001).

Part VI: The difference in the level of quality of life of anxiety and depression patients with regard to their demographic characteristics (Table 4-12)

The current study shows that there is a significant difference in the quality of life in anxiety group with regard to age groups; These findings is

agree with (Kousha et al., 2016) in Iran who showed that younger mothers had better psychological health related to quality of life (20.08+3.41). This result is also similar to (KOÇAK et al., 2017) who found a significant difference between the quality of life regarding to the age.

The current study found that there is a significant difference in the quality of life regarding monthly income in anxiety group, this result is consistent with Abbas Tavallaii et al. (2009); they found that there is a significant difference in the quality of life regarding monthly income. The findings reveal that if the monthly income is low, moderate, high, the quality of life was sequentially QOL= 51.76 ± 10.70, QOL= 53.89 ± 10.39, QOL= 59.02 ± 7.98, respectively. Tavalaii concluded that there is a significant difference in quality of life with regard to the level of monthly income. The current result is also similar to the study of (Amin et al., 2022) conducted in Bangladesh; they aimed to "show the whole range of QOL deficits using the World Health Organization Quality of Life brief version in diabetic patients", which revealed that there is a significant difference in the quality of life according to monthly income. Also this result agrees with the (Siboni et al., 2019) who show that there is a high significant difference in quality of life regarding the economical satisfaction.

The current study result shows that there is a significant difference in the quality of life with regard to educational level for depression group. This result is similar to the study of (Barbareschi et al., 2011) conducted in Netherlands which revealed that there is a significant difference in the quality of life with regard to educational level. This result is also similar to (Siboni et al., 2019) who found a high significant difference in the quality of life with regard to the educational level.

Chapter Six

Conclusions and Recommendations

Chapter six

Conclusions and Recommendations

6.1. Conclusions:

1. The level of anxiety for the majority of sample of the study was the high level.
2. The majority of depressed patients have a severe level of depression.
3. There is unacceptable quality of life for the anxiety and depressive patients, and the depression has a negative impact on quality of life.
4. The level of quality of life is affected in anxiety group by patients' age and monthly income, and by patients' educational level in depression group.

6.2. Recommendations:

1. Attempting to find out an effective solution to reduce anxiety and depression in patients to improve the quality of life, such as activate the new technology for communication and follow up the patients, also activate the group therapy.
2. Attempting to study the demographic factors affecting the quality of life such as, economic factors, and the level of education because of their effect on increasing the level of anxiety and depression, and trying to find solutions to it, such as raising the socioeconomic status, emphasizing compulsory education or extending it to the secondary stage, or any other solutions that may appear in subsequent studies in this regard.
3. Activating the other therapeutic aspects and not relying only on the biological theory in treatment. such as activating the role of specialized nurses such as researchers of psychology, educators, and home visitors for follow up the patients and find out the required solutions for their problems.
4. Conducting national studies on the issue of quality of life in Iraq.

5. Conducting a comparative study assessing the impact of anxiety and depression disorders upon the quality of life, and comparing them to the quality of life for healthy groups.

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Appendices

Appendix A

Republic of Iraq
Ministry of higher education & scientific research
University of Karbala
College of Nursing
Graduate studies Division

جمهورية العراق
وزارة التعليم العالي والبحث العلمي
جـــامعة كربلاء
كـلية التـمريـض
شعبة الدراسات العليا

العـدد: ٦٠٩ / ١١١
التاريخ: 22/ 11 / 2021

الى / دائرة صحة كربلاء / مركز التدريب و تطوير الملاكات

م/ تسهيل مهمة

تحية طيبة...

يرجـى التفضـل بالموافقـة علـى تسـهيل مهمـة السـيد (علـي صـبري ناصـر) وهـو احـد طلبة الدراسات العليا / الماجستير في كليتنا / للعام الدراسي (2020-2021)

لغـرض جمـع عينـات لإنجـاز رسـالة الماجسـتير الموسـومة (Impact of Anxiety and Depression Illnesses Upon Quality of Life of Patients in Holy (Kerbala City

(أثر اضطرابات القلق والاكتئاب في جودة حياة المرضى في مدينة كربلاء المقدسة)

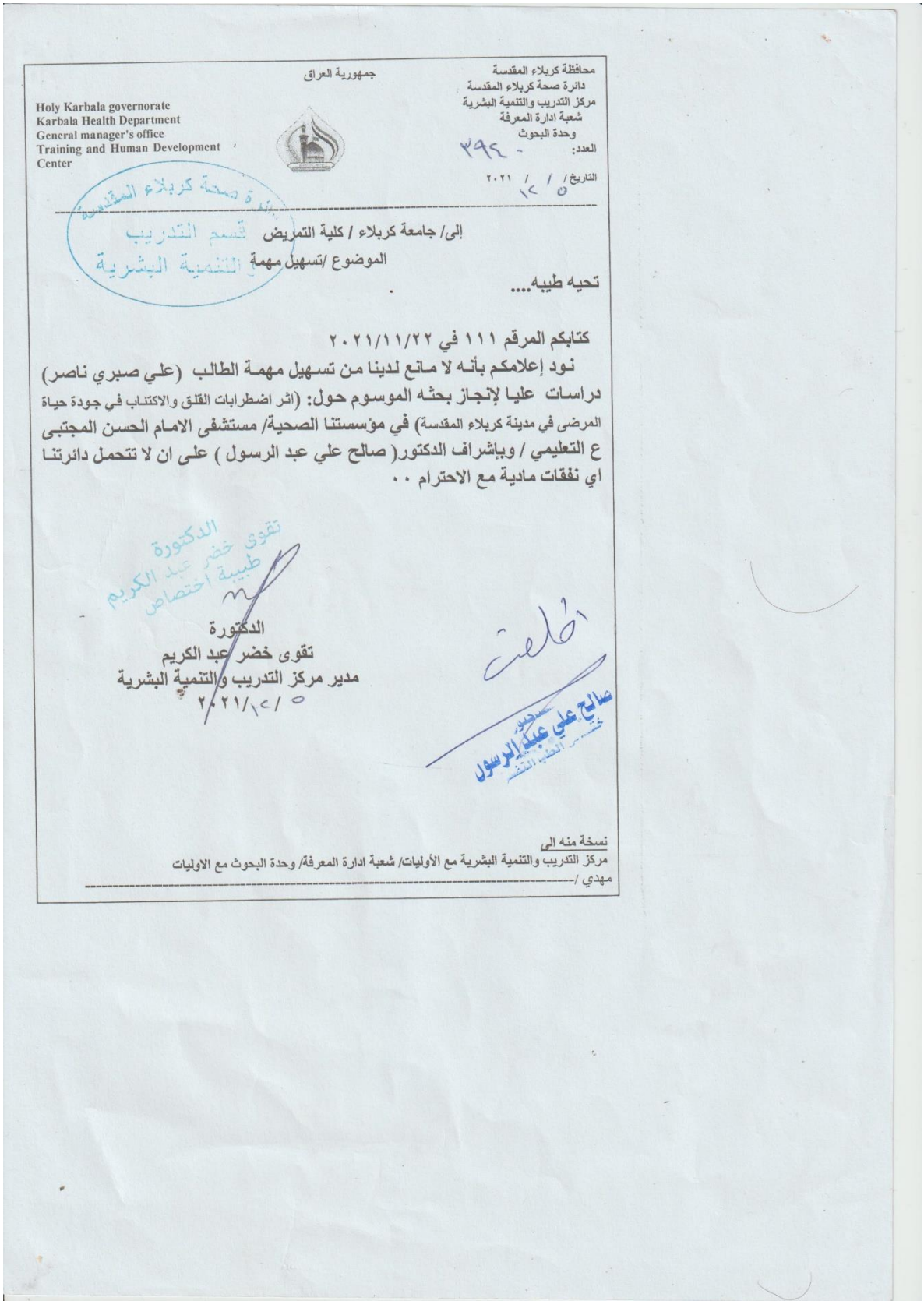
... مع التقدير ...

أ.م.د. سلمان حسين فارس الكريطي
معاون العميد للشؤون العلمية و الدراسات العليا
2021 / 11 / 22

نسخة مـ
- مكتب السيد
- شعبة الدراسات العلي

العـ . العراق - محافظة كربلاء المقدسة ـ حي الموظفين - جامعة كربلاء
Mail: nursing@uokerbala.edu.iq website: nursing.uokerbala.edu.iq

Appendix AI



محافظة كربلاء المقدسة
دائرة صحة كربلاء المقدسة
مركز التدريب والتنمية البشرية
شعبة ادارة المعرفة
وحدة البحوث
العدد: ٢٩٤ -
التاريخ / ١٧ / ١١ / ٢٠٢١

جمهورية العراق

Holy Karbala governorate
Karbala Health Department
General manager's office
Training and Human Development Center

دائرة صحة كربلاء المقدسة
قسم التدريب والتنمية البشرية

إلى/ جامعة كربلاء / كلية التمريض
الموضوع /تسهيل مهمة

تحيه طيبه....

كتابكم المرقم ١١١ في ٢٠٢١/١١/٢٢

نود إعلامكم بأنه لا مانع لدينا من تسهيل مهمة الطالب (علي صبري ناصر) دراسات عليا لإنجاز بحثه الموسوم حول: (اثر اضطرابات القلق والاكتئاب في جودة حياة المرضى في مدينة كربلاء المقدسة) في مؤسستنا الصحية/ مستشفى الامام الحسن المجتبى ع التعليمي / وبإشراف الدكتور(صالح علي عبد الرسول) على ان لا تتحمل دائرتنا اي نفقات مادية مع الاحترام ..

الدكتورة
تقوى خضر عبد الكريم
طبيبة اختصاص

الدكتورة
تقوى خضر عبد الكريم
مدير مركز التدريب والتنمية البشرية
١٧ / ١١ / ٢٠٢١

صالح علي عبد الرسول

نسخة منه الى
مركز التدريب والتنمية البشرية مع الأوليات/ شعبة ادارة المعرفة/ وحدة البحوث مع الاوليات
مهدي /

Appendix B

Ministry of Higher Education and Scientific Research
University of Karbala / College of Nursing
Scientific Research Ethics Committee

وزارة التعليم العالي والبحث العلمي
جامعة كربلاء / كلية التمريض
لجنة اخلاقيات البحث العلمي

استمارة اخلاقيات البحث العلمي

عنوان مشروع البحث	
English	باللغة العربية
Impact of Anxiety and Depression Illnesses Upon Quality of Life of Patients in Holy Kerbala City	اثر اضطرابات القلق والاكتئاب في جودة حياة المرضى في مدينة كربلاء المقدسة

بيانات عن الباحث الرئيسي .			
الاسم الثلاثي	اللقب العلمي او العنوان الوظيفي	رقم الهاتف/ الموبايل	الايميل
علي صبري ناصر	ممرض جامعي	07812106866	alisabryn@gmail.com

بيانات الباحث او الباحثين المشتركين			
الاسم الثلاثي	اللقب العلمي او العنوان الوظيفي	رقم الهاتف/ الموبايل	الايميل
أ.د. علي كريم خضير	استاذ دكتور	07712733433	

اهمية موضوع البحث واهدافه (Importance of the research and its objectives)

this study assumes decrease quality of life (QOL) level in severe mental illnesses patients, so the Awareness of the subject in research of psychiatric specialty is a rise as increase using quality of life in research as a patient-related outcome, to identity the impact of factors influencing quality of life have special interest in these patients

1. To assess the level of anxiety and depression among patients.
2. To assess the level of quality of life of patients.
3. To identify the impact of anxiety and depression Upon patients' quality of life.
4. To find out the difference in the level of quality of life of anxiety and depression patients with regard to their demographic characteristics of age, gender, educational level, economic status, marital status.

وقت ومكان اجراء البحث (الاماكن المقترحة لأجراء البحث فيها) Time and Setting of the Research

Expected time for this study from 29/10/2021 to 1/11/2022
The place: in kerbala city

منهجية البحث (Methodology)

Comparative study to measure the quality of live in patient who suffering from anxiety and depression

عينة الدراسة Sample of the study

Patient with anxiety disorders and depression disorders who live in kerbala city. I will use non-probability sampling method for collect the sample. The expected sample size is 100 sample.

الاعتبارات الاخلاقية خلال اجراء البحث (Ethical consideration during research)

التعهد

- اني الموقع ادناه ,علي صبري ناصر اتعهد بان اقوم باجراء البحث وفقا لما ذكر في البروتوكول اعلاه وان التزم باتباع القوانين والتعليمات فيما يخص اجراء البحوث والالتزام بأخلاقياتها ، كما واتعهد باخذ الموافقة من افراد العينة للمشاركة في الدراسة واخذ موافقة من ولي أمر المشارك الشرعي في حال كون عمر الشخص المشارك اقل من 18 سنة، او كونه غير قادر على الفهم ، وان اقدم الإيضاحات و المعلومات الخاصة بالدراسة لافراد العينة للمشاركين في حال طلبها. وان اتعامل بسرية تامة مع بيانات افراد العينة.

اسم وتوقيع الباحث
علي صبري ناصر

توصية لجنة اخلاقيات البحوث في الكلية

نحن اعضاء اللجنة الاخلاقية نوصي بان موضوع الباحث : ذو قيمة علمية ومهم للمجتمع والمريض

رئيس اللجنة
عضو
عضو
عضو

Appendix C

Reliability Statistics			
Cronbach's Alpha	Part 1	Value	.414
		N of Items	25[a]
	Part 2	Value	.565
		N of Items	25[b]
	Total N of Items		50
Correlation Between Forms			.771
Spearman-Brown Coefficient	Equal Length		.871
	Unequal Length		.871
Guttman Split-Half Coefficient			.837

Taylor scale for anxiety

Appendix D

Reliability Statistics			
Cronbach's Alpha	Part 1	Value	.660
		N of Items	11[a]
	Part 2	Value	.378
		N of Items	10[b]
	Total N of Items		21
Correlation Between Forms			.668
Spearman-Brown Coefficient	Equal Length		.801
	Unequal Length		.802
Guttman Split-Half Coefficient			.747

Reliability beck scale for depression

Appendix E

Reliability Statistics			
Cronbach's Alpha	Part 1	Value	-.248[a]
		N of Items	13[b]
	Part 2	Value	.275
		N of Items	13[c]
	Total N of Items		26
Correlation Between Forms			.713
Spearman-Brown Coefficient	Equal Length		.832
	Unequal Length		.832
Guttman Split-Half Coefficient			.812

WHOQOF-Brief scale

Appendix F

ت	أسم الخبير	اللقب العلمي	التخصص	سنوات الخبرة	مكان العمل
.1	د.عبدالمهدي عبد الرضا	أستاذ	تمريض الصحة النفسية والعقلية	45 سنة	كلية التمريض/ جامة بابل
.2	د. سجاء هاشم محمد	استاذ	تمريض الصحة النفسية والعقلية	42 سنة	كلية التمريض/ جامعة بابل
.3	د.عرفات حسين الدجيلي	أستاذ	أستشاري الطب النفسي	18 سنة	كلية الطب/ جامعة الكوفة
.4	د. معن حميد ابراهيم	أستاذ مساعد	تمريض الصحة النفسية والعقلية	40 سنة	كلية التمريض/ جامعة بغداد
.5	د. سلمان حسين فارس	أستاذ مساعد	تمريض صحة المجتمع	24 سنة	كلية التمريض/ جامعة كربلاء
.6	د. قحطان قاسم محمد رضا	أستاذ مساعد	تمريض الصحة النفسية والعقلية	23 سنة	كلية التمريض/ جامعة بغداد
.7	د. حيدر حمزة الحدراوي	أستاذ مساعد	تمريض الصحة النفسية والعقلية	20 سنة	كلية التمريض/ جامعة بابل
.8	د. حسن عبدالله عذبي	أستاذ مساعد	تمريض البالغين	18 سنة	كلية التمريض/ جامعة كربلاء
.9	د.صافي داخل نوام	أستاذ مساعد	تمريض الصحة النفسية والعقلية	18 سنة	كلية التمريض/ جامعة كربلاء
.10	د. حسام مطشر العامري	أستاذ مساعد	تمريض الصحة النفسية والعقلية	15 سنة	كلية التمريض/ جامعة الكوفة
.11	د. حسن علي حسين الزيدي	أستاذ مساعد	تمريض الصحة النفسية والعقلية	14 سنة	كلية التمريض/ جامعة بغداد

Appendix G

الجزء الاول: المعلومات الديموغرافية والاجتماعية

العمر ☐

الجنس: ذكر ☐ أنثى ☐

المستوى التعليمي: لا يقرا ولا يكتب ☐ يقرا ويكتب ☐ ابتدائي ☐

ثانوية ☐

معهد ☐ بكالوريوس ☐ ماجستير ☐ دكتوراه ☐

الحالة الاجتماعية: أعزب ☐ متزوج/ة ☐ أرمل/ة ☐ مطلق/ة ☐

الدخل الشهري: يكفي ☐ يكفي الى حد ما ☐ لا يكفي ☐

Appendix H

الجزء الثاني: مقياس بيك للاكتئاب

ت	المجموعة	الاسئلة
1	**الحزن**	a-لا أشعر بالحزن. b-أشعر بالحزن في كثير من الأحيان. c-أنا حزين طوال الوقت. d-أشعر بالحزن أو التعاسة إلى درجة لا تطاق.
2	**التشاؤم**	a-لم تضعف همتي فيما يخص مستقبلي. b-أشعر بضعف همتي فيما يخص مستقبلي على غير عادتي. c-أتوقع أن لا تسير أموري على بشكل جيد. d-أشعر أن مستقبلي لا أمل فيه، وأن الأمور تزداد سوءاً.
3	**الفشل او الاخفاق فيما سبق من العمر**	a-لا أشعر بأني فاشل. b-فشلت أكثر مما ينبغي. c-كلما أفكر في حياتي السابقة أكتشف الكثير من الفشل.

		d-أشعر أني فاشل في حياتي تماماً.
4	**فقدان المتعة أو الاستمتاع**	a-أستمتع دائما بالحياة كما كنت من قبل. b-لا أستمتع بالحياة بالقدر الذي اعتدت عليه. c-أحصل على قدر قليل جدا من الاستمتاع بالحياة مما تعودت عليه من قبل. d-لم أحصل على أي استمتاع بالحياة كعادة استمتاعي سابقا.
5	**الشعور بالذنب أو الإثم**	a-لا أشعر شعوراً خاصاً بالذنب. b-أشعر بالذنب من عديد الأشياء التي فعلتها، أم من أشياء واجبة الأداءولم أقم بها. c-أشعر بالذنب معظم الأوقات. d-أشعر بالذنب جُل الأوقات.
6	**الشعور بالعقاب أو الأذى**	a-لا أشعر بأن هناك عقاباً أو اذى يحل بي. b-أشعر بأن عقاباً أو أذى سيحدث أو سيحل بي. c-أتوقع عقاباً يقع علي بالفعل. d-أشعر اني سأتعرض للعقاب أو ألأذى.
7	**الاحساس السلبي نحو الذات**	a-شعوري نحو ذاتي لم يتغير. b-فقدت الثقة في نفسي. c-خاب أملي في نفسي. d-لا أحب نفسي.
8	**موقف نقد الذات**	a-لا الوم ولا أنتقد نفسي أكثر من المعتاد. b-أنتقد نفسي أكثر من المعتاد. c-ألوم نفسي لما أرتكب اخطاء. d-ألوم نفسي على كل ما يحدث من سوء بسببي.
9	**الأفكار أو الرغبة في الانتحار**	a-لا تنتابني أي أفكار للتخلص من نفسي. b-تراودني أفكار للتخلص من حياتي ولكن لا أنفذها. c-أريد أن أنتحر. d-سانتحر في أي فرصة متاحة.

10	**البكاء**	a-لا أبكي أكثر من المعتاد. b-أبكي اكثر من المعتاد. c-أبكي لأتفه الأسباب أو لأقل أصغر الاشياء. d-كنت قادراً على البكاء ولكنني أعجز الآن عن البكاء حتى لو أردت ذلك.
11	**الهيجان أو الاستثارة**	a-لست منزعجاً أو متوتراً هذه الأيام عن أي وقت مضى. b-أشعر بالانزعاج أو التوتر هذه الأيام عن أي وقت مضى. c-أتهيج وأتوتر الى درجة يصعب علي البقاء هادئاً. d- أتهيج وأتوتر الى درجة تدفعني إلى الحركة أو فعل شيء ما.
12	**فقدان الاهتمام**	a- لم أفقد اهتمامي بالآخرين أو بالأنشطة. b-أنا قليل اهتمام بالآخرين أو بالأنشطة عن السابق. c-فقدت معظم اهتمامي بالآخرين وبالأمور الأخرى. d-لدي صعوبة في أن أهتم بأي شيء مهما كان.
13	**التردد في اتخاذ القرار**	a-أتخذ قرارات صائبة وحكيمة دائما كمثل ما كنت عليه سابقا. b-أجد صعوبة في اتخاذ القرارات. c-لدي صعوبة كبيرة أكثر من ذي قبل في اتخاذ القرارات. d-اعجز تماما عن أتخاذ أي قرار مهما كان بالمرة.
14	**انعدام القيمة**	0-أظن أني شخص مهم ولدي قيمة. b-أعتقد أني لست شخصا مهما وذا قيمة كما تعودت. c-أشعر أني أقل قيمة مقارنة بالاخرين. d-أشعر أني عديم القيمة تماما.
15	**فقدان الطاقة**	0-لدي دائما نفس القدر من الطاقة كما كنت من قبل. b-لدي قدر من الطاقة أقل مما كنت عليه من قبل. c-ليس لدي طاقة كافية للتمكن من فعل أشياء كبيرة. d-ليس لدي طاقة لفعل شيء مهما كان.

16	**التغير في عادات النوم**	a-عادات نومي لم تتغير. bأ-أنام أكثر بقليل على ما تعودت عليه. bب-أنام أقل بقليل على ما تعودت عليه. cأ-أنام أكثر مما تعودت عليه بشكل كبير. cب-أنام اقل مما تعودت عليه بشكل كبير. dأ-أنام تقريبا كل اليوم. dب-أستيقظ من النوم مبكراً من 2-3 ساعات\، وأعجز عن استئناف نومي.
17	**قابلية الغضب**	a-لا أغضب أكثر من المعتاد. b-أغضب أكثر من المعتاد. c-أغضب أكثر بكثير من المعتاد. d-أنا دائم الغضب.
18	**تغير الشهية**	a-شهيتي لم تتغير. b أ-شهيتي أقل بقليل من السابق. b ب-شهيتي أكبر بقليل من السابق. c أ-شهيتي أقل بكثير من السابق. c ب-شهيتي أكبر بكثير من السابق. d أ-ليست لدي شهية على الاطلاق. d ب-لدي رغبة دائمة في الأكل.
19	**صعوبة التركيز**	a-أستطيع التركيز دائما كما تعودت. b-لا أستطيع التركيز كما تعودت. c- لدي صعوبة في أن أركز لمدة طويلة في أي شيء كان. d- أجد نفسي عاجزاً على التركيز في أي شيء مهما كان.
20	**الإرهاق أو الإجهاد**	a-لست أكثر ارهاقاً من السابق. b-أرهق وأتعب بسهولة أكثر مما تعودت عليه. c-كثرة الإرهاق تعيقني عن القيام بأشياء كثيرة اعتدت عليها. d-أصبحت مشغولاً تماماً بأموري الصحية.

21	**فقدان الاهتمام بالجنس**	a-لم ألاحظ أي تغييرات حديثة في رغبتي الجنسية. b-أصبحت اقل اهتماماً. c-قلت رغبتي الجنسية بشكل ملحوظ. d-فقدت تمام رغبتي الجنسية.

Appendix I

الجزء الثالث: مقياس تايلور للقلق

ت	العبارة	نعم	الاجابة	لا	الاجابة
1.	انام بصورة مضطربة والنوم متقطع غير مريح	نعم		لا	
2.	مرت بي أوقات لم أستطع خلالها النوم بسبب القلق	نعم		لا	
3.	مخاوفي قليلة جداً مقارنتاً بأصدقائي	نعم		لا	
4.	اعتقد أنني أكثر عصبية من معظم الناس	نعم		لا	
5.	تنتابني أحلام مزعجة (أو كوابيس) لعدة ليالي	نعم		لا	
6.	بعض الاحيان أشعر بأضطرابات ومشاكل في معدتي	نعم		لا	
7.	غالبا ما ألاحظ أن يداي ترتجفان عندما أحاول القيام بعمل ما	نعم		لا	
8.	أعاني أحيانا من نوبات إسهال بدون سبب مرضي	نعم		لا	
9.	.يثير قلقي الأمور المتعلقة بوضعي الوظيفي او عملي	نعم		لا	
10.	تصيبني نوبات من الغثيان .(لعبان نفس)	نعم		لا	
11.	كثيراً ما أخشى من احمرار وجهي خجلا؟	نعم		لا	
12.	. أشعر بجوع في كل الأوقات تقريبا	نعم		لا	
13.	أثق في نفسي كثيراً	نعم		لا	
14.	أتعب بسرعة	نعم		لا	
15.	يجعلني الانتظار عصبياً	نعم		لا	
16.	أشعر بالتوتر لدرجة لااستطيع النوم	نعم		لا	

17.	عادةً ما أكون هادئاً	**نعم**	**لا**
18.	تمر بي فترات من عدم الاستقرار لدرجة أنني لا أستطيع الجلوس طويلا في مقعدي	**نعم**	**لا**
19.	لا أشعر بالسعادة معظم الوقت	**نعم**	**لا**
20.	من السهل أن أركز ذهني في عمل ما	**نعم**	**لا**
21.	أشعر بالقلق على شئ ما، أو شخص ما، طوال الوقت تقريبا	**نعم**	**لا**
22.	لا أخشى أو لا اخاف الأزمات والشدائد	**نعم**	**لا**
23.	أود أن أصبح سعيداً كما يبدو الآخرين	**نعم**	**لا**
24.	كثيراً ما أجد نفسي قلقاً على شيء ما	**نعم**	**لا**
25.	أشعر أحياناً وبشكل مؤكد اني عديم الفائدة	**نعم**	**لا**
26.	أشعر أحياناً أنني أتمزق	**نعم**	**لا**
27.	أعرق بسهولة حتى في الأيام الباردة	**نعم**	**لا**
28.	الحياة صعبة بالنسبة لي	**نعم**	**لا**
29.	لا اقلق ولا اهتم لسوء الحظ الذي يلازمني	**نعم**	**لا**
30.	إنني حساس بدرجة غير عادية	**نعم**	**لا**
31.	لاحظت أن قلبي يخفق بشدة	**نعم**	**لا**
32.	لا أبكي بسهولة	**نعم**	**لا**
33.	خشيت أشياء أو أشخاص أعرف أنهم لا يستطيعون إيذائي	**نعم**	**لا**
34.	أتأثر بالأحداث تأثراً شديداً	**نعم**	**لا**
35.	كثيراً ما اعاني من الصداع	**نعم**	**لا**
36.	شعرت بالقلق على أشياء لا قيمة لها	**نعم**	**لا**
37.	لا أستطيع أن أركز تفكيري في شيء واحد	**نعم**	**لا**
38.	لا أرتبك بسهولة	**نعم**	**لا**
39.	اعتقد أحياناً أنني ضعيف ولا فائدة مني	**نعم**	**لا**
40.	أنا شخص متوتر جداً	**نعم**	**لا**

41.	أرتبك أحياناً بدرجة تجعل العرق يتساقط مني بصورة تضايقني جداً	**نعم**	**لا**
42.	يحمر وجهي خجلاً بصورة مفرطة عندما أتحدث للآخرين	**نعم**	**لا**
43.	أنا أكثر حساسية من غالبية الناس	**نعم**	**لا**
44.	مرت بي أوقات شعرت خلالها بتراكم الصعاب بحيث لا أستطيع التغلب عليها	**نعم**	**لا**
45.	أكون متوتراً للغاية أثناء القيام بعمل ما	**نعم**	**لا**
46.	يداي وقدماي باردتان في العادة	**نعم**	**لا**
47.	أحيانا أحلم بأشياء أفضل الاحتفاظ بها لنفسي	**نعم**	**لا**
48.	ثقتي بنفسي عالية	**نعم**	**لا**
49.	أعاني أحيانا من الإمساك	**نعم**	**لا**
50.	لا يحمر وجهي أبداً من الخجل	**نعم**	**لا**

Appendix J

الجزء الرابع: مقياس جودة الحياة لمنظمة الصحة العالمية

ت	العبارة
1	ما هو تقديرك لنوعية حياتك ؟ (أ) سيئة جداً (ب) سيئة إلي حد ما (ج)جيدة إلي حد ما (د) لا سيئة ولا جيدة (هـ) جيدة جداً
2	ما هو مدى رضاك عن حالتك الصحية ؟ (أ) راضي جداً (ب) راضي نوعاً ما (ج)غير راضي نوعاً ما (د) لا راضي ولا غير راضي (هـ) غير راضي أبداً
3	في رأيك إلي أي مدى يمكن أن يؤدي مرضك إلي عجزك عن القيام بالعمل ؟ (أ) ليس دائماً (ب)بدرجة قليلة (ج)بدرجة متوسطة (د) كثيراً (هـ) بدرجة بالغة
4	حتى تستمر حياتك، ما مقدار الرعاية التي تحتاج إليها ؟

	(أ) ليس دائماً (ب)بدرجة قليلة (ج)بدرجة متوسطة (د) كثيراً (هـ) بدرجة بالغة
5	ما مدى استمتاعك بالحياة ؟ (أ) ليس دائماً (ب)بدرجة قليلة (ج)بدرجة متوسطة (د) كثيراً (هـ) بدرجة بالغة
6	ما مدى شعورك بوجود معني لحياتك ؟ (أ) ليس دائماً (ب)بدرجة قليلة (ج)بدرجة متوسطة (د) كثيراً (هـ) بدرجة بالغة
7	إلي أي مدى يمكنك تركيز عقلك ببساطة ؟ (أ) ليس دائماً (ب)بدرجة قليلة (ج)بدرجة متوسطة (د) كثيراً (هـ) بدرجة بالغة
8	ما مدى شعورك بالأمن في الحياة ؟ (أ) ليس دائماً (ب)بدرجة قليلة (ج)بدرجة متوسطة (د) كثيراً (هـ) بدرجة بالغة
9	ما مدى الاهتمام الصحي في بيئتك الطبيعية ؟ (أ) ليس دائماً (ب)بدرجة قليلة (ج)بدرجة متوسطة (د) كثيراً (هـ) بدرجة بالغة
10	هل لديك الكفاية و الفاعلية الكافية للقيام بواجبات الحياة اليومية ؟ (أ) ليس دائماً (ب)بدرجة قليلة (ج)بدرجة متوسطة (د) كثيراً (هـ) بدرجة بالغة
11	هل أنت متقبل لبنائك الجسدي ؟ (أ) سيئ جداً (ب) سيئ نوعاً ما (ج)جيد نوعاً ما (د) لا سيئ ولا جيد (هـ) جيد جداً
12	هل أنت كفء لإشباع احتياجاتك ؟ (أ) سيئ جداً (ب) سيئ نوعاً ما (ج)جيد نوعاً ما (د) لا سيئ ولا جيد (هـ) جيد جداً
13	ما مدى توافر المعلومات اللازمة و التي تحتاج إليها في حياتك إليومية ؟

	(أ) ليس دائماً (ب)بدرجة قليلة (ج)بدرجة متوسطة (د) كثيراً (هـ) بدرجة بالغة
14	إلي أي مدى تتوافر لديك الفرصة للراحة و الاسترخاء ؟ (أ) ليس دائماً (ب)بدرجة قليلة (ج)بدرجة متوسطة (د) كثيراً (هـ) بدرجة بالغة
15	كم أنت قادر علي التنقل هنا و هناك ؟ (أ) ليس دائماً (ب)بدرجة قليلة (ج)بدرجة متوسطة (د) كثيراً (هـ) بدرجة بالغة
16	إلي أي مدى أنت راضي عن نومك ؟ (أ) غير راضي أبداً (ب)سيء نوعاً ما (ج) لا راضي ولا غير راضي (د) جيد نوعاً ما (هـ) راضي جداً
17	ما مدى رضاك عن أدائك لواجباتك اليومية ؟ (أ) غير راضي أبداً (ب)سيء نوعاً ما (ج) لا راضي ولا غير راضي (د) جيد نوعاً ما (هـ) راضي جداً
18	ما مدى رضاك عن قدرتك علي العمل ؟ (أ) غير راضي أبداً (ب)سيء نوعاً ما (ج) لا راضي ولا غير راضي (د) جيد نوعاً ما (هـ) راضي جداً
19	ما مدى رضاك عن نفسك ؟ (أ) غير راضي أبداً (ب)سيء نوعاً ما (ج) لا راضي ولا غير راضي (د) جيد نوعاً ما (هـ) راضي جداً
20	ما مدى رضاك عن علاقاتك الشخصية ؟ (أ) غير راضي أبداً (ب)سيء نوعاً ما (ج) لا راضي ولا غير راضي (د) جيد نوعاً ما (هـ) راضي جداً
21	ما مدى رضاك عن حياتك الجنسية ؟ (أ) غير راضي أبداً (ب)سيء نوعاً ما (ج) لا راضي ولا غير راضي (د) جيد نوعاً ما (هـ) راضي جداً
22	كم أنت راضياً عن المساندة الاجتماعية التي يقدمها لك أصدقائك ؟

	(أ) غير راضي أبداً (ب)سيء نوعاً ما (ج) لا راضي ولا غير راضي (د) جيد نوعاً ما (هـ) راضي جداً
23	ما مدى رضاك عن سكنك أو المكان الذي تعيش فيه ؟ (أ) غير راضي أبداً (ب)سيء نوعاً ما (ج) لا راضي ولا غير راضي (د) جيد نوعاً ما (هـ) راضي جداً
24	ما هو مدى رضاك عن الخدمات الصحية التي تقدمها المؤسسات الصحية ؟ (أ) غير راضي أبداً (ب)سيء نوعاً ما (ج) لا راضي ولا غير راضي (د) جيد نوعاً ما (هـ) راضي جداً
25	ما هو مدى رضاك عن مزاجك وسفراتك ؟ (أ) غير راضي أبداً (ب)سيء نوعاً ما (ج) لا راضي ولا غير راضي (د) جيد نوعاً ما (هـ) راضي جداً
26	الى اي مدى شعرت فيها بالحزن ، الاكتئاب ، والقلق ؟ (أ) ليس دائماً (ب)بدرجة قليلة (ج)بدرجة متوسطة (د) كثيراً (هـ) بدرجة بالغة

Appendix K

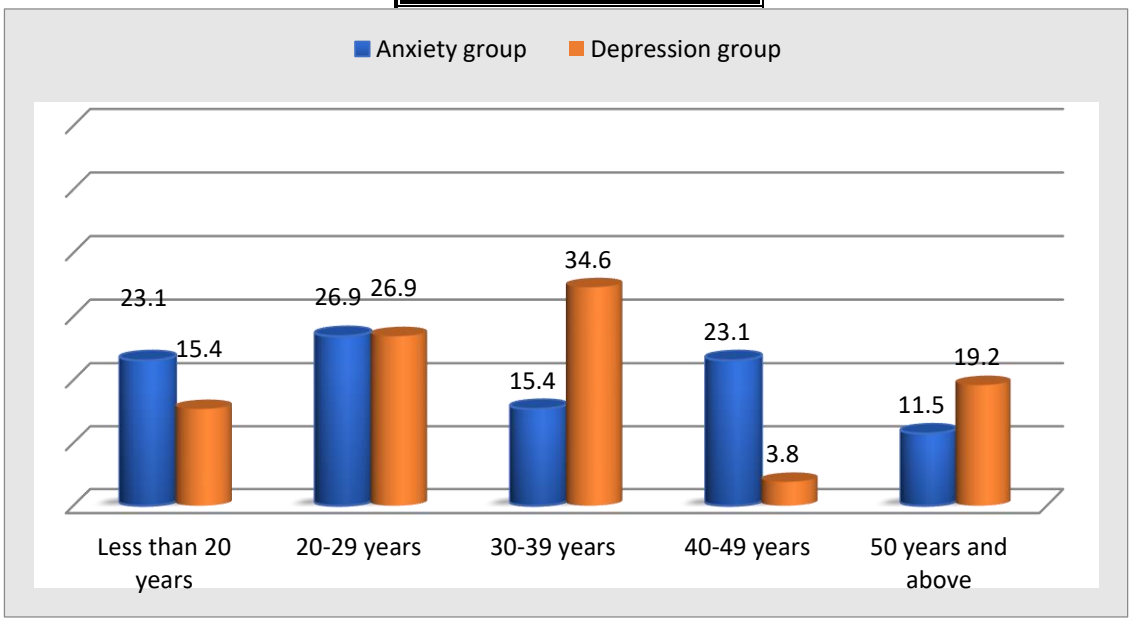


Figure (4-1): Distribution of participants of age for the anxiety and depression groups.

Appendix L

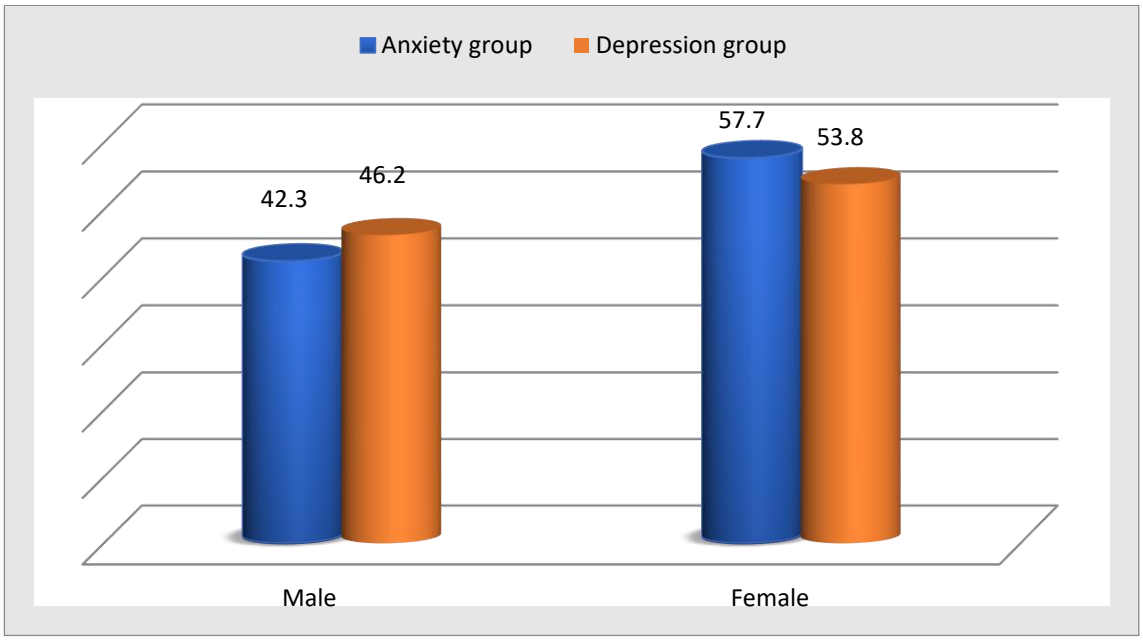


Figure (4-2): Distribution of participants of gender for anxiety and depression groups.

Appendix M

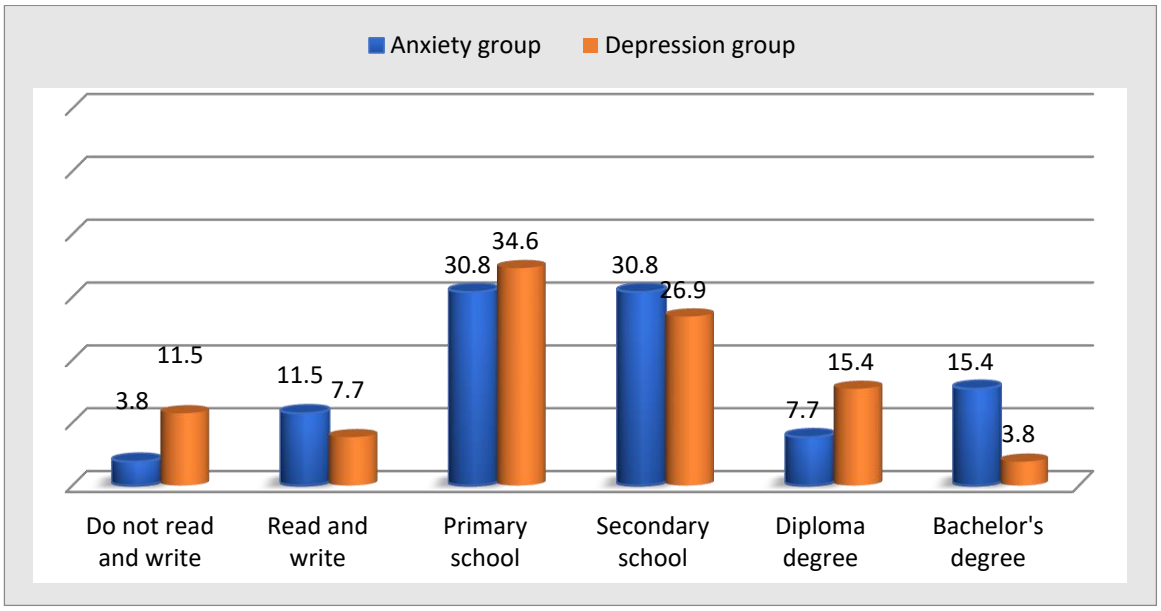


Figure (4-3): Distribution of participants of educational for the anxiety and depression groups.

Appendix N

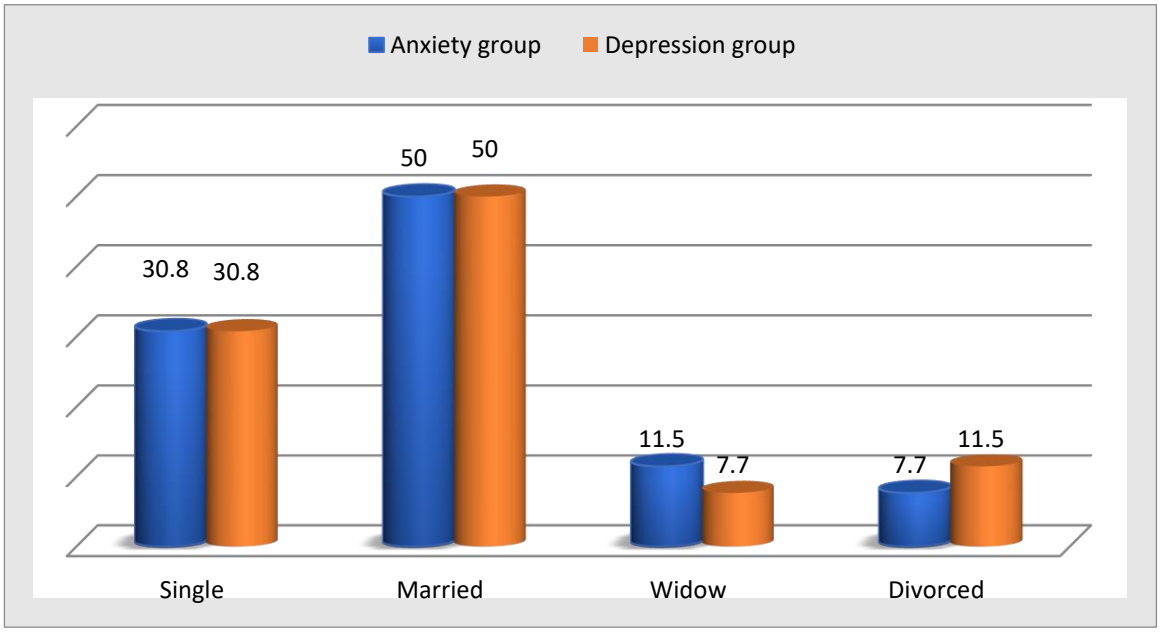


Figure (4-4): Distribution of participants of marital status for the anxiety and depression groups.

Appendix O

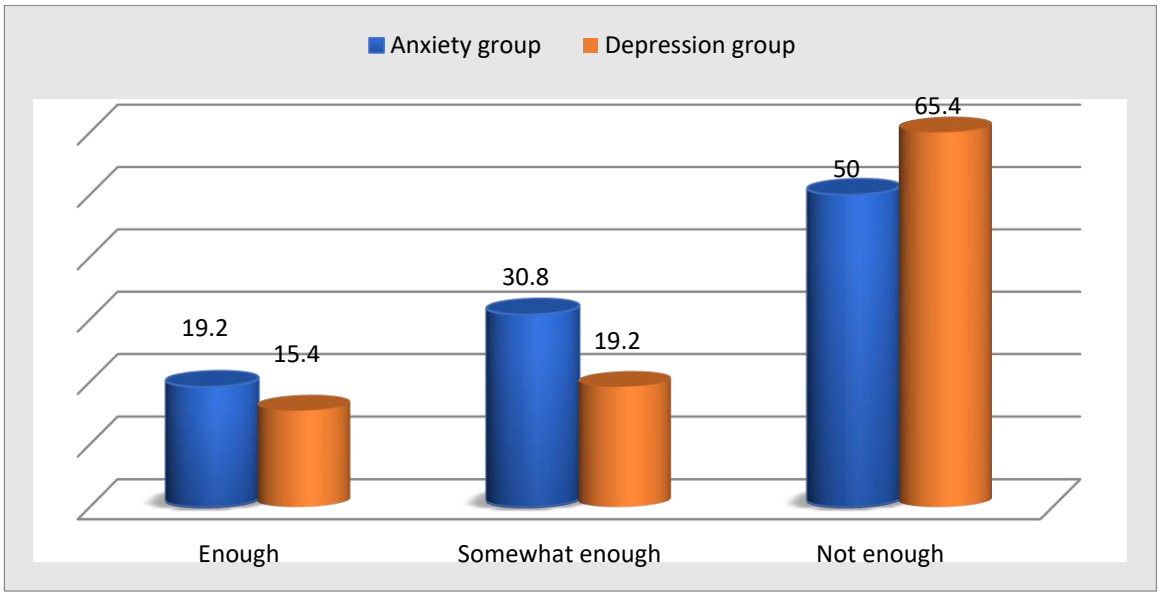


Figure (4-5): Distribution of participants of monthly income for the anxiety and depression groups.

Appendix P

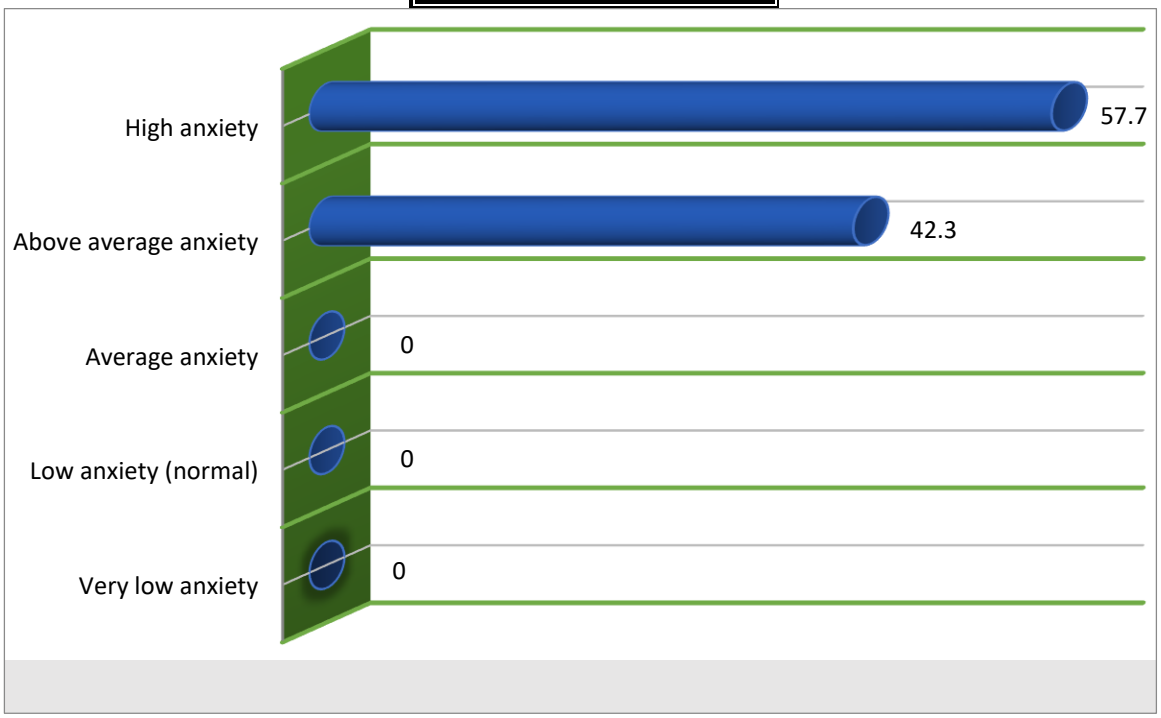


Figure (4-6): Distribution for the levels of anxiety among each participant with anxiety illness

Appendix Q

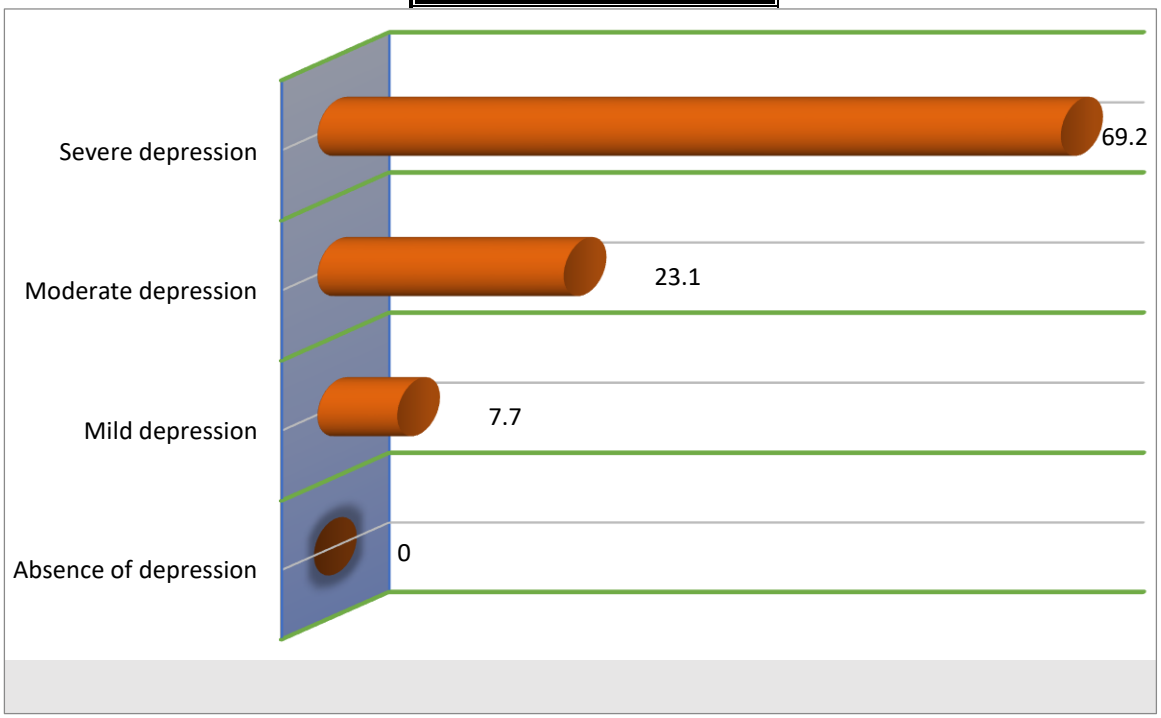


Figure (4-7): Distribution for the levels of depression among each participant with depression illness

Appendix R

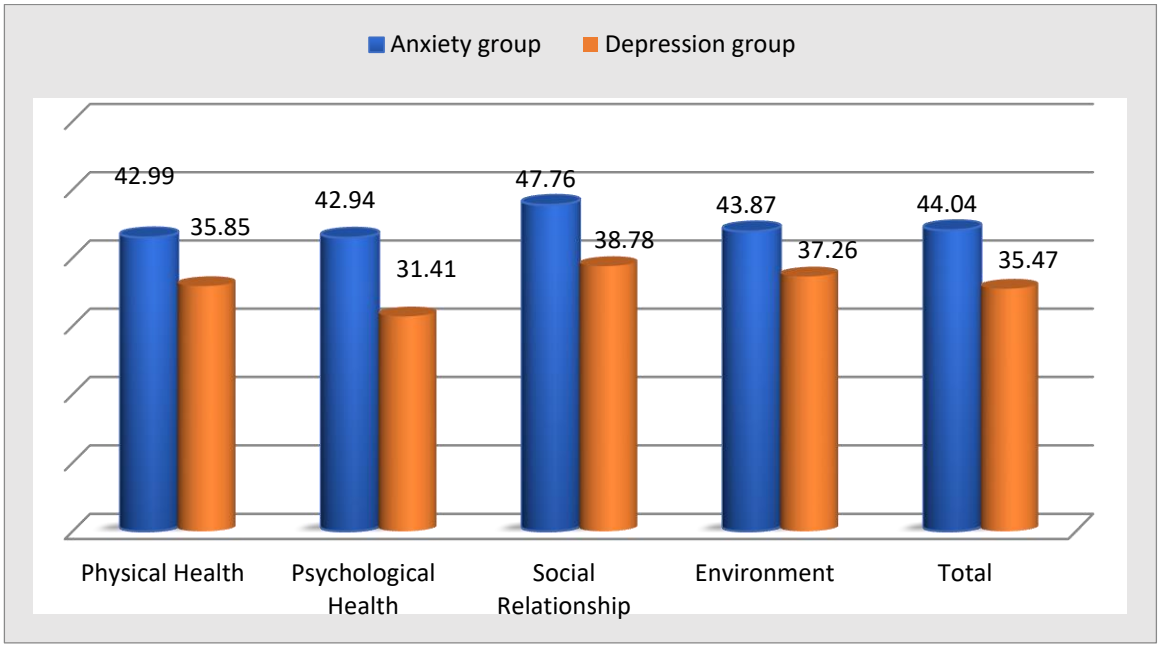


Figure (4-8): Distribution the differences in the level of quality of life for patients with anxiety and depression illness.

Appendix S

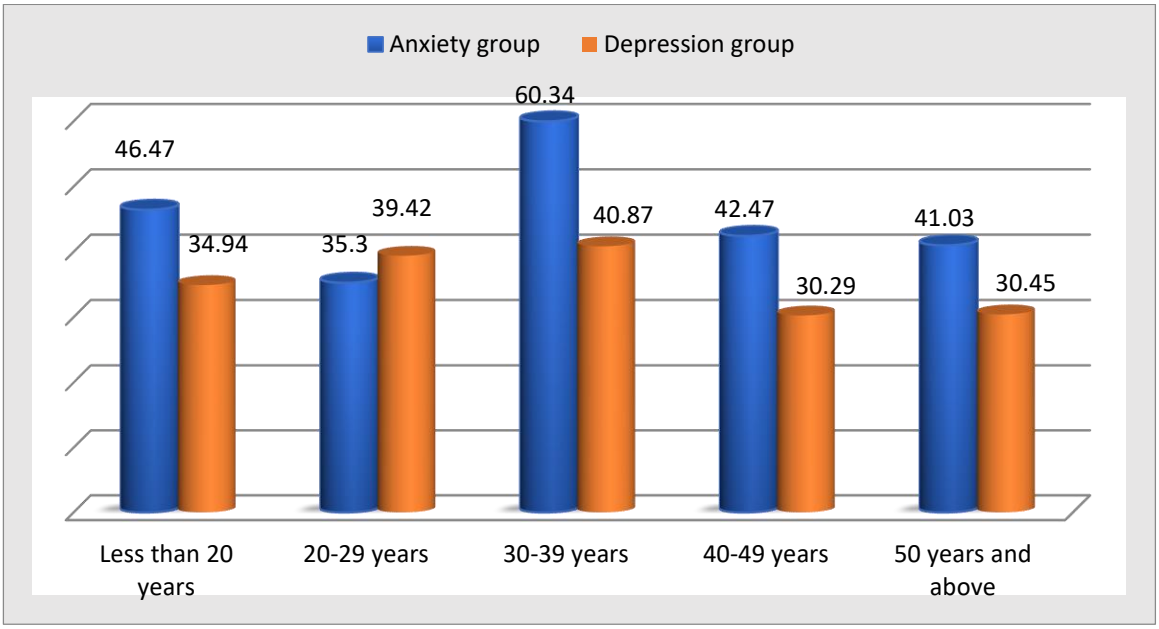


Figure (4-9): Distribution the level of quality of life for anxiety and depression patients with regard to their age values.

Appendix T

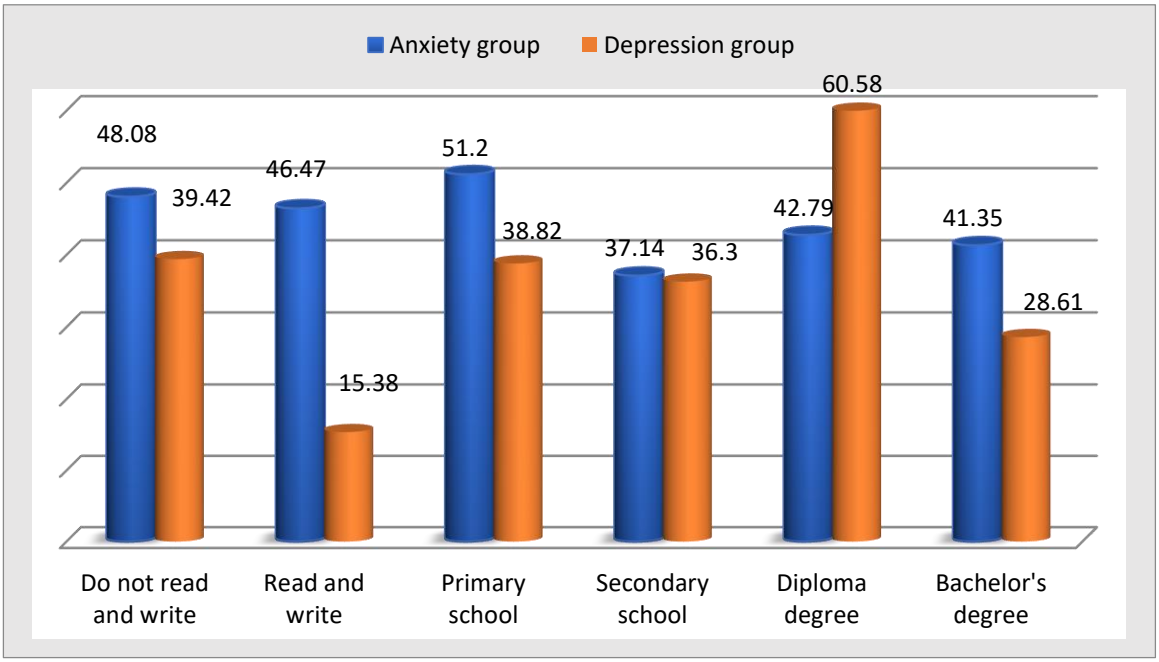


Figure (4-10): Distribution the level of quality of life for anxiety and depression patients with regard to their educational values.

Appendix U

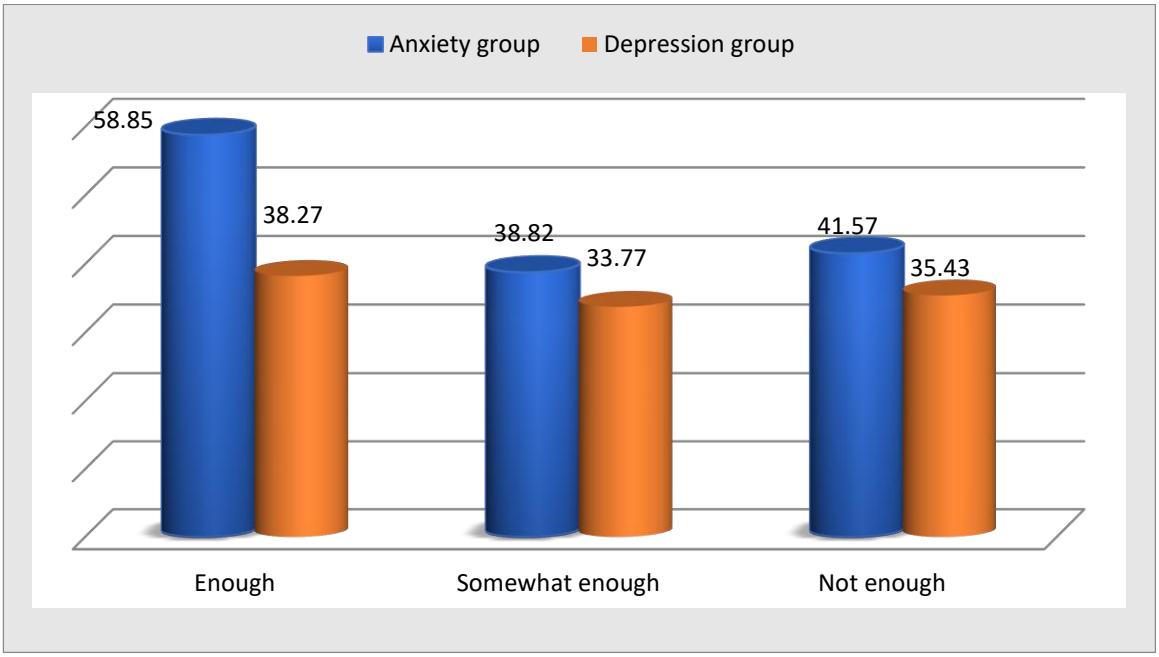


Figure (4-11): The level of quality of life for anxiety and depression patients with regard to their monthly income values.

Opinion of the statistician

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جامعة كربلاء
كلية التمريض
الدراسات العليا

اقرار الخبير الاحصائي

اشهد بان الرسالة الموسومة :

(اثر اضطرابات القلق والاكتئاب في جودة حياة المرضى في مدينة كربلاء المقدسة)
(Impact of Anxiety and Depression Illnesses Upon Quality of Life of Patients in Holy Kerbala City)

قد تم الاطلاع على الاسلوب الاحصائي المتبع في تحليل البيانات واظهار النتائج الاحصائية وفق مضمون الدراسة ولأجله وقعت.

توقيع الخبير الاحصائي:
الاسم واللقب العلمي: مدرس الدكتور نغاوي قاسم حسين
الاختصاص الدقيق: احصاء رياضي
مكان العمل: جامعة كربلاء / كلية الادارة والاقتصاد
التاريخ: 17/ 5/ 2022

Opinion of the Linguist's

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Ministry of higher education & scientific research
University of Kerbala
College of Nursing

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وزارة التعليم العالي والبحث العلمي
جامعة كربلاء
كلية التمريض
الدراسات العليا

اقرار الخبير اللغوي

اشهد بان الرسالة الموسومة :

(اثر اضطرابات القلق والاكتئاب في جودة حياة المرضى في مدينة كربلاء المقدسة)
(Impact of Anxiety and Depression Illnesses Upon Quality of Life of Patients in Holy Kerbala City)

قد جرى مراجعتها من الناحية اللغوية بحيث اصبحت بأسلوب علمي سليم خال من الاخطاء اللغوية ولأجله وقعت.

توقيع الخبير اللغوي:
الاسم واللقب العلمي: أ.م.د. غانم جويد عيدان السعيدي
الاختصاص الدقيق:
مكان العمل: جامعة كربلاء / كلية التربية للعلوم الانسانية
التاريخ: 19/ 10 / 2022
07702611080

المستخلص

جودة الحياة (QOL) هو مفهوم واسع ومتعدد الأبعاد وله تقييمات ذاتية لجميع جوانب الحياة إيجابياً وسلبياً. أجريت هذه الدراسة لفهم تأثير القلق والاكتئاب على نوعية حياة المرضى في مدينة كربلاء المقدسة. أجريت هذه الدراسة بغرض مقارنة القلق والاكتئاب وتأثيرهما على نوعية حياة هؤلاء المرضى.

الدراسة وصفية تحليلية ، تمت الدراسة بعينة تتكون من 104مريضا ، مجموعتين من 52 مريضا يعانون من اضطراب القلق ، و 52 مريضا يعانون من اضطراب الاكتئاب لمعرفة أثر أمراض القلق والاكتئاب على جودة حياة المرضى النفسيين. أجريت الدراسة في مستشفى الحسن المجتبى التعليمي بمدينة كربلاء بالعراق في الفترة من 5 ديسمبر 2021 إلى 30 سبتمبر 2022. تستخدم هذه الدراسة ثلاثة مقاييس: تايلور للقلق، مقايس بيك للأكتئاب، ومقياس جودة الحياة لمنظمة الصحة العالمية ، كانت درجة الثبات بالتتابع 0.837 ، 0.747 ، 0.812. كما أن الأدوات موثوقة ؛ تم إحالتها إلى 11 خبيرا في مختلف التخصصات ومن عدة كليات في العراق.

أظهرت النتائج أن مستوى جودة الحياة غير مقبول لمجموعة القلق 44.04 ومجموعة الاكتئاب 35.47. مجموعات القلق والتخلص من الضغط لها تأثير سلبي على نوعية الحياة ، وهناك اختلاف في نوعية الحياة للمجموعتين وفقًا لخصائصهم الديمغرافية. خلصت الدراسة إلى أن القلق والاكتئاب ونوعية الحياة تتأثر بالعوامل الديموغرافية ، وهذا التأثير يختلف باختلاف الاضطراب.

يوصي الباحث بإيجاد حلول فعالة لتقليل القلق والاكتئاب لدى المرضى لتحسين نوعية الحياة ، مثل تفعيل التقنية الجديدة للتواصل ومتابعة المرضى ، وكذلك تفعيل العلاج الجماعي.

جامعة كربلاء/كلية التمريض

أثر اضطرابات القلق والاكتئاب في جودة حياة المرضى في مدينة كربلاء المقدسة

رسالة تقدم بها

علي صبري ناصر

الى مجلس كلية التمريض/ جامعة كربلاء وهي جزء من متطلبات نيل درجة الماجستير علوم في التمريض

بإشراف

أ.د.علي كريم خضير

ربيع الاول- 1444هـ **تشرين الاول – 2022 م**