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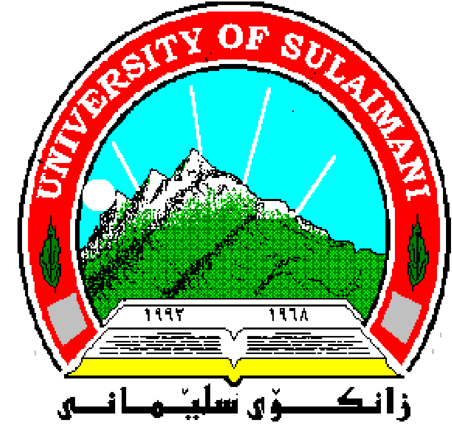


# *ASSESSMENT OF SELF-ESTEEM AND FEELING OF LONELINESS IN PATIENTS WITH MAJOR DEPRESSIVE DISORDER AT MENTAL HEALTH CENTER IN SULAIMANI CITY*

***A THESIS SUBMITTED TO THE COUNCIL OF THE COLLEGE OF NURSING / UNIVERSITY OF SULAIMANI IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE MASTER DEGREE IN PSYCHIATRIC AND MENTAL HEALTH NURSING***

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**بِسْمِ اللَّهِ الرَّحْمَـٰنِ الرَّحِيمِ**

**﴿ يَا أَيُّهَا النَّاسُ إِنَّا خَلَقْنَاكُم مِّن ذَكَرٍ وَأُنثَىٰ وَجَعَلْنَاكُمْ شُعُوبًا وَقَبَائِلَ لِتَعَارَفُوا ۚ إِنَّ أَكْرَمَكُمْ عِندَ اللَّهِ أَتْقَاكُمْ ۚ إِنَّ اللَّهَ عَلِيمٌ خَبِيرٌ ﴾**

**سورة الحجرات : الآية ١٣**

صدق الله العظيم

## *DEDICATION*

I dedicate this thesis with my love to:

- My parents **(my father; Haji Sabr & my mother; Jihan)** for their unconditionally supportive and, I appreciate their effort in helping me get to this point.

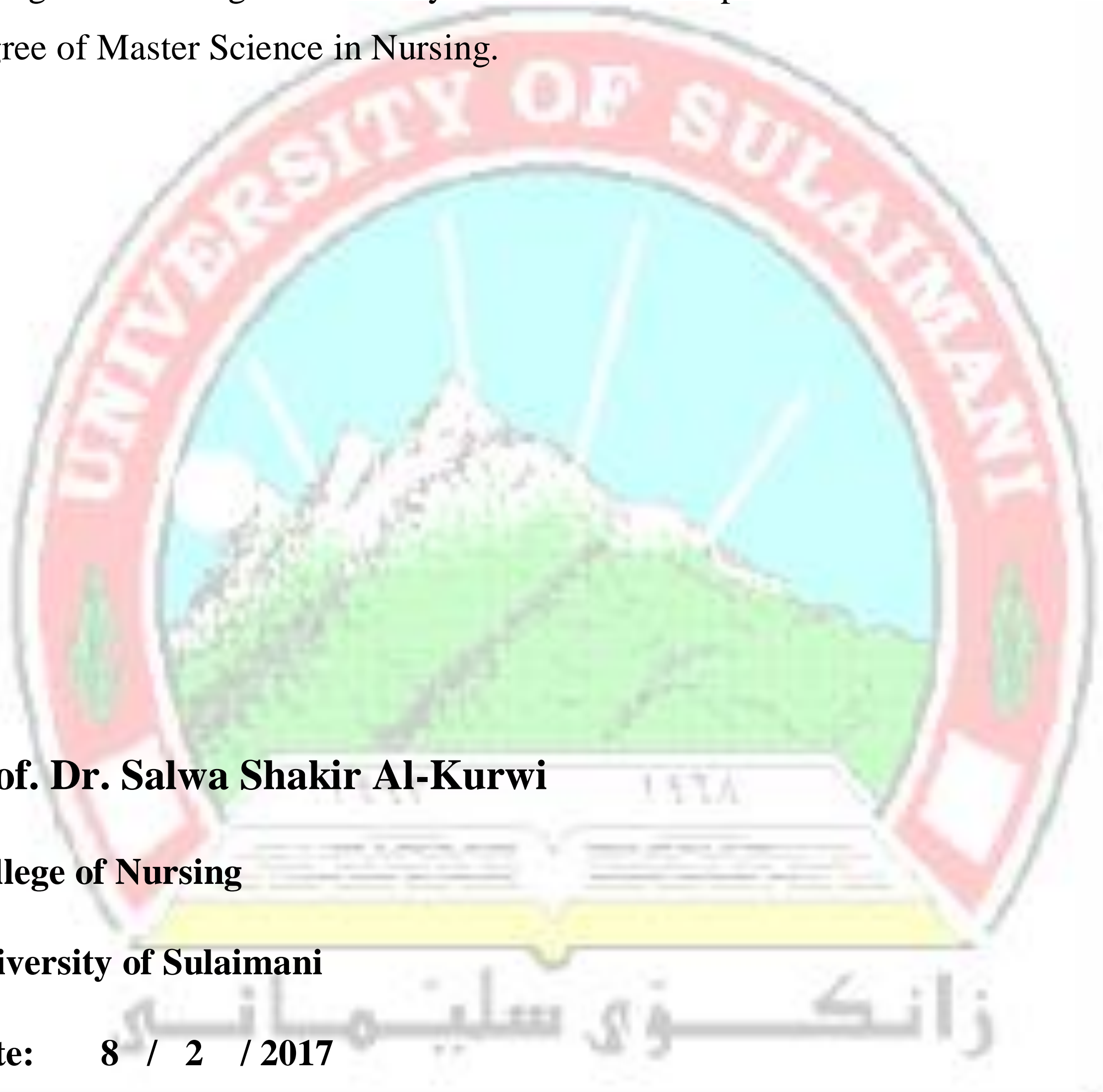
-My wife; Sara Saeed**,** who have always stood by me and dealt with all of my absence with a smile, who gave me strength, and support in my pursuit of professional education, for their undying and unconditional love, endless support and encouragement .

-My two amazing children Soma (susu) & Barham (bulbul).

- All My family members for their support and encouragement.

## *Supervisor's Certificate*

I hereby certify that the thesis entitled **"Assessment of Self-esteem and feeling of Loneliness in patients with Major Depressive Disorder at Mental Health Center in Sulaimani City"** was prepared under my supervision at the department of Psychiatric and Mental Health Nursing / College of Nursing / University of Sulaimani in partial fulfillment for the degree of Master Science in Nursing.

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**Date: 8 / 2 / 2017**

## *Committee's certification*

We ,the member of the examining committee, certify that after reading the thesis entitled **"ASSESSMENT OF SELF-ESTEEM AND FEELING OF LONELINESS IN PATIENTS WITH MAJOR DEPRESSIVE DISORDER AT MENTAL HEALTH CENTER IN SULAIMANI CITY "** which is submitted by student **(DIARY SABR AHMAD)** from the department of Psychiatric and Mental Health Nursing /College of Nursing /University of Sulaimani, we have examined the student in its contents and what is related to it ,we agree that it is adequate for the award of the Degree of Master Science in Nursing .

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I hereby certify that the thesis titled "**Assessment of Self-esteem and feeling of Loneliness in patients with Major Depressive Disorder at Mental Health Treatment Center in Sulaimani City**" has been reviewed linguistically by my self and I acknowledge that it is written in proper and scientific style far from linguistic mistakes.

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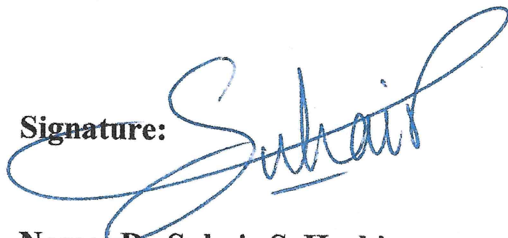

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## ABSTRACT

**Background:** low self-esteem and feeling of loneliness are psychological destress which lead to lower wellbeing, which may experience by depressed patients.

**Aim**: To assess the self-esteem and feeling of loneliness levels among patients with major depressive disorder.

**Methods**: A quantitative design, a descriptive study was conducted at mental health center in teaching hospital in Sulaimani city, during the period from 23rd May 2016 to 8th September 2016 .Purposive sample size (58) inpatients were selected from MHC .A questionnaire was developed and adopted which consisted of three parts; part one includes the sociodemographic and psychiatric characteristics; part two refers to Rosenberg self-esteem scale and the last part deals with Russel loneliness scale. The patients were interviewed by the researcher for data collection. Data was analyzed by using of statistical package for social science (SPSS-21).

**Result**: almost all studied depressed patients had feeling of loneliness ranging from frequent (60.3%) to severe (30.3%) level, with high percentage (84.4%) low self-esteem with mean score (8.51±3.02).The measurement of loneliness &self-esteem variables estimated on the Russel and Rosenberg scale were significantly negative correlated ($P<0.00$,$P<0.01$) respectively .

**Conclusion**: frequent feelings of loneliness and low self-esteem are perceived problems by patients with major depressive disorder in this study.

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## List of Abbreviations

%: Percentage

A D: After Death

APA: American Psychiatric Association

B C: Before Christ

CBT: Cognitive Behavioral Therapy

CED: Camber age English Dictionary

DOH: Directorate of Health

DSM: Diagnostic & Statistical Manual

ECT: Electro Convulsive Therapy

EE: Express Emotion

F: Frequency

GABA: Gaba Amino Butyric Acid

HPA: Hypothalamic-Pituitary-Adrenal

HS: Highly Significance

ICD: International Classification of Disease

IMHS: Iraqi mental health survey

IPT: Interpersonal Therapy

MAOIs: Monoamine Oxidase Inhibitors

MDD: Major Depressive Disorder

MHC: Mental Health Center

MSEI: Multidimensional Self-Esteem Inventory

NANDA: North American Nursing Diagnosis Association

NS: Not Significant

R: Pearson’s correlation

RSS: Rosenberg Self-Esteem Scale

S: Significance

SD: Standard Deviation

SSRIs Selective Serotonin Reuptake Inhibitors

TCAs: Tricyclic Antidepressants

UCLA: University of California at Loss Angels

USA: United States of America

WHO: World Health Organization

# List of Appendices



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# Chapter one

## Introduction

# Chapter one

# Introduction

## 1.1 Introduction:

Experiencing low self-esteem and feeling of loneliness are common and interrelated to lower wellbeing (Vanhalst et al, 2012). Studies show that low self-esteem positively associated with various indices such as depression ,eating disorder and engagement in risk behavior (Baumeister et al,2003;Harter,2006).similarly feeling of loneliness is related to anxiety ,depression ,sleep disturbance and even in cardiovascular disease (Heinrich &Gullone,2006).

Low self-esteem and feeling of loneliness are psychological distress that may affect people with specifically depression (Yaacob et al, 2009; Alkhatab, 2012).

Depression is associated with social withdrawal, negative appraisal of self-perceived and social failure, which may increase the risk of feeling of loneliness (Lasgaard et al, 2011).

Loneliness is the experience of solitude, disconnection and lack of closeness (Yaacob et al, 2009).it may be the discrepancy between ones desired and achieved level of social contact (Ahmad et al,2016).loneliness is a condition with feeling of distress of detachment due to a gaping emptiness in a person's social and/or emotional life (Vanhalst et al ,2012),it is repeatedly associated with depression (Yousafzai and Siddiqi,2007;Uba et al ,2012).

Also low self-esteem may contribute to development of depression (Orth et al,2009).Low self-esteem means the development of poor or

negative self-image ,such beliefs can become a self-fulfilling prophecy of expecting to fail (Orth et al,2009) .

Self-esteem is how people view themselves positively or negatively, it is the overall attitude toward oneself (Khaidzir & Ong, 2007) .Low self-esteem is commonly seen to be low in people with feeling of loneliness and can lead to depression (Uba et al 2012;Ahmed et al 2016).

Depression is a mental disorder that causes significant emotional suffering and health complication (Boyd, 2006; Bergdahl et al, 2011). Approximately 350 million people live with depression, and it is the leading cause of morbidity worldwide. It will become the second foremost source of disease related disability among folks of all ages by the year 2020 (WHO, 2012).

By the world mental health service initiative during 2007-2008 surveyed 4,332 Iraqi, the study revealed that 18.8% lifetime prevalence of any mental disorders in Iraq, mentioned anxiety and depression were the most common (Alhasnawi,S, et al, 2009) . Untreated major depression is linked to significant emotional suffering and physical health problems; the most tragic outcome of untreated depression is suicide (APA, 2000; Kim,C,et al .,2004).

Depression is pervasive alteration in the body, mood and thoughts. Such alterations significantly interfere with the daily lives and normal functioning of those who are affected, causing distress for both the persons with depression and those around them (Fortinash &Worret 2012).The resulting self-doubt ,guilt, and anger affect the self-esteem ,interpersonal relationships ,and livelihood of these individual(Boyd ,et al,2014).

The contributory factors to depression are many and varied, of the many contributory factors to depression are feeling of loneliness and low self-esteem (Cacippo et al, 2006; Yaacob et al, 2009) .

Loneliness is a more prevalent and serious problem among depressive patients, it may has been identified a risk factor for depression symptoms in both cross sectional (Nolen & Ahrens, 2002; Chou & Chi, 2004).and in longitudinal (Heikkinen & Kauppinen, 2004) studies.

The short –term and longitudinal research suggests that low self-esteem prospectively predicts depression .Also ,depression and self-esteem are intertwined and contribute to negative effect (Sowislo & Orth, 2013) .Research has shown that self-esteem influence depression (Yousafzai&Siddiqi.2007)often studies have suggested that depression works negatively to decrease self-esteem during episode (Daskalopoulou, et al. 2002; Tarrier, 2008).

The evolutionary theory and cognitive theory models, have acknowledged the association between loneliness and self-esteem. The low self-esteem and loneliness are closely and reciprocally interrelated (vanhalst et al, 2012) and correlate with depression (Uba et al, 2012).

**1.2 Importance of the study**

The accessible literatures reported that feeling of loneliness and low self-esteem may be risk factors for depression symptomatology, the previous studies also provide for this view (Alpas and Neville ,2003;Yaacob et al ,2009;Fortinash &Worret,2012) .

Feeling of loneliness represent a distressing situation that is associated by limited social relationship and the perception of being isolated and can lead to the onset of depression (Savikko *et al.*, 2005) .Moreover ,studies have sought the complex relationship between self-esteem and depression

(Kernis ,2006 ) and between loneliness and depression (Heinrich &Gullone ,2006).

The human experience low self-esteem &high level of loneliness during depression disorder tended to lead onto the formation of unhelpful ritual behavioral patterns that shaped the participation life by way of the maintaining their suffering . Suffering was maintained through resistance to change, persistence rumination, inability, internalization, habitual poor health practices, and destructive behavior and may associated with suicide attempts (Lasgaard et al 2011;fortinash&worret,2012),and thus increased need of help and use of metal health service (Jylhä 2004).

The fundamental mental health nursing focuses on patients' subjective experience to understand patients' inner world and focus on understanding how patients then relate to themselves and the world around them ,thus professional nursing practice requires a theoretical evidence base ,technical skills in practice to perform the appropriate care (Morrison and Valfre, 2005). Accordingly, identification the prevalence and level of self-esteem and feeling of loneliness during nursing assessment of patients with major depression disorder have short and long term benefit for interventions and prognosis of such patient.

Previous studies confidence the self-esteem, feeling of loneliness and depression are intertwined process and need to be more studied (Yaacob et al, 2009; Uba et al 2012). More over such studies have limited in mental health nursing field and is absent in Kurdistan /Iraqi. The above mentioned issues highlight the need of the present study .Therefore, the current study aims to assess the proportion and the levels of severity of feeling of loneliness and low self –esteem among patients with major depressive disorder, since these variables were critical assessment areas in the psychiatric mental health nursing process.

### 1.3 The Statement of the problem:

"Assessment of Self-Esteem and Feeling of Loneliness in Patients with Major Depressive Disorders in Mental Health Center in Sulaimani city" .

### 1.4 objectives of the study:

1- To identify the socio-demographic characteristics of the patients previously diagnosed with major depressive disorder including (age, gender, and marital status, level of educational, occupation, economic status, and residency area).

2- To identify the psychiatric clinical characteristics of the patients including, (number of hospitalization, adherence to medication, receiving ECT, number and method of attempted suicide).

3- To measure the proportion and level of feeling of loneliness &self-esteem among the patients with major depressive disorder.

4- To find out the relationship between the levels of self-esteem and feeling of loneliness with socio-demographical & psychiatric clinical characteristics of the patients.

### 1.5 Definition of Terms

1. Assessment

**Theoretical definition**

A systematic collection of data about individual health status, concerns mainly with current situation and needs that may hinder the achievement of optimal health and wellbeing (Boyd, 2008).

**Operational definition**

A systematic data collection done by the researcher for inpatients with major depressive disorder, regarding their status condition including feeling of loneliness and self-esteem by using a questionnaire of current study .

2. **Self-esteem:-**

**Theoretical definition**

Self-esteem is a personal judgment of worthiness that is expressed in the attitudes the individual holds towards h/herself (Al katib, 2012).

**Operational definition:**

The overall attitude towards oneself made by depressive patients in Mental Health Center in Sulaimani city and that's measured by Rosenberg's self-esteem scale in three levels: low, average and high.

3. **Loneliness**

**Theoretical definition:**

The negative emotional response to a discrepancy between the desired and achieved quality of one's social network (Vanhalst et al, 2012) .

**Operational definition:**

A subjectively experienced aversive emotional state that is related to the perception of unfulfilled intimate and social needs of depressive patients in Mental Health Center in Sulaimani city and that is measured by Russel loneliness scale which include, average, frequent and severe .

# Chapter two

## Literature Review

# Chapter two:

# Review of literature:

**Section one**

## 2.1. Depression:

### 2.1.1 Historical background

In Latina the word depression stem of the word "demission" meaning "mourn" or "depression" meaning "glooming" (Taylor&Fink,.2006).In English the word depression meaning "unhappiness" ,"sadness" or "dejection" (Turner &Bryan, 2015) .

Historically, the physician Hippocrates (460-377BC) described the symptoms of an early representation of depression and used the term melancholia. Aristotle (384-322 BC ) linked the etiology of melancholia to excess of black bile (Horwitz&Wakefileld ,2007).

The modern era of psychiatry began with German psychiatrist, Emil Kraeplin (1856-1926).Kraeplin is most notably known as the father of nosology in psychiatry and the person most often associated with the emergence the term depression instead of melancholia (Shorter, 2013).Kraeplin was the pioneer in the field of biological psychiatry, arguing that depression and other mental disorders are brain disease (Lowis ,2012).

Sigmund Freud, 1920 explained melancholia as the responses to loss, and linked the state of melancholia to mourning and advocated the psychoanalysis approach to resolve unconscious conflicts (Ebert and Bar, 2010). Adolf Meyer, 1866-1950, argued that the term depression should be used instead of melancholia (Paykel, 2008). Depression is a common

mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration. At its worst, depression can lead to suicide (WHO, 2012).

The term “depression” was included in the first version of international classification of disease by world health organization (ICD-1) in 1948, along with diagnostic and statistical manual of mental disorder (DSM) in 1952. Reviewing the DSM-IV-TR (1998) the major depressive disorder are grouped under mood disorders, while in DSM-V (2013), the major depressive disorder changed to be a separate disorder (APA,2013).

**2.1.2 The classification of depressive disorder:-**

In DSM-5, 2013 the depressive disorders present only with depressive episodes or only symptoms without the opposite pole of elation of manic or hypomanic symptoms (Rahim, 2015).

According to DSM-5 (APA, 2013) depressive disorders include:-

- Major depressive disorder
- Persistent depressive disorder (Dysthymia)
- Premenstrual dysphoric disorder
- Disruptive mood dysregulation disorder
- Substance /medication depressive disorder
- unspecified depressive disorder

Depression can be single episode or recurrent and categorized in term of severity as mild, moderate, sever and psychotic. Depression also specified by causes as in-patient remission, in full remission and unspecified (APA, 2013).

Additional specification such as catatonia, melancholia, atypical, features, anxious distress, mixed features, mood congruent psychotic feature, mood –incongruent psychotic features, per partum onset and seasonal pattern exist for major depressive disorders (DSM-5).

### 2.1.3 Major depressive disorder: an overview

Major depressive disorder is a serious depressive illness label as clinical depression (Paykel, 2008). It has become one of the most common mental disorders with high prevalence throughout a lifetime (Uba et al, 2012).

Major depressive disorder is the leading cause of disability among sufferers, and at its most severs can lead to suicide (Mohammad, 2012). It is characterized by clear cut changes in affect, cognitive, neuro vegetative function, a companied by low self-esteem, loss of interest or pleasure in normally enjoyable activities, and deficits in interpersonal skills which produce loneliness (Fortinash and Worret, 2012; Lasgaard, 2011and Roger, 2009). The severity of symptoms and degree of functional impairment vary widely and comparable with the individual's sense of helplessness and hopelessness (Videbeck, 2011).

### 2.1.4 Etiology of depression:

Multifactorial theories have been developed during different historical periods to explain and understand depression. In general particular models are as follows:-

#### 2.1.4.1 Psychoanalytic model:

The psychoanalytic model is only one of many explanations that attempt to explain the internal dynamics of depression (Lewis, 2012).

The basic premise of psychoanalytic model is that unconscious processes result in expression of symptoms, including depression. Freud 1957 distinguished between depression and normal grief, citing both as a response to real or symbolic loss. According to Freud, in depression the loss generates intense, hostile feelings toward the lost object that are turned inward onto self creating guilt and loss of self-esteem (Fortinash &Worret ,2012 and Gabbard ,2005).

Thus depression is viewed together with loss and aggression .The loss of an object either physically or emotionally is compounded by the development anger (Lewis, 2012). Early in childhood, struggling with feeling of rejection, the child is unable to direct anger and hostility toward the lost love object for fear of more rejection with loss and because of a strong, punitive superego. The child experiences ambivalence, or both love & hate for the lost love object. Feeling of anger and aggression are repressed, and the child interprets the loss as rejection and a reflection of his or her own luck self-worth. As a result, patterns of low self-esteem, depression and helplessness become established and endure as the person confronts future loss, creating a vulnerability to red or perceived loss throughout adulthood that results in period of depression (Fortinash &Worret, 2012, 2005).

**2.1.4.2 Neurobiological model:**

This model suggesting multiple biological factors, independently or together may predispose or precipitate depression (Garcia-Toro&Aguirre, 2007). Investigation between depressed and non-depressed samples have found differences in neurotransmitter function, hormones, brain structure and immune function (Sharpley, 2013and Garcia –Toro&Aguirre, 2007) .

Current research reported that monoamine neurotransmitter system, especially those of norepinephrine and serotonin, their metabolites and their receptor are somehow altered during episode of depression .In addition recent research noted that there is a change in the sensitivity or density of presynaptic and /or post synaptic receptors specific to particular neurotransmitters (Hardeveld, 2013& Fortinash and Worret, 2012).

The monoamine theory relates depression to decreased activity of monoamine neurotransmitters such as norepinephrine, dopamine and serotonin (Mulinari, 2012). Also, depression has been linked to reduced gamma-amino butyric acid activity. Dysregulation of the glutamine system and defects in GABAergic activity are implicated in depression (Sharpley, 2013&Luscher et al, 2011). The role that neurotransmitters play in depression is not yet fully understood (Sharpely, 2013). Another area of studies indicate that dysregulation of the hypothalamic –pituitary – adrenal (HPA) axis is associated with depression (Haster, 2010).

Genetic studies on family, twin and adoption support evidence that depression is a familial disorder with genetic factors explaining approximately 30-40%of the variance in the development of depressive disorder (Haster, 2010). Structural studies discovered that the limbic system such as hypothalamus, amygdala, and hippocampus, may associated with depression (Roy &Compbell, 2013).

**2.1.4.3 Cognitive model:**

This model includes; Beck cognitive theory and hopelessness theory (Disner et al, 2011).

- ❖ Beck cognitive theory proposed that biased acquisition and processing of information is involved in the development and maintenance of depression over time. Information processing is

influenced by activation of schemas to internal or external events. Schemas are structures ideas and experiences that exert great influence over thoughts, attitudes and behaviors. Rooted in early life, negative self-referential schemas are activated by adverse events .They are subsequently activated by future stressors, which are reflective of early life activation, When negative self-referential schemas are activated, it results in an increased vulnerability for depression (Disner et al, 2011).

- The hopelessness theory of depression proposed that an individual's attributional style together with negative life events interact to develop hopelessness depression. According to this theory individual who consider negative life events as stable and global are more likely to experience hopelessness depression than individuals who do not hold that particular attributional style (Spinhoven et al., 2011).

**2.1.4.4 Biopsychosocial model:**

This model acknowledges that depression has both a biological and social etiology (Roy & Campbell, 2013). One of the most prominent theories is the diathesis-stress model. Diathesis refers to both the biological and psychosocial vulnerabilities to depression such as early life experiences, genetics, cognitions and personality. Individual differences in genetic predisposition and inherent vulnerabilities to depression, in combination with individual differences in stress exposure, result in fluctuating levels of symptom severity and variation in the degree of risk in developing depression (Willner et al, 2013).

**2.1.4.5 Evolutionary models:**

Evolutionary theory suggests that disproportionate sadness of depression occurs in response to complex adverse problems which require complex solution. Suicide attempts and deliberate self-harm would be a valid solution for such individuals (Hagen, 2011). Some evolutionary theorists considered depression as an adaption which may function to communicate a need for help (Nesse, 2000) .Excessive rumination and anhedonia may function to promote problem solving and deliberate self-harm and suicidality could be an adaptive form of help seeking (Hagen ,2011).

**2.1.5 Diagnostic criteria of major depressive disorder**

DSM-5 Major Depressive Disorder (MDD) criteria can possible based single episode or recurrent *(APA, 2013).* The criteria for diagnosis are:-

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad, empty, and hopeless) or observation made by others (e.g. appears tearful)

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or by observation)

3. Significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day

4. Insomnia or hypersomnia nearly every day

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

6. Fatigue or loss of energy nearly every day

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan or a suicide attempt or specific plan for committing suicide

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode (APA, 2013).

### 2.1.6 Epidemiology:

Major depressive disorder affects approximately 253 million in 2013(3.6%) of the global population (Global burden of disease study, 2015). Studies in the United States and Europe reported an increase in the prevalence of depression overtime and in subsequent generations (Kessing L, 2007 and Andrade, et al 2003). Whether or not the prevalence of depression in increasing overtime, it is currently highly prevalence in both high and low to middle income countries and the comparable prevalence was 5.9% and 5.5%respectivily (Kessler &Bromet, 2013).

In Iraqi the prevalence of major depressive disorder was 932:100,000 in adult (Alhasnawi et al, 2009) .Uba et al (2012) mentioned that depression is the leading cause of disability among individuals aged 18-44 years. It occurs across the lifespan and often starts at a younger age; it affects women more often than men (5.6% vs 3.4%) (Ustun , 2004) and has 1.5 to 3 times greater incidence in first-degree relative than in the general population ,also ,affects single ,divorced and unemployed people with high risk(Spinhoven et al ,2011).

### 2.1.7 Major depression: prognosis

Studies indicated that around half of those who have first –lifetime depressive episode, recover and remain well, the other half will have at least one more episodes (35%) or experienced unremitting chronic course (15%) (Eaton et al, 2008). The lower recovery and higher chronicity, recurrence in more likely, if symptoms have not fully resolved with treatment, continuing treatment after six month after remission prevent relapse (Howland, R. H. (2008).

Poor prognosis are associated with inappropriate treatment, sever initial symptoms that may include psychosis ,early age of onset ,more

previous episodes ,incomplete recovery after one year ,preexisting medical disorder and family dysfunction (Trangle et al ,2012,and Fava et al ,2007) .

Depressive individuals have shorter life expectancies than those without depression in part because of suicide (Fortinash &Worret, 2012). Major depressive disorder is very serious illness which demands treatment, delay or failure in treatment after relapse, and the failure of professionals to provide treatment are barriers to reducing disability (Eaton. 2008).

**2.1.8 Treatment of depression:**

2.1.8.1 Antidepressant medication, Major categories of anti-depressants include:-

- Selective serotonin reuptake inhibitors (SSRIs): are considered to be the most tolerable and safest anti-depressants. (Malhi et al., 2013).
- Serotonin–norepinephrine reuptake inhibitors (SNRIs): it is important in mood regulation .SNRI tend to have fewer side effects than tricyclic antidepressants.
- Tricyclic antidepressants (TCAs): Are the oldest anti-depressant drugs they work similarly to the SNRIs, but have other neurochemical properties and have a greater side effect profile.
- Monoamine Oxidase Inhibitor (MAOIs): these antidepressant drugs have greater side effect and are associated with greater risk of toxicity. (Malhi, et al., 2013& Fortinash &Worret, 2012).

**2.1.8.2 Electroconvulsive therapy (ECT):**

Electroconvulsive therapy (ECT) may be the strategy of choice for patients with major depressive disorder with psychotic symptoms who

have not responded to antidepressant medication plus antipsychotic medications (Karasu et al., 2006).The ECT is the induction of a generalized seizure through the application of electrical current to the brain which is typically at least 3-5 seconds in duration (Morrison & Valfery ,2005) .

ECT may be administrated either bilaterally or unilaterally .The total course of treatment typically 6-12 treatments and generally does not exceed 20 treatments. The chief side effects are cognitive, some degree of amnesia and cardiovascular side effect (Fortinash &Worret, 2012).

**2.1.8.3 Psychodynamic therapy:**

Psychodynamic therapy is one of three main types of therapy used to treat depression .The other two are cognitive behavior therapy (CBT) and interpersonal therapy (IPT) (Mohamed, 2012). Patient preference for psychotherapeutic approaches is an important factor. Clinical features that may suggest the use of psychotherapeutic interventions include the presence of significant psychosocial stressors, intrapsychic conflict and interpersonal difficulties (Joiner et al, 2009). The combination of specific effective psychotherapy and medication may be a useful initial treatment choice for such patients (Morrison-Valfree, 2005).

Psychodynamic therapy, in its broadest sense, is an approach that emphasized the psychological forces that underlie human behavior, feeling, and emotions and how they might relate to early experience (Fortinash &Worret, 2012). The psychodynamic therapy is designed to help patients explore the full range of patient's emotions including feelings they may not be aware, by making the unconscious element of their life a part of their experience, the therapy help them understood how their behavior and mood are affected by unresolved issues and

unconscious feeling. Freud's psychoanalysis was the original of psychodynamic therapy. The aim of psychoanalysis therapy is to release repressed emotions and experiences to make the unconscious conflict to conscious (Fortinash &Worret, 2012).

The cognitive –behavioral therapy (CBT) is the dominant form of psychotherapy recommended for the treatment of depression (Lampe et al ,2013).The therapy focus on assisting patients in recognizing perceptual and cognitive errors ,instructing patients to perceive external problem more realistically perceived situations (Salih,M,2016).

Interpersonal therapy (ITP), also have clinical utility in treatment of depression (Lampe et al, 2013). Interpersonal therapy relies that depression as developing from pathological early interpersonal relationship patterns that continue to be reputed in adulthood (Mohammed, 2012).

Hildegard peplan's nursing theorist of interpersonal relation theory emphasized on social functioning, interpersonal relation with particular focuses on the milieu. The client and nurse therapist select one or two current interpersonal problem and examine new interpersonal strategies for more effective relationship (Fochtman et al, 2005).

**2.1.8.4 Family therapy:**

Depressive disorder affects the entire family, not just the client, and the usual family role functioning may disrupted teaching family members about clients disorder allows them to reframe the situation and minimizing blame on the clients (Fortinash &Worret ,2012).

Family therapy is a form of group therapy in which the client and family member participate. The goal to assess client –family interactions,

their concerns, and identify potential problem areas, and assist family in problem solving and adaptation (Townsend, 2011) .

**2.1.9 The nursing process:**

Recent statistical data about the epidemiology and recurrent course of depression provides the basis for caring for people with depression disorders in the hospital and in the community (Fortinash &Worret, 2012). Nursing care addresses the acute episodes of the disorder and the client's risk for recurrent episodes (Morrison &Valfree, 2005).

Intervention during the acute depressive episodes can be affective, but too often the patient and family are left with little understanding of the importance of long-term management and self-care strategies. Interventions could be planed for each client based on particular behaviors and concerns (Boyd, 2008).

.*Nursing diagnosis:

Data from all sources, objective and subjective data including the client, significant others which obtained during the nursing assessment are organized into a pattern that reflect the patient's major areas of health care needs(Fortinash &Worret ,2012). The North American Nursing Diagnosis Association (NANDA, 2013) put the following nursing diagnosis of depressive disorder:-

1. Risk for self-directed violence/Risk for suicide

2. Ineffective coping

3. Hopelessness

4. Social isolation

5. Imbalanced nutrition, less than body requirements

6. Self-care deficient

7. Low self-esteem

8. Ineffective sexuality patterns

9. Spiritual distress

**Nursing interventions:**

Townsend, (2015) and Fortinash &Worret, (2012) stated the main nursing interventions for patients with major depressive disorder, they are:-

- ✓ Create a safe environment for the client. Remove all potentially harmful objects from client's access (sharp objects, straps, belts, ties, glass items). Supervise closely during meals and medication administration. Perform room searches as deemed necessary.
- ✓ Encourage the client to attend a support group of individuals who are experiencing life situations similar to his or her own. Help the client to locate a group of this type.
- ✓ Spend time with the client. This may mean just sitting in silence for a while. Your presence may help improve client's perception of self as a worthwhile person.
- ✓ Help the client set realistic goals. Unrealistic goals set the client up for failure and reinforce feelings of powerlessness.
- ✓ Convey your acceptance of client's need for the false belief, while letting him or her know that you do not share the delusion. A positive response would convey to the client that you accept the delusion as reality.
- ✓ Weigh client daily. Weight loss or gain is important assessment information.

- ✓ Keep strict records of sleeping patterns. Accurate baseline data are important in planning care to assist client with this problem, Discourage sleep during the day to promote more restful sleep at night.
- ✓ Educate the client with depression and family caregiver about the disorder and symptoms and treatment as appropriate to lessen feeling of inadequacy, minimize guilt, and increase the knowledge about the effects of illness.
- ✓ Spirituality is essential human dimension that helps connect people to each other, the community and the world , and can be influenced by culture ,as well as experiences . Encourage the client to be independent and self-sufficient are important value to improve self-esteem and interpersonal communication.

**Section two:**

**2.2 Self-esteem: conceptualization**

The term self-esteem comes from a Greek word meaning “reverence for self”. The self-pertain to the values, beliefs and attitudes that human hold about themselves (Hewitt, 2009). Self-esteem play a central role in a number of psychological theory, each of which offers it is own definition of the term (Brunner&Suddarth, 2003).

Early the concept of self-esteem was introduced by the social scientist James, 1890. He recognized that human has the capacity to view themselves as objective and to develop feeling and attitude toward self (Peterson, 2010, and Grisp and Taylor, 2010).

Rosenberg 1965 explored self-in-depth. His self-esteem theory relies on two factors; the reflected appraised and social comparison .He viewed self-esteem as a favorable or unfavorable attitude that people have about themselves, which is a result of the influence of culture, society, family and interpersonal relationship. Rosenberg refers self-esteem as positive or negative attitude toward self (Neff, 2011; Rosenberg and Owens, 2001).

Coppersmith’s definition of self-esteem to which the person believes himself to be capable, significant, and successful and worth (Baumester et al 2003) . Numerous scholar definition the concept of self-esteem, one of the earliest ways of systematically classifying definitions of self-esteem was developed by Wells and Marwell, 1976, based on two psychological process; the evaluation (sense of value) and affection (the extend of value) (Brunner&Suddarth, 2003).

Elder et al ,(2012)define self-esteem is the evaluation one makes toward the self in reference to the self-worth ,self-respect and self-acceptance .while Robin et al (2012) define self-esteem as an individual’s

positive or negative attitude toward the self as a whole . Moreover Hewitt (2009) define self-esteem as feeling good about oneself unconditionally.

Sowislo and Orth, (2013) stated that the elf-esteem refers to feeling and attitudes toward the self. These are described and measured along continuums that range from high to low or positive to negative .in general high self-esteem reflects or predicts good adjustment and value, which is contrast with low self-esteem which refers unworthy ,incompetent, insignificant or luck of importance .

### 2.2.1 Self-esteem: components

According to Rosenberg theory, self-esteem has two components the competence and worthiness. The competence is an attitude toward oneself that is the result of an evaluative process in which personal abilities, performance or characteristics which are compared to the standards of others. It is a feeling that is dependent on the effectiveness of one's action .whereas worthiness means that an individual simply feels that he is a person of worth, he respects himself for what he is, worthiness expressed through verbal attitudes and behavior (Neff, 2011).

Butler and Constantine (2005) mentioned that self-esteem has a dual nature including both global and selective component, and the relationship between components varies. According to the elements that are of deferent importance to each individual, what others think and state about others affects how people perceive themselves .Global self-esteem is an overall estimate of general self-worth, while selective self-esteem examines specifics traits and qualities within the self.

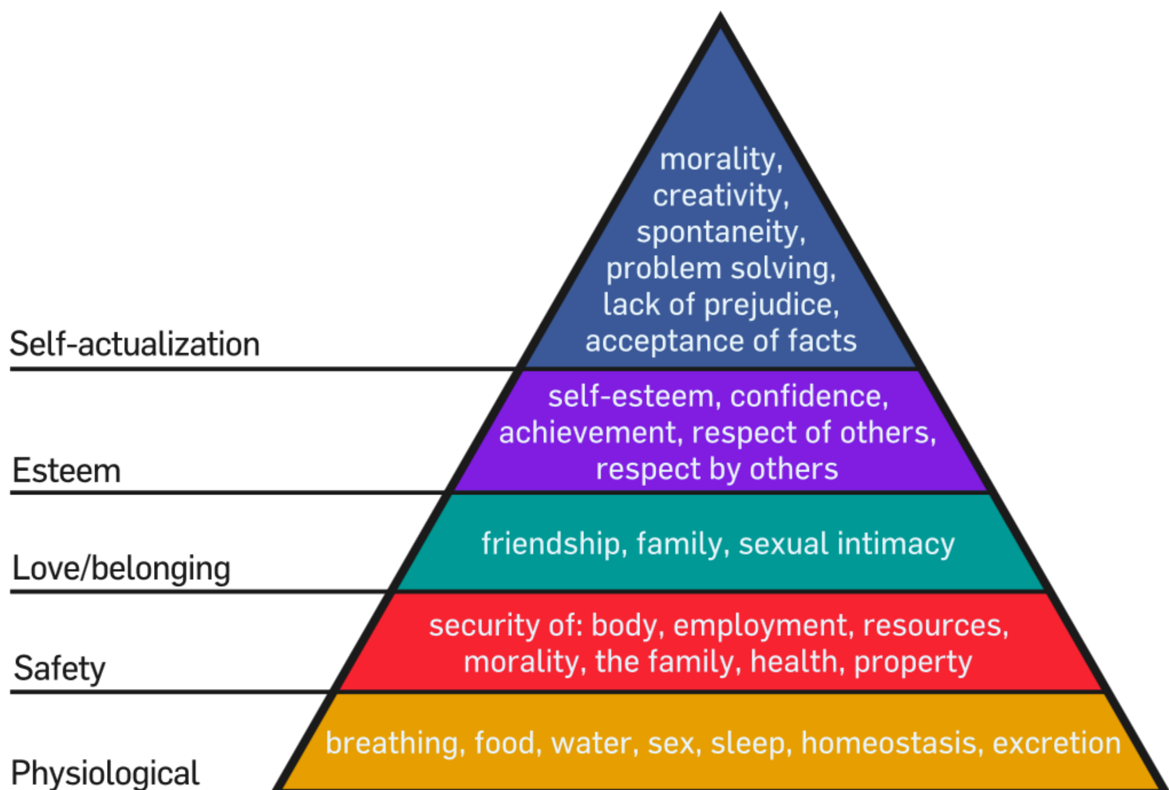
Many psychological studies that concerned with studying the self-esteem focus on both components of self-esteem and frequently used the Rosenberg's components; the competence and worthiness aspects of self-

esteem (Elder et al 2012; Peterson, 2010; Krueger,et al 2008;Rosenberg and Owens,2001).

**2.2.2 The major elements of self-esteem:**

Mruk (2006) described the major elements of self-esteem as follow:-

1. Self-esteem is a basic human need, makes an essential contribution to the life process. It's indispensable to normal and healthy self-development, and has a value to the survival. Abraham Maslow supported this notion of self-esteem as a basic human need, by including self-esteem in his hierarchy of human needs (figure 1):-




** Fig (1) Maslow's hierarchy of needs (Maslow A, 1999).

Maslow described the self-esteem need as the individual seeks self-respect and respects from others, works to achieve success and

recognition in work and desires prestige from accomplishments (Townsend, 2009).

2. Self-esteem is an automatic and inevitable consequence of the sum of individuals' conscious choices.

3. Self-esteem is something experienced as a part of, or background to, all of individual's thoughts, feelings and actions, which is reflected in behavior.

4. Self-esteem is a viewed as a consequence of an individual understands of the world and others, and where individual fits in relation to them. It is a drive to maintain equilibrium of the self.

**2.2.3 Self-Esteem and Depression:**

Interpreting and understanding ones sense of self-worth and value in society develops early in life during their formative years of adulthood and moderating the level and shape of the trajectory of self-esteem into late adulthood (Erol&Orth2011).

Feeling of inferiority or failure to life up to the expectation of significant others govern people's reactions and their behaviors (Johnson 2010). Once these negative core beliefs become manifested and rigid during the developmental stage of young adolescent and adult, increasing access to negative attribution styles, reduce self-efficacy, limits alternative and restricts structured problem solving (Leahy,Holland &McGinn2012).These negative perceptions exacerbate low self-esteem and restrict a person's ability to connect with their goals and purpose in life. During on negative conclusions leads to feeling of global pessimism ,this global pessimistic attribution style of thinking and negative self judgements continues to patterns of thinking, feeling and behavior which

is likely to maintain or exacerbate depression ( Butcher,et al 2007; Stranmark 2004).

Sowislo & Orth (2013) found that low self-esteem and depression are strongly correlated with each other, and low self-esteem can predict depression when the individual's depressive symptoms are high, the self-esteem tends to be low.

One of the underlying cause patterns that are common in people who are depressed is what psychology calls the "negative triad". The negative triad is cognitive distortion or negative thought about:

- The self; negative perception of self.
- The world /other people; thought's that people are generally untrustworthy, cruet
- The future; pessimistic thought holds about future. (Fortinash&Worret, 2012).

Low self-esteem is most closely linked to the first part of negative triad negative thoughts about self, but on average, people with low self-esteem also tend to be more pessimistic about other people and the future (Mohammed, 2012).

Kernis et al, (2006) described the characteristics of individual with low self-esteem .They have:

- negative of life
- perfectionist attitude
- mistrusting others
- blaming behavior
- fear of taking risk
- feeling of being unloved and unlovable

- Dependence –letting others make decisions

Depression and low self-esteem are complex mood disorders and can be overwhelming human experience for people causing significant psychological distress impacting on their quality of life and their relationship with others (Johnson, 2010).

Part of treatment for depression is learning to overcome low self-esteem thoughts by using cognitive behavioral therapy and using affirmation technique to help or improve self-esteem which aim to stop negative self-talk and to counter negative messages with positive ones(Fortinash and Worret,2012;Morrison and Vafree,2005) .

### 2.2.4 Measuring Self-Esteem

The literature distinguishes between two sub disciplines of self-esteem, namely explicit and implicit self-esteem. The explicit form of self-esteem is evaluated by what we say about ourselves (conscious), while implicit self-esteem is judged by automatic responses (often unconscious), such as how we associate words that have positive or negative connotations with ourselves and refers to an individual's ability to evaluate themselves and objects closely associated with themselves in a unstructured, automatic, or unconscious manner (Tafarodi and Ho, 2006).

An instrument widely used to measure explicit self-esteem is the Rosenberg self-esteem scale. The Rosenberg scale normally consists of ten-question instrument scored on a four-point response-system that requires participants to indicate their level of agreement with a range of statements about themselves. Rosenberg's scale was originally developed to measure global feelings of self-worth or self-acceptance. The Rosenberg Self-esteem scale translates into 28 languages, across 53 nations (Schmitt, 2005).

Other inventories like coppersmith Self-Esteem Inventory 1967 were created to evaluate attitude toward oneself in general, and in specific domains: peers, parents, school, and personal interests, and the Collective Self Esteem (CSE) scale by Luthanen and Crocker, 1992 which assess individual differences in collective, rather than personal, self-esteem (Luhtanen & Crocker, 1992). The Multidimensional Self-Esteem Inventory (MSEI; O'Brien & Epstein, 1983, 1988) this questionnaire is time-consuming to administer, it has the advantage of addressing global/situational self-esteem and defensiveness (Greer, 2003).

A variety of definitions, theories, criticism, support, trains of thought and instruments have been dedicated to the study of self-esteem and it continues to be a very actual theme in psychology and other related fields such as mental health nursing (Robins,2012and Salgodo,2010). The Rosenberg Self-Esteem Scale has been used in thousands of empirical studies of self-esteem in sociology and psychology (Salgodo, 2010).

**2.2.5 Self-esteem and feeling of loneliness:**

Self-esteem has been regarded as an essential component of mental health, many studies showed that self-esteem was negatively correlated with loneliness (Lasgaard & Elklit, 2009; Çivitci, 2009) found that self-esteem was significantly predictive of loneliness.

Mahon et al. (2006) reported that the relationship between loneliness and self-esteem, were in the range of a high to medium. When low self-esteem is formed, it affects all aspects of an individual's life especially the relationship with others. Individuals with low self-esteem usually avoid social settings and isolate themselves resulting in having the feelings of loneliness from their lack of confidence.

Al Khatib, (2012) found that a correlation between the measurement of loneliness and self-esteem, indicating that higher levels of self-esteem were related to lower levels of loneliness. Other studies exploring this relationship have yielded slightly weaker correlation between self-esteem and loneliness, (Haines, et al 1993).

McWhirter (1997, 2007) found that self-esteem not only negatively predicted global loneliness, but also predicted lower levels of social and emotional loneliness, and seems clear that self-esteem is related both to gender roles and to loneliness, and found that Higher masculinity is likely to be linked with higher self-esteem, and higher self-esteem may be further related to lower global, social and emotional loneliness.

**2.2.6 Self-esteem: Application in nursing practice:**

Nurses have argued that a patient's beliefs, feelings, and expectations about the self play a fundamental role in shaping health outcome and therefore, should be a primary focus of nursing interventions (Morrison-Valfre, (2009). As a result, the majority of nursing research about the self-concept has focused narrowly on the single more measurable aspect of the construct is self-esteem (Mohammed T, 2012).

Townsend(2015) and Morrison and Valfree (2005) out lined the basic nursing interventions regarding low self-esteem, negative self-evaluation among client with depressive disorders in points and interventions that are applicable to various health-care settings, such as inpatient and partial hospitalization, community outpatient clinic, home health, and private practice . The caregivers should:-

- ✓ Accept the client with his or her negativism. An attitude of acceptance enhances feelings of self-worth. Spend time with client to convey acceptance and contribute toward feelings of self-worth.

- ✓ Help client to recognize and focus on strengths and accomplishments. Minimize attention given to past (real or perceived) failures. Lack of attention may help to eliminate negative ruminations.
- ✓ Encourage participation in group activities from which client may receive positive feedback and support from peers.
- ✓ Ensure that client is not becoming increasingly dependent and that he or she is accepting responsibility for own behaviors. Client must be able to function independently if he or she is to be successful within the less-structured community environment.
- ✓ Offer recognition and positive feedback for actual accomplishments. Successes and recognition increase self-esteem.
- ✓ Teach effective communication techniques, such as the use of "I" messages. "I statements" can be used to take ownership for one's feelings rather than saying "They are" caused by the other person.
- ✓ Assist client in performing aspects of self-care when required. Offer positive feedback for tasks performed independently. Positive feedback enhances self-esteem and encourages repetition of desirable behaviors.

**Section Three:**

## 2.3 – loneliness: introduction

Loneliness is the feeling of distress that arises when an individual perceives his or her social relationships as being less satisfying than what is desired or situations where the intimacy an individual wishes for has not been realized(Friday et al ,2016). Discussions surrounding loneliness have been dated since the ancient times and have been continued to emerge until recent years. From the times of Plato and Aristotle (427-322 BC), Aristotle argues that human beings are social by nature and it is unusual for someone to not need to socialize with other human beings (Hossain & Ali, 2014).

Many studies show that loneliness associates with a range of severe health problems including poor cognitive impairment (Cacciopo,et al 2010), higher symptoms of depression (Singh & Misra, 2009), increased rates of mortality and mental morbidity, (Luo *et al.*, 2012; Victor et al 2005), and poor physical health ( Mushtaq *et al.*, 2014; Shiovitz-Ezra, 2014).

Loneliness has been described as a complex set of feelings encompassing reactions to the absence of intimate and social needs. It is the state of an incongruity between the social relationships persons wish to have, and those that they currently have. In this view “loneliness is clearly distinguishable from the objective state of solitude, social isolation, or being alone”, it is not just being alone physically but feeling alone emotionally (Heinrich and Gull one 2006).

### 2.3.1 Loneliness: conceptualization:

Many authors have attempted to provide definitions of loneliness. A key explanation for the variability of the definitions of the concept of loneliness, it is multidimensional and subjective nature (Uba et al, 2012).

Sullivan 1953 and Weiss's 1973 describe loneliness as the need for interpersonal relationships with others. When such needs are not fulfilled, loneliness is experienced. Needs for attachment and intimacy are the key aspects of this definition. People who fail to discharge their needs of love and 'closeness', thus attachment, with others are vulnerable to loneliness. According to Sullivan, the unfulfilled needs of attachment and intimacy are the main cause of loneliness (Victor, et al .2005).

Peplau and Perlman 1982, view loneliness as an unpleasant experience, occurs when there are deficiencies to one's social relationships, both qualitatively and quantitatively, which may have adverse effects on peoples' lives, social deficiencies are one key element in causing loneliness, that is, people may endure loneliness both because of the lack of an 'enough' number, according to one's desires, of social contacts and lack of a 'good quality', according to one's wishes, of social contacts. Peplau concept's highlights the subjective nature of loneliness (Happel et al, 2008).

Sorkin et al, (2002) mentioned that loneliness is an unpleasant condition which causes emotional distress, and occurs when a person feels rejected by others or lacks opportunities both for social integration and emotional intimacy. In this definition the objective features of loneliness are described. That is, lack of opportunities for social integration and emotional intimacy through estrangement, marginalization and rejection result to experiences of loneliness. The role of society on the

way people experience and perceive loneliness is apparent in definition of loneliness (Sorkin et al, 2002).

De jong Glerveld(1998) views loneliness as a situation that results from the discrepancies between an individual's wished and real social relationships. Glerveld's definition seems to be influenced by the Peplau definition of loneliness. Both definitions describe loneliness by subjective, discrepancies of social relationships and cognitive processes.

There are several definitions of the concept of loneliness and despite the differences and similarities on the definitions of loneliness, three aspects of the concept are universally agreed upon, that is the pervasive and subjective nature of loneliness which occurs due to deficiencies in our lives (Victor et al, 2005).

### 2.3.2 Loneliness theoretical approaches

Three predominant theories are considerate to be significant and elaborative on the concept of loneliness, including interactionist, psychodynamic and cognitive approaches:-

1- The interactionist approach, proposes that loneliness results by the combination of the absence of an adequate social network and the lack of an intimate figure. This approach proposed that loneliness is the deficiency of one's basic need for intimate relationships which occur when ones social needs are inadequately met. The basic social needs of an individual are: attachment, social integration, opportunity for nurturance, Reassurance of worth, sense of reliable and obtaining of guidance. Deficiencies in the experience of such needs results in lost opportunities for social interactions and ultimately an increased risk of loneliness (Singh & Kiran, 2013).

There are two distinct types of loneliness: emotional loneliness and social loneliness. The emotional loneliness results from the lack of emotional connections that are caused by deficiencies of intimate relationships. Loss of a loved one, divorce, and absence of friends are only some of a number of facets which form this type of condition. On the other hand social loneliness results from the lack of social relations. Relocating, unemployment, being excluded from community and not belonging to groups are some examples of this type of loneliness. Both forms of loneliness involve its own symptoms. The emotional loneliness may cause anxiety, and hostility and the social loneliness may cause boredom, marginality and restlessness (Singh &Kiran, 2013).

This theoretical approach has been criticized as it attributes the causes of loneliness solely on negative factors. Studies examining loneliness, however, reveal that other factors, such as age (Drageset *et al.,* 2011) culture (Chalise *et al.*, 2010) ,gender (Wang *et al.*, 2011) are often involved in causing loneliness.

2-The psychodynamic approach: - According to this approach deficits in people's attachments that stem from infant and childhood periods are considered to cause loneliness in later life. People have a need for intimate relationships since infancy which are depicted as a need for contact with their parents. People who lack the social skills to develop intimate relationships in childhood are more likely to experience loneliness in later life. The view of Sullivan and Forman-Reichmann consider loneliness as a pathological phenomenon which occurs when difficulties to form social relationships exist because of the absence of social skills (Donaldson & Watson, 1996).

3- The cognitive approach: - this approach underlines the influential role of the personality of an individual on the way that the person perceives

and experiences his/her loneliness. Cognitive approach evaluation of human's relationships against standards of social relations because loneliness emerged from his/her evaluation about what social or intimate relationships can offer to individuals (Donaldson & Watson, 1996).

People who think that deficits to their social relationships exist are more likely to experience loneliness. This approach therefore emphasizes as a key factor in determining the way people feel about their condition (Singh & Kiran, 2013). Cognitive theorists give much weight to one's social skills and self-esteem in alleviating loneliness (Fortinash &Worret, 2012). In general there is no consensus among scholars on the definition and conceptualization of loneliness because of its universal and subjective nature. The different types of theoretical approaches of loneliness underline the complexity of the phenomenon (Wright, 2007; Heinrich and Gullone, 2006).

**2.3.3 Loneliness: measurement:**

The more commonly used instruments developed to measure loneliness in adult depending on whether a unidimensional versus multidimensional approach on loneliness. Unidimensional approaches assume that loneliness is a global phenomenon that mainly varies in intensity. This approach has common themes in the experience of loneliness across different situations and relationships. Multidimensional approaches, by contrast, assume that loneliness is a complex phenomenon that takes on different forms in different situations and relationships, several measures– both unidimensional and multidimensional – have been developed (Weeks & Asher, 2012; Goossens et al., 2009; Goossens & Beyers, 2002).

Regarding unidimensional measures of loneliness, the most frequently used instrument is the Loneliness Scale developed at the University of California at Los Angeles by Russell, 1996( UCLA,20items). Items probe the frequency and intensity of loneliness-related experiences (Hawkley et al., 2004).Among the multidimensional scale, is the De Jong Gierveld Loneliness Scale. The De Jong Gierveld Loneliness Scale consists of 34 items with a 6-point Likert-type scale response format, this scale probe social and emotional relational deficits (De Jong-Gierveld & Tilburg, 1999).

According to a meta-analysis of studies of loneliness the most frequently used loneliness scale was the UCLA Loneliness Scale by Russell 1996. The De Jong-Gierveld Loneliness Scale 1999 was less used (Pinquart&Sorenson, 2001). Single-item measures have been used in gerontology research to loneliness (Hughes et al., 2004).

**2.3.4 Loneliness and depression:**

Most scholars agree that loneliness represents a destressing situation, that is occasioned by limited social relationships and the perception of being isolated (Heinroch and Gullone, 2006; Savikko et al, 2005). Loneliness can lead to the onset of depression (Cacioppo&Hawkly, 2006). The attachment approach model of loneliness indicated that attachment insecurity is correlated and linked with loneliness (Uba et al, 2012).

Self-esteem might indeed be an early and long lasting manifestation of depression (Hermann & Betz (2006). Numerous scholars found that loneliness could affect depression through self-esteem (Uba et al, 2012).

Fortinash &worret (2012) stated that whether social isolation is self-imposed or result from avoidance of others, individuals with major

depression often lonely persons. In addition, loneliness occurs when the need for intimacy is not met, it renders people emotionally disabled and helpless.

People with major depression are often unable to express their feelings of loneliness and may withdraw further in fear of rejection (Boyde, 2008). Depressive people experience a significant amount of psychological distress in attempting to describe their feeling of loneliness (Fortinash &Worret, 2012).

Loneliness is difficult for anyone, yet people with major depression are often unable to make the needful changes in their lives or behavior to produce the experience of loneliness (Barg et al 2006).

**2.3.5 Loneliness: nursing interventions:**

It is important to consider the individual's priorities when planning to care for depression clients with manifestation of loneliness & low self-esteem.(Ahmad et, al 2016).

However, nursing interventions may be applied toward achievement of the goals, although goals may take longer especially for person with severe depression. Townsend (2015) mentioned the interventions are as follows:-

- Encourage the client to engage in conversation with others to promote socialization and decreased isolation.
- Listen activity to the client's verbal and nonverbal communication to elicit the client's style of communication and to better understand and anticipate the client's needs.
- Praise attempts to speak clearly and effectively to encourage repetition of the client's clear, expression behavior.

- Enhance social skills, social activities to promote the client's acceptability by others and to increase self-esteem.
- As a nurse, act as a role model for effective social interaction to teach the client effective social skill.
- The nurse should teach client's anxiety –reducing techniques when they are experiencing impaired communication to reduce anxiety when clients are having difficulty experiencing themselves.

## Section four:

### 2.4 Previous study:

1. Yousafzai A and Siddiqi M. (2007) conducted a study title "Association of lower self-esteem with depression" The study carried out in psychiatric out patient's clinic of the Aga Khun university hospital, Karachi, Pakistan. A convenient sample size of 150 depressive patients compared with 150 non- depressive subjects control group. The self-esteem was assessed by Urdu version of Rosenberg self-esteem scale. The results of the study show that patients with depression had significantly lower self-esteem than the control group ($p<0.001$). The male depressive patients, advancing age, low education status significantly had lower level of self-esteem ($p<0.005$).The study recommended that low self-esteem is a state dependent on depressed mood.

2. In Malaysia, Yaacob et al,(2009) carried out a study titled "loneliness ,stress, self-esteem and depression among adolescence . The sample were, 1407 (male=679 and female=728) selected randomly from identified daily second schools, clustered into five zones in Malaysia .Data were collected by using four instruments, depression inventory, perceive stresses scale ,UCLA loneliness and Rosenberg self-esteem scale. Hierarchical multiple regression analysis was used to identify independent variables that are used in predicting depression among respondent. Results of bivariate analysis for variable were significantly correlated with each other, stress was highly correlated with depression ($r=0.505, p \leq 0.01$),loneliness ($r=0.470, p \leq 0.01$)and self-esteem ($r=0.465, p \leq 0.01$) had moderate significant correlation with depression .The participants with high loneliness have high depression while high self-esteem tend to have lower depression symptoms .The study concluded that the participants who are stressful ,lonely and have low self-esteem may lack social support ,social skill and have interpersonal deficiency .

3. Lasgaard M,et al (2011) carried out cross-sectional study titled: loneliness depressive symptomatology and suicidal ideation in Denmark. A stratified sample of students (time 1n=1009; 57%female; time 2 n=541; 60%female). Cross lagged structural equation modelling indicated that depression symptoms had more loneliness across time, whereas loneliness did not predict high level of depression symptoms a cross time. Loneliness was found to be a correlate of depression symptoms at the cross sectional level, independent of gender, other demographic factors multiple psychosocial variables and social desirability. Loneliness did not predict suicidal ideation over time or at the cross –sectional level .when controlling for the depression symptoms .gender did not predict loneliness, depressive symptoms or suicidal ideation.

4. Uba et al (2012) carried out a study in Malaysia titled: “Dose self-esteem mediate the relationship between loneliness and depression. The sample of the study were 242 subjects selected from the central zone, Selangor of Malaysia, they were 119 males and 123 females. Depression inventory (CDI: KOVACS, 1985) was used to measure depression. Loneliness was assessed using the Revised UCLA loneliness scale, self-esteem was measured using the 10-item Rosenberg self-esteem scale. The study indicated that self-esteem had negative and moderate correlation with loneliness ($r=-0.380,p<0.01$)and depression ($r=-0.497,p<0.01$). Also, the study significantly found a positive and medium correlation between loneliness and depression. The study revealed that self-esteem is significantly related to depression, and associated with high level of depression, and play as partial mediator between loneliness and depression. The study recommended that the need to develop self-esteem among depressive clients.

5. Daniel, K., (2013) conducted a research titled “loneliness and depression among university students in Kenya”. The purpose of a research was to examine the predictive role of attachment style on loneliness and depression .The participants in the study were 652 (313females; 339 males), mean age =22.35 years, SD±1.55) randomly selected from different departments in one university in Kenya. Data collected by using adult attachments scale, and university of California Los Angeles loneliness scale. Also, Beck depression inventory measuring the intensity of depression in both the depressive and normative sample. The analysis of data was performed by Pearson’s product, moment correlation and multiple regression analysis. A results found that a relationship among attachment style, loneliness and depression, ($p<0.01$), and a significant positive relationship between loneliness and depression ($p<0.01$).

6. Ahmad,et al. (2016) studied the loneliness ,self-esteem and depression among elderly people of Kashmir. The sample of the study consisted of 100 old age (≥50 years) person selected from deferent district of Kashmir in India .The geriatric depression scale, Rosenberg self-esteem and UCLA loneliness scale .These instruments were used to collected data. The SPSS version 20 used as a statistical approach to analyze the data .The results indicate that loneliness and self-esteem was significant deference on the measure of loneliness as well as on the measure of self-esteem at 0.001 level of significance .Lonely people suffer from more depressive symptoms .Depression was positively and significantly correlated to loneliness but negatively correlated to self-esteem .No significant deference were found among gender and domicile of the sample .The study concluded that loneliness most important determinants of depressive symptoms.

# Chapter three

## Methodology

# Chapter Three

# Methodology

## 3.1. Research design:

This quantitative design a descriptive study was carried out to assess self-esteem and feeling of loneliness in patients whose main diagnosis is major depressive disorder attended to MHC in Sulaimani city. The study has been carried out during the period from 23rd May to 8th September 2016.

## 3.2- Administrative arrangement:

An official letter has been extend from the College of Nursing /University of Sulaimani / to Directorate of Health (DOH) in Sulaimani and Mental health center to carry out this study (appendix A). Also ethical approval for conducting this study was obtained from the ethical committee in College of Nursing (appendix B).

## 3.3- Setting of the study:

This study was conducted out at the mental health center (MHC) in the General Teaching Hospital in Sulaimani. This is the center serves psychiatric inpatients and outpatient of both gender. The center includes 40 beds, distributed as 16 beds in male ward in the ground floor, and the same number of bed (16) in female ward in the first floor, 4 beds specified for patients with Substances abuse and also 4 beds specified for children with psychiatric disorders.

In addition, the center includes rooms specified to carry out inpatient's interview, Electroconvulsive therapy, psychotherapy and a

lecture hall for teaching students of medicine, nursing college and nursing institute .

**3.4-Sample of the study**

A non-probability, purposive sample size of (58) inpatients with major depressive disorder were selected from the mental health center under following criteria:

**The inclusion criteria for sample selection were:**

1. Patient's being aged 18 years old and above of both genders.

2. Patients being already diagnosed with major depression disorder by the consultant psychiatrist in the MHC.

3. Patients who have accepted to participate in this study.

**Exclusion criteria:**

- Patients with major depressive disorder with psychotic features.

**3.5- The study instrument:**

A questionnaire was adapted and developed by the researcher for the purpose of the present study, mainly used to assess self-esteem and feeling of loneliness among patients with major depression disorders. The development of the questionnaire is based on the following resources:

1. The extensive reviewed of literature and related previous studies.

2. The standardized Rosenberg self-esteem scale (RSS) (Rosenberg 1965).

3. The standardized Russell loneliness scale (Russel, D.W. Version-3, 1996).

Based on the above scientific resources, the questionnaire format contains three parts:-

Part (I): it consists of:

1. **Patient's sociodemographic characteristics**; which contains age, gender, marital status, educational status, occupation, economic status, and residency area.
2. **Patient's psychiatric characteristics;** which contains number of hospitalization, adherence to medication, receiving ECT, number and method of attempted suicide.

**Part (II): Rosenberg self-esteem scale:-**

This is a standardized ten items which were used to measure the level of self-esteem ,each item has four responses on Likert scale that are ranked from 0-3,and the patient selected one response that is more suitable with his self-esteem status ,the scale ranging from strongly agree to strongly disagree. Five items scored in positively framed direction which include items number 1, 2, 4, 6, 7(Strongly Agree=3, Agree=2, Disagree=1 and Strongly Disagree=0). The other 5 items scored in negatively framed direction which include items number 3,5,8,9,10 (Strongly Agree=0 Agree=1,Disagree=2 and Strongly Disagree=3).The sum scores for all ten items ,the higher score indicates more self-esteem .

Scoring:-

0-14 Low Self-esteem

15-24 Average Self-esteem

25-30 High Self-esteem

**Part (III): Russell Loneliness Scale**

This is standardized (20) items awarded on a 4-point Likert scale (never=1, rarely=2, sometime=3, often=4). Nine items number 1, 5, 6, 9, 10, 15, 16, 19, 20) are negatively scored while eleven (11) items (2, 3, 4, 7, 8, 11, 12, 13, 14, 17, 18.) are positively scored. The responses to the 20 items are summed, producing a possible range of 20 to 80 item score with higher scores indicating greater loneliness.

Scoring system:

20-40, average level of loneliness

41-60, frequent loneliness

61-80, sever loneliness

The final English questionnaire (appendices C) was translated into Kurdish language.(Appendices D).The "forward-backward" procedure was applied to be translated from English to Kurdish and then translate back into English language. Translation of questionnaire was done by the involvement of language experts.

### 3.6-Testing validity of the questionnaire:

The validity is a measure of authenticity of the fact on the issues at hand that the researcher investigated. It refers to the degree to which an instrument measures is supposed to measure (Johnson and Kuby, 2007).

The questionnaire has been validated by (12) experts in the field of psychiatry, nursing and psychology (appendices E) to investigate the clarity, relevancy and adequacy. The vast majority of experts had agreed that the questionnaire was appropriately designed to measure the phenomenon underlining the study.

**3.7- pilot study:**

A pilot study was carried out on 10 patients with major depressive disorder, interviewed by researcher from the mental health center. The study was carried out for the period of 23rd and 24th May 2016 to 8th and 9th Jun, 2016. The pilot study aimed to achieve the following aims:

1. To determine the reliability of questionnaire.

2. To evaluate the time required for data collection.

3. To know whether items of the questionnaire are clear, understood and applicable.

4. To identify the barrier and difficulties facing the researcher during data collection.

The patients were interviewed by the researcher guided by the items of the questionnaire. The results of the pilot study revealed that the items of the questionnaire were, clear and understandable to the patients. The time required for each interview to fill questionnaire by the researcher is approximately around 1 hour. The sample of the pilot study was excluded from the original sample of the present study.

**3-8 Reliability of the questionnaire:**

Reliability means the consistency or repeatability of the measure (Johnson and kuby, 2007). For the purpose of measuring reliability of questionnaire a test –retest statistical technique was used.

Patients diagnosed with major depression disorder were selected from (MHC). The researcher interviewed the patients. The interview is guided by the items of research questionnaire, and after 2-3 weeks the

researcher repeated the same procedure (re-test) with same patients to find the statistical correlation between the pre and posttest. Pearson's coefficient correlation was used and the result was (r= 0.82) and it's significant (p >0.01) that means the questionnaire was reliable.

With respect of the pilot study finding, conclusion is driven that the questionnaire is adequately reliable and valid measure.

**3-9 Data collection procedure:**

Following the official permission to conduct the present study, the researcher establish contact with the consultant psychiatrist of the MHC for the purpose of explaining the objectives of this study, selection of patients and to make arrangement for gathering information. Before data collection interview, the researcher explained the purpose of this study to patients and family selective to request verbal consent for participation in current study. And the questionnaire was administered personally by the researcher to the patient, using interview method for data collection .The data collected through the utilization of the Kurdish version of the questionnaire.

**3.10-Statistical method:**

Data were coded ,tabulated and presented in descriptive form .The data collection were analyzed using statistical package for social science version 21(SPSS).Frequencies and percentage were used for categorical variable .Pearson coefficient correlation and fisher test as inferential statistics. Fixing the threshold of significance at 5 % for significant results, the probability (P) value indicated the degree of significance.

**3.11 limitation of the study:-**

1. The period of data collection was limited from 23rd may 2016 to 8th September 2016. (Also, including the period of pilot study) .

2. The sample is limited to inpatients previously diagnosis with major depressive disorder and currently without psychotic feature, who were admitted to mental health treatment center in Sulaimani city in Kurdistan /Iraqi.

# Chapter four

## Results

# Chapter Four

## Results of the study

The main purpose of this research was to assess self-esteem and feeling of loneliness in patients with major depressive disorder. The results in this chapter were presented systematically as follow:-

First: Description of sociodemographic and psychiatric characteristics of the sample.

Second: Descriptive statistics utilized to describe the self-esteem and loneliness level among the sample.

Third: statistical analysis to compare studied variables, in relation to some patient's demographical & psychiatric characteristics.

**Table (1): Distribution of socio-demographics of the patients**

| Characteristics | Frequency | Percent | Mean ± S.D |
|---|---|---|---|
| **Age** | | | |
| 18-27 | 19 | 32.8 | 35.18 ± 1.26 |
| 28-37 | 15 | 25.9 | |
| 38-47 | 18 | 31.0 | |
| 48-57 | 0 | 0.0 | |
| 58 and more | 6 | 10.3 | |
| Total | 58 | 100.0 | |
| **Gender** | | | |
| Male | 15 | 25.9 | |
| Female | 43 | 74.1 | |
| Total | 58 | 100.0 | |
| **Marital status** | | | |
| Single | 22 | 37.9 | |
| Married | 28 | 48.3 | |
| Widow/er | 5 | 8.6 | |
| Divorced | 3 | 5.2 | |
| Total | 58 | 100.0 | |
| **Level of Education** | | | |
| Illiterate | 17 | 29.3 | |
| Primary school | 28 | 48.3 | |
| Secondary school | 8 | 13.8 | |
| Institute& University | 5 | 8.6 | |
| Total | 58 | 100.0 | |
| **Occupation** | | | |
| Employed | 6 | 10.3 | |

| | | |
|---|---|---|
| Unemployed | 52 | 89.7 |
| Total | 58 | 100.0 |
| **Economic status** | | |
| Sufficient | 7 | 12.1 |
| Barely Sufficient | 31 | 53.4 |
| Insufficient | 20 | 34.5 |
| Total | 58 | 100.0 |
| **Residential Area** | | |
| Urban | 43 | 74.1 |
| Suburban | 10 | 17.2 |
| Rural | 5 | 8.7 |
| **Total** | 58 | 100.0 |

Table (1) shows that the mean of age was 35.18 years ranging from 18 to 57 years or more (SD ± 1.26). Of the total responses: 32.8% were age between18 to 27; 25.9% were age between28 to 37; 31.0% were age between 38 to 47; no sample of age between 48 to 57 and also merely 10.3% of them were age 58 and more. Two third of the patients are female (74.1%). With regard to their marital status, 28(48.3%) married; 22(37.9%) unmarried; 5 (8.6%) were widow; 3 (5.2%) were divorced. Moreover, 48.3% of the total sample had primary school degree; 29.3% of them had illiterate degree; 13.8% of them had secondary school degree and only 8.6% of the total sample had institute and university degree. In addition, 89.7% of the total respondents were unemployed and also 10.3% of them were employed. The table appears that 53.4% of the patients were barely sufficient of economic status; 34.5% were insufficient of economic status and merely 12.1% were sufficient of economic status. Majority 74.1% of the total patients were living in urban area, 17.2%

of them were living in suburban area and only 8.7% of them were living in rural area.

**Table (2): Distribution psychiatric characteristics of the patients**

| Characteristics | Frequency | Percent |
|---|---|---|
| **number of hospitalization** | | |
| One time | 44 | 76.0 |
| Two times | 11 | 18.9 |
| More than three times | 3 | 5.1 |
| Total | 58 | 100.0 |
| **ECT** | | |
| Yes | 21 | 36.2 |
| No | 37 | 63.8 |
| Total | 58 | |
| **Adherence to medication** | | |
| Yes | 42 | 72.4 |
| No | 16 | 27.6 |
| Total | 58 | |
| **Attempted suicide** | | |
| Yes | 20 | 34.4 |
| No | 38 | 65.6 |
| **Total** | 58 | 100.0 |
| **How many attempts** | | |
| One attempt | 8 | 40.0 |
| Two attempts | 8 | 40.0 |
| More than Two attempts | 4 | 20.0 |
| **Total** | **20** | **100.0** |
| **Method of suicide** | | |

| | | |
|---|---|---|
| Burn | 4 | 20.0 |
| Hanging | 7 | 35.0 |
| Gun | 4 | 20.0 |
| Overdose | 1 | 5.0 |
| self-cut | 4 | 20.0 |
| **Total** | 20 | 100.0 |

Table (2) shows that 76.0% admitted one time of hospitalization; 18.9% admitted two times of hospitalization; merely 5.1% admitted more than three times. Otherwise, 63.8% were not received ECT. Majority of patients (72.4%) have been adherence to medication. The table indicates that of the total sample 38 out of 58 (65.6%) of the total participation have not been attempted suicide and 20 (34.4%) of them have been attempted suicide, 40.0% of the 20 patients were attempted one or two attempts and also 20.0% of them were more than two attempts, in method of suicide, 35.0% of the attempted patients used hanging; 20.0% used burn, gun and self-cut; and merely 5.0% used overdose, as shown in fig(2).

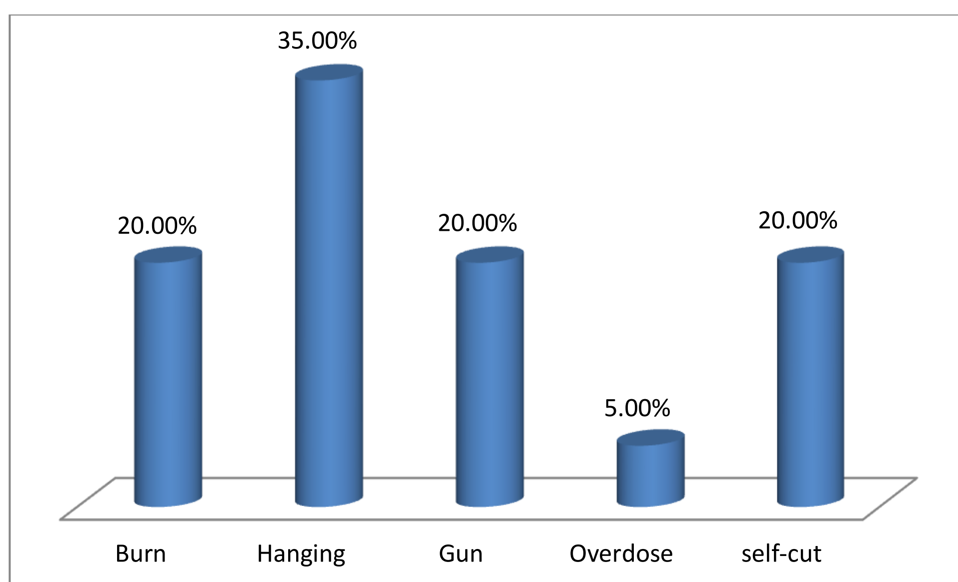



**Figure (2): Method of Suicide Attempts**

Fig (2) demonstrates method of suicide attempt .The figure illustrate that 35% among sample who attempted suicide (20 patient's) hanging method they used while 5% of them used overdose method.

**Table (3): Distribution self-esteem level of severity of the patients by frequency and mean**

| self-esteem level | Frequency | Percent % | Mean ± SD |
|---|---|---|---|
| Low (0-14) | 49 | 84.4 | 8.51± 3.02 |
| Average (15-24) | 9 | 15.6 | 16.88± 1.83 |
| High (25-30) | 0 | 0.0 | 0.0 |
| Total | 58 | 100.0 | - |
| F-test | 63.99 | | |
| P-value | 0.00 | | |

Table (3) shows the distribution self-esteem level of severity of the patients, there was statistically significance between levels of self-esteem of severity because the result of p-value was less than 0.05. Moreover, 84.4% of the total patients were low of self-esteem and also the mean and standard deviation were (8.51, 3.02) respectively, 15.6% of them were moderate self-esteem and the mean and standard deviation were (16.88, 1.83) respectively, the table show that no high level of self-esteem among sample.

**Table (4): Distribution Loneliness level of severity of the patients by frequency and mean**

| Loneliness severity | Frequency | Percent | Mean ± S.D |
|---|---|---|---|
| Average loneliness | 2 | 3.4 | 35.0± 2.82 |
| Frequent loneliness | 35 | 60.3 | 54.2± 4.95 |
| Sever loneliness | 21 | 36.3 | 65.2± 3.38 |
| Total | 58 | 100.0 | - |
| F-test | 70.48 | | |
| P-value | 0.00 | | |

Table (4) this table show that the majority of patients have frequent loneliness and the result of mean and standard deviation were (54.2, 4.95) respectively. Followed, 36.3% of the total patients have severe loneliness and the results of mean and standard deviation were (65.2, 3.38) respectively. In addition, merely 3.4%of the total patients have average loneliness and the mean and stander deviation was (35.0±2.82).

**Table (5): correlation coefficient between variables**

| Variable | Feeling of Loneliness | | |
|---|---|---|---|
| | N | R | Sig. |
| Self- esteem | 58 | -.45** | .00 |
| | P* <0.01 | | P** < 0.001 |

It is clear in table (5) that self-esteem would be negatively associated with Feeling of Loneliness; Bivariate Pearson's correlations between these variables were conducted and are displayed in Table 5. The table shows a negative and moderate correlation between loneliness and self-esteem ($r = -.45$, $p < .001$). Although the variables are significantly related to each other, they also possess correlation coefficients lower than .60, which indicates their utility in accounting for greater amounts of unique variance in subsequent regression analyses.

**Table (6): Patients age groups differences in regard of loneliness, and self-esteem scales .**

| Variables | Age group | Mean | ±SD | F-test | p-value | Sig. |
|---|---|---|---|---|---|---|
| **Feeling of Loneliness** | 18-27 | 58.52 | 6.40 | .68 | .83 | NS |
| | 28-37 | 56.20 | 8.76 | | | |
| | 38-47 | 56.94 | 9.22 | | | |
| | 48-57 | 0.0 | 0.0 | | | |
| | 58 and more | 60.50 | 9.50 | | | |
| **Self-esteem** | 18-27 | 9.68 | 3.63 | .575 | .92 | NS |
| | 28-37 | 11.0 | 4.85 | | | |
| | 38-47 | 9.16 | 4.23 | | | |
| | 48-57 | 0.0 | 0.0 | | | |
| | 58 and more | 9.16 | 4.40 | | | |

Table (6) shows that the difference among age groups in loneliness and self-esteem were not statistically significant because the p-value for both variables were greater than the common alpha 0.05,(P>0.05).

**Table (7): Patients gender differences in regard of loneliness and self-esteem scales.**

| Variables | Gender | Mean | S.D | F-test | p-value | Sig. |
|---|---|---|---|---|---|---|
| **Feeling of Loneliness** | Male | 56.01 | 8.96 | -5.52 | 0.00 | S |
| | Female | 58.86 | 9.21 | | | |
| **Self-esteem** | Male | 10.14 | 3.24 | 2.35 | 0.002 | S |
| | Female | 8.86 | 4.11 | | | |

Table (7) shows that statistically significant differences in the loneliness and self-esteem mean scores between male and female patients. The female patients' loneliness mean score (M=58.86, SD±9.21) is higher than male patients (M=56.01, SD±8.96) at significant level P<0.001. Also, the table reveals that male patients self-esteem mean score (M=10.14, SD±3.24) is higher than female patients (M=8.86, SD±4.11) at significant level P<0.002.

**Table (8): Patients marital status differences in regard of loneliness and self-esteem scales**

| Variables | marital status | Mean | SD | F-test | p-value | Sig. |
|---|---|---|---|---|---|---|
| **Feeling of Loneliness** | Single | 59.13 | 8.60 | 3.75 | 0.02 | S |
| | Married | 55.17 | 7.57 | | | |
| | Widow/er | 61.80 | 8.07 | | | |
| | Divorced | 62.66 | 5.85 | | | |
| **Self-esteem** | Single | 8.95 | 4.44 | 4.19 | 0.01 | S |
| | Married | 11.03 | 3.99 | | | |
| | Widow/er | 8.20 | 3.42 | | | |
| | Divorced | 7.33 | 3.05 | | | |

Table (8) shows that statistically significant differences in the loneliness and self-esteem mean scores between patients marital status groups. The divorced patients loneliness mean score (M=62.66, SD±5.85) is higher than other groups. The married patients have lowest loneliness mean score (M=55.17, SD±7.57) at significant level P<0.02.

The table shows that married patients self-esteem mean score (M=11.03, SD±3.99) is higher than other groups. The lowest mean score of self-esteem is among divorced patients (M=7.33.SD±3.05) at significant level P<0.01.

**Table (9): Patients educational level differences in regard loneliness and self-esteem scale**

| Variables | Education level | Mean | SD | F-test | p-value | Sig. |
|---|---|---|---|---|---|---|
| **Feeling of Loneliness** | Illiterate | 60.11 | 7.18 | 3.33 | 0.045 | S |
| | Primary school | 57.28 | 8.54 | | | |
| | Secondary school | 58.62 | 4.65 | | | |
| | Institute& University | 49.60 | 8.18 | | | |
| **Self-esteem** | Illiterate | 9.05 | 4.19 | .584 | 0.628 | NS |
| | Primary school | 9.92 | 3.88 | | | |
| | Secondary school | 11.37 | 3.46 | | | |
| | Institute& University | 9.20 | 4.19 | | | |

Table (9) reveals that statistically significant differences in the loneliness mean scores between patients educational level groups (P<0.045), and there is no statistically significant differences in the self-esteem mean scores between patients educational level of groups (P>0.05) . The table shows that illiterate patients loneliness mean score (M=60.11, SD±7.18) is higher among other groups and the lowest loneliness mean score is among patients with institute &university educational level (M=49.60, SD±8.18) .

**Table (10): Patients occupation differences in regard loneliness and self-esteem scales**

| Variables | Occupation | Mean | ±SD | F-test | p-value | Sig. |
|---|---|---|---|---|---|---|
| Feeling of Loneliness | Employed | 46.50 | 8.64 | 15.57 | 0.00 | S |
| | unemployed | 58.92 | 7.15 | | | |
| Self-esteem | Employed | 13.0 | 5.96 | 4.087 | 0.048 | S |
| | unemployed | 9.44 | 4.19 | | | |

Table (10) reveals that statistically significant differences in the loneliness and self-esteem mean scores between employed and unemployed patients. The unemployed patients loneliness mean score (M=58.92, SD±7.15) is higher than employed patients (M=46.50, SD±8.64) with significant level $P<0.001$. The table shows that mean score of self-esteem of employed patients (M=13.0, SD±5.96) is higher than unemployed patients (M=9.44, SD±4.19) at significant level $P<0.04$.

**Table (11): Patients economic status differences in regard of loneliness and self-esteem scales**

| Variables | economic status | Mean | SD | F-test | p-value | Sig. |
|---|---|---|---|---|---|---|
| Feeling of Loneliness | Sufficient | 58.14 | 5.6 | .745 | .479 | NS |
| | Barely Sufficient | 56.45 | 9.03 | | | |
| | Insufficient | 59.30 | 8.18 | | | |
| Self-esteem | Sufficient | 10.28 | 3.09 | .495 | .612 | NS |
| | Barely Sufficient | 10.19 | 4.60 | | | |
| | Insufficient | 9.05 | 3.91 | | | |

Table (11) shows that the difference between economic status in loneliness and self-esteem were not statistically significant because the p-value for both variables were greater than the common alpha 0.05.

**Table (12): Patients residence areas differences in regard of loneliness and self-esteem scales**

| Variables | residence area | Mean | SD | F-test | p-value | Sig. |
|---|---|---|---|---|---|---|
| Feeling of Loneliness | Urban | 58.02 | 8.6 | .574 | .567 | NS |
| | Suburban | 56.20 | 6.19 | | | |
| | Rural | 58.20 | 8.2 | | | |
| Self-esteem | Urban | 9.67 | 4.22 | .118 | .889 | NS |
| | Suburban | 10.40 | 4.52 | | | |
| | Rural | 9.80 | 4.19 | | | |

It appears in table (12) that the difference between residence area in loneliness and self-esteem were not statistically significant because the p-value for both variables were greater than the common alpha 0.05.

**Table (13): Loneliness and self-esteem scales by patient's number of hospitalization**

| Variables | number of hospitalization | Mean | SD | F-test | p-value | Sig. |
|---|---|---|---|---|---|---|
| **Feeling of Loneliness** | One time | 58.68 | 8.58 | .158 | .854 | NS |
| | Two times | 58.27 | 5.23 | | | |
| | More than three times | 56.00 | 9.16 | | | |
| **Self-esteem** | One time | 9.87 | 4.62 | .546 | .586 | NS |
| | Two times | 8.90 | 2.66 | | | |
| | More than three times | 11.66 | 3.51 | | | |

As it shown in the table (13) that there were not statistically significant differences between number of hospitalization with feeling of loneliness and self-esteem because p-value was greater than the common alpha 0.05.

**Table (14): Loneliness &self-esteem scales by ECT treatment**

| Variables | ECT | Mean | S.D | F-test | p-value | Sig. |
|---|---|---|---|---|---|---|
| **Feeling of Loneliness** | Yes | 60.14 | 5.46 | 4.020 | 0.041 | S |
| | No | 56.29 | 8.76 | | | |
| **Self-esteem** | Yes | 8.95 | 3.68 | 1.839 | .182 | NS |
| | No | 10.62 | 4.48 | | | |

Table (14) shows the mean scores for yes and no of ECT treatment on the loneliness and self-esteem level of participants. Receiving ECT patient's

loneliness level (M = 60.14, SD = 5.46) is higher than not receiving ECT patient (M = 56.29, SD = 8.76). With a significant difference between receiving ECT and not receiving ECT in terms of loneliness level (F = 4.020, p < .001). While the results of the F-test showed that there were not a significant difference in self-esteem scores between receiving ECT and not receiving ECT patients (F = .182, p > .001).

**Table (15): patient's adherence to medication differences in regard of loneliness &self-esteem scale**

| Variables | Adherence to Medication | Mean | S.D | F-test | p-value | Sig. |
|---|---|---|---|---|---|---|
| Feeling of Loneliness | Yes | 57.82 | 6.72 | 5.052 | .020 | S |
| | No | 58.37 | 9.48 | | | |
| Self-esteem | Yes | 10.21 | 3.86 | 4.323 | .033 | S |
| | No | 9.50 | 4.45 | | | |

Table (15) shows the mean scores for (yes) and (no) of adherence to medication on the loneliness and self-esteem level of participants. Patient not adherence to medication their loneliness level (M = 58.37, SD = 9.48) is higher than taking medication patient (M = 57.82, SD = 6.72). With significant difference between taking medication and not taking medication in terms of loneliness level (F = 5.052, p < .05). Also the table shows that there are a significant difference in self-esteem scores between taking medication and not taking medication patients (F = 4.323, p < .05). Patient's taking medication self-esteem (10.21±3.86) is higher than not taking medication patients (9.50±4.45).

**<u>Table (16)</u>: Patients attempted suicide differences in regard of loneliness &self-esteem scales**

| Variables | Attempted suicide | Mean | S.D | F-test | p-value | Sig. |
|---|---|---|---|---|---|---|
| Feeling of Loneliness | Yes | 57.05 | 6.13 | .020 | .888 | NS |
| | No | 57.02 | 6.31 | | | |
| Self-esteem | Yes | 10.50 | 4.80 | .824 | .368 | NS |
| | No | 9.44 | 3.84 | | | |

Table (16) shows that there were not statistically significant differences between attempted suicide with feeling of loneliness and self-esteem because p-value was greater than the common alpha 0.05 .

**<u>Table (17)</u>: Patients how many attempted suicide (n=20) differences in regard of loneliness & self-esteem scales**

| Variables | How many Attempted suicide | Mean | SD | F-test | p-value | Sig. |
|---|---|---|---|---|---|---|
| Feeling of Loneliness | One attempt | 55.0 | 12.0 | 1.54 | .242 | NS |
| | Two attempts | 63.25 | 8.46 | | | |
| | More than Two attempts | 57.0 | 4.76 | | | |
| Self-esteem | One attempt | 14.62 | 4.20 | 4.783 | .221 | NS |
| | Two attempts | 7.50 | 4.50 | | | |
| | More than Two attempts | 10.25 | 5.73 | | | |

Table (17) shows the mean scores for how many attempted suicide on the loneliness and self-esteem level of participants. The table appears that there were not statistically significant differences between how many attempted

suicides in terms of loneliness level (F = 1.54, p > .05). Also, the table indicates a not statistically significant difference in self-esteem scores with how many attempted suicide patients (F = 4.783, p > .05) .

**Table (18): Patient's Method of suicide attempts (n=20) differences in regard of loneliness & self-esteem scores**

| Variables | Method of suicide | Mean | SD | F-test | p-value | Sig. |
|---|---|---|---|---|---|---|
| **Feeling of Loneliness** | Burn | 61.50 | 9.60 | 6.23 | 0.88 | NS |
| | Hanging | 63.28 | 7.04 | | | |
| | Gun | 54.0 | 14.98 | | | |
| | Overdose | 42.0 | 4.27 | | | |
| | self-cut | 56.75 | 3.65 | | | |
| **Self-esteem** | Burn | 10.25 | 4.64 | 7.52 | 0.36 | NS |
| | Hanging | 9.28 | 4.60 | | | |
| | Gun | 10.75 | 7.32 | | | |
| | Overdose | 18.0 | 4.63 | | | |
| | self-cut | 12.75 | 6.65 | | | |

Table (18) shows that there was not statistically significant difference between methods of attempted suicide in terms of loneliness scale (F = 6.23, p > .05). Also, the table shows not statistically significant difference in self-esteem scores with method of suicide, because p-value was greater than the common alpha 0.05. .

# Chapter five

## Discussion

# Chapter five

# Discussion

Low-self-esteem and feeling of loneliness with depression are intervened together. In the present study an attempt was made to assess these two variables and to predict their inter correlation to one another among patients with major depressive disorder.

## 5.1 The patient's sociodemographic characteristic:-

In this study, the statistical analysis of patient's socio-demographical characteristics revealed that the patient's mean of age 35.18 ±1.26, two third of them female, around half were married, with low education level (primary school) 48.3%, majority of them unemployed likewise on residential area majority of the sample from urban area and more half of them with barely sufficient economic status.

The results of this study are in agreement with the finding of Salih (2016) who conducted a study about patients with major depressive disorder in Sulaimani city; also Townsend (2011) confirmed the results of this study. Similarly, previous studies supported the result of this study and found that the incidence of depressive disorder was higher in female than male (Lasgaard et al ,2011),approximately by ratio 1.5to 2fold :1(De Graf et al ,2002,Eaton et al .,2008,Wang et al .,2010,Klein et al 2013).in contrary to the result of this study, Jassim (2009)found that the majority of patients with major depressive disorder in Sulaimani were in twenties, while Daniel (2013)found male more than female in Kenya.

The result of this study may be due to hormonal changes in woman's life might explain part of the higher prevalence of depression among female (Buttener et al., 2013and Schiller et al 2015) .In addition, Seedat et

al (2009) noted that the male –female difference decreased over time, of age and added that the female employment promoted women's mental health's.

In this study, low education, barely or insufficient economic status common among depressive patients. A meta-analysis study found a1.8-fold prevalence and 1.2-incidence of depression among those with lowest education and economic status (Lorant et al., 2003) However, other studies from high income countries have found depression common in younger age group. This may partly explained lack of significant association with education &economic position with depression disorder (Torikka et al, 2014).

**5.2 patient's psychiatric clinical characteristics:**

This study found that around two third of depressive patients admitted to mental health treatment center (MHTC)in Sulaimani one time ,one third of them receiving electroconvulsive therapy (ECT)and majority of them claimed adherence to medication ,twenty out of 58 sample patients were attempted suicide mostly 1-2 attempts using hanging as method of attempted suicide .The results of this study agree with finding of Jassim (2009)who found that the majority of depressive patients adhering to medication and some of them receiving electro convulsive therapy .

Mohammed (2012) and Salih(2016)supported the result of this study concerning suicide attempts ,they reported that one third of depressive patients attempted suicide with less than 5 times ,but in-contrary they found that overdose was most common methods of attempted suicide among depressive patients in Sulaimani city ,and a result of Mekonnen & Kebede (2011)indicate that 19.2%of the depressive patients had suicide

attempt, and found that hanging most common used method of suicide attempt .

Regarding number of hospitalization, the results of this study indicated 76%of sample have one admission in MHTC .This result goes with interpretation of Fortinash &Worret (2012),they mentioned that major depressive disorder is, for many, a recurrent disorder among those suffering from an episode of major depressive disorder ,between 50%-80%will go on to have at least one life time recurrence ,usually within 2-3years .In addition, factors that have been found to be associated with increased severity of subsequent episodes include history of a prior episodes complicated by serious suicide attempts ,psychotic feature or sever functional impairment .

In this study one third 36.2% of the sample receiving ECT; this result supported by Karasu et al, (2006) stated that ECT has the highest rate response’s treatment modality of choice for patients with major depressive disorder in whom there is an urgent need for response such as patients who are suicidal attempt or not responsive to pharmacological intervention .

**5.3 Self-esteem:-**

The present results showed that majority of the depressive patients (84.4%) have a significant low self-esteem mean score 8.5±3.02 in comparison to the standard scoring (0-14),(Table3,fig 2)and only few of them (15.6%)have a significant border to the average self-esteem with mean score (16.8±1.83)as compared to the standard scoring (15-24).The frequent finding of low self-esteem among depressive patients in this study was supported by the results from another study carried out by Yousafzai&Sidiqi,(2007)in Pakistan ,Yaacobe et al (2009) in Malaysia

and Daniel (2013)in Kenya. They found that low self-esteem was significantly associated with depression.

Although the finding of this study pointed a significant high frequent low self-esteem among depressive patients, yet the causal direction between low self-esteem and depression is not studied in this research. Otherwise the finding by Frank et al (2007) and Schmitz, N., et al (2003) were revealed that low self-esteem on it is own does not predict future depressive episode. Nonetheless, it may do so in interaction with other factors such severe stress (Lasgaard et al, 2011) and loneliness (Uba et al 2012).

The finding of this study therefore add to the evidence that low self-esteem arises among patients with major depressive disorder ,and may acts as vulnerability factor to the development of major depression and it may be a part of the definition of major depressive disorder .This is supported by the finding of Faizi et,al (2006), they noted that severity of the level of self-esteem significantly associated with major depression, and self-esteem can both lead to and result from clinical depression and they suggested that self-esteem fluctuation is a factor in the etiology and maintenance in the depression .

**5.4 Feeling of loneliness**

The result of this study indicates that almost all depressive patients' participants in this study significantly have feeling of loneliness (Table 4, fig 3). The finding reveals that 60.3%of the sample have frequent loneliness level with mean score 54.2±4.95 in comparison to the standard scoring system (41-60) while one third of the sample (36.3%) have severe feeling of loneliness with mean score (65.2±3.38) in comparison with

standard scoring system (61-80), only 2 patients (3.4%) have average level of loneliness with mean score 35±2.82.

The result of this study goes with the findings of a previous studies; Lasgaard et al.,(2011), Uba et al (2012) and Daniel (2013),who found that a significant positive relationship between feeling loneliness and depression. Teppers et al (2014) pointed that loneliness could be identified as both a risk factor for and a future of depression, while Lim &Kue (2011) reported that loneliness was a more robust predictor of depression. In the same line with the result of present study Adams et al (2004)and Stek et al (2005)found that feeling loneliness more prevalent in people with depression .

The exact nature of association between depression and feeling of loneliness is not yet fully understood (Cacioppo et al ,2010) however some studied noted that ,perceived severe feeling of loneliness may be as a gateway to depression (Barg et al ,2006)or loneliness may be as one of the most important determinants of depressive symptoms (Adams et al ,2004).Negative perception of one's social relationship may form the basis for the development of depression symptoms ,and depression may contribute to impairment in social relationship and hence to feeling of loneliness (Joiner &Timmonse ,2009) . Moreover, the depressed individual desires the social contact, yet may lacks the behavioral activation to address the situation, leading to a discrepancy between the desired and achieved levels of interpersonal relationship that is the feeling of loneliness (Heinrich and Gullone ,2006).

**5.5 Correlation between self-esteem and loneliness:-**

Bivariate Pearson's correlation was predicted in this study to find out the relationship between low self-esteem with feeling of loneliness

among depressive patients among the sample of the present study. The result of this study revealed a negative and moderate correlation between feelings of loneliness with low self-esteem. This result indicates that feeling of loneliness was negative and moderate correlated with low self-esteem and vice versa, at p-value <0.001 (Table 5).

The result of this study is similar with the study conducted by Ahmad et al (2016) who found a significant negative correlation between self-esteem with loneliness in the depressive patients, the result of this study coincides with the finding of Mahon et al (2006),Lasgaard &Elkrit (2009) and Alkhatab (2012).

The finding of the present study indicated that if the feeling of loneliness level decreased, (according to the Russel scale), the self-esteem level (according to Rosenberg scale) of depressive patients be increased.

**5.6 Feeling of loneliness & self-esteem difference in regard to patients' socio-demographical characteristics**

The results indicated statistical significant differences in mean score of feeling of loneliness and self-esteem levels related to patient's gender, marital status and employment (Table 7, 8, 10).

The female depressive patients have more feeling of loneliness (58.86±9.21) and lower self-esteem (8.86±4.11) than male (56.01±8.96), (10.14±3.24) respectively .This is similar to finding of Yaacob et al (2009) who found that the feeling of loneliness is stronger for women than men. In contrary to the result of this study Mruk (1995) found that there are no statistical significant differences of self-esteem between male and female. Also Lasgaard et al (2011) found that age did not predict to loneliness among depressive patients.

Regarding marital status, the result of current study indicated severe level of feeling of loneliness among divorced (62.66±5.85) and widow/er (61.8±8.07) with lower mean score of self-esteem (7.33±3.05) (8.20±3.42) respectively, than other marital status.

This result coincides with the findings of Chalise, (2010) and Jeyalakshmi and Chakrabarti (2011) who found that the single are twice as likely to experience loneliness as people living in couple household.

The result of the present study show that unemployed depressive patients had more feeling of loneliness in mean score measurement (58.9±7.15) with lower self-esteem (9.44±4.19) than the employed depressive patient (46.5±8.6)(13.0±5.9)respectively .The occupation – related differences in the studied variables are consistent with the findings of Yousafzai and Siddiqi(2007).The result might be due to the fact the employment reflects the effects of financial security ,respect ,social position and prestige on the self-esteem of individuals . Thus the study the employment status is an important factor which affects the level of self-esteem &loneliness clients (Yousafzai &Siddiqi., 2007).

This study found that illiterate depressive patients have significantly severe feeling of loneliness (60.1±7.18) than other depressive patients with other educational level while the institute and college graduate depressive patients have the lowest feeling of loneliness (49.6±8.18, Table 9).This finding is possibly related with other factors like unemployment, no financial security or lack of social position likely to diminish their interactions and communication (Yaacob et al, 2009).

The other socio-demographical characteristics have no statistical significant differences such as age, economic status and residential area; the result might be due to small sub-sample size in this study.

## 5.7 Feeling of loneliness & self-esteem differences in regard to the patient psychiatric characteristics

This study found that significant statistical differences in feeling of loneliness and self-esteem mean score measurements among patient adherence to the medication, and the method of suicide attempts. The finding revealed that patients with non-adherence to the medication have more feeling of loneliness (58.37±9.48) and lower self-esteem (9.5±4.45) than those with adherence to the medication (57.82±6.72) (10.21±3.86) respectively .This is similar to the result found by Lehtinen et al (2005) and Luutonen et al (2011), they noted that the depressive patient not adherence to antidepressant medication associated with their severity of depression and low self-esteem.

It has been found in this study the depressive patients who used hanging as methods of attempted suicide have lowest self-esteem mean score (9.28) than patients used other methods of attempted suicide, similarly to the result of Mekonnen (2011) who found that hanging most common used methods among patients with severe depression with aim to complete suicide (Karasu et al 2009). This finding suggests that lowest self-esteem increase the risk of suicide attempts in patients, it may be an indirect relationship mediated by depression (Lasgaard et al, 2011).

# Chapter six

# Conclusions&

# Recommendations

# Chapter six

## Conclusions and Recommendations:

Based on interpretations and discussion of the results of the study, the researcher concludes the following:-

1. Low self-esteem and loneliness are closely and reciprocally interrelated, that low self-esteem possibly leads to increased loneliness, and loneliness is a risk factor for lowered self-esteem among depressive patients.
2. Low self-esteem and feeling of loneliness are associated to many factors that might be seen as risk factors in depressive patients live.
3. The patients gender, marital status, occupation and medication regime, significant impact factors affected the variation in loneliness and self-esteem level. The female, divorced, unemployed and non-adherence to medication were most feeling of loneliness and lowest self-esteem than other categorical groups.
4. The patient's educational status and receiving ECT treatment an impact factors affected the variation in feeling of loneliness. The illiterate status and receiving ECT severely affect feeling of loneliness than other categorical groups.
5. The depressive patients who used hanging method of suicide attempt had the lowest self-esteem level & higher level of loneliness among suicide attempters.
6. The age, economic status, residence area, number of hospitalization and attempted suicide appeared a non-significant contributor in influencing variations of self-esteem and feeling of loneliness among depressed patients.

**Recommendations:**

1. Greater importance should be given to the feeling of loneliness and self-esteem during nursing assessment of depression by employing the assessment tools used in this study.
2. Effective nursing intervention that aims to improve patient's interpersonal skills is needed.
3. Support and encourage the patients to participate in occupational &recreational activity to enable depressed patients to express themselves and interact positively with others and would be beneficial especially for women.
4. Psychoeducation programs aim for promoting the intact family structure and closer relationship between individuals needed to be encouraged and facilitated for patients & family.
5. Important needs for nurse's counselors to be recommended in MHC for patients and families education.
6. Longitudinal study requires determining whether increase attachment family style is predictive factors of loneliness &poor self-esteem among depressed patient.
7. A comparative study to estimate the level of self-esteem and loneliness among depressed patient with control group.

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# Appendices

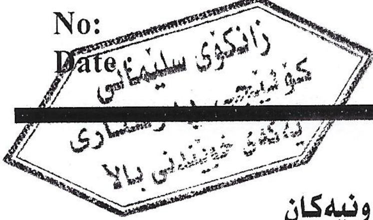
# Appendix A

**KURDISTAN REGIONAL GOVERNMENT**
**Council Of Ministers**
**Ministry of Higher Education & Scientific Research**
**University of Sulaimani Presidency**
**The Deanary of Faculty of Medical Science**
**School of Nursing**

حکومەتی هەرێمی کوردستان – عێراق
سەرۆکایەتی ئەنجوومەنی وەزیران
وەزارەتی خوێندنی باڵا و توێژینەوەی زانستی
سەرۆکایەتی زانکۆی سلێمانی
ڕاگرایەتی فاکەڵتی زانستە پزیشکییەکان
سکوڵی پەرستاری

خوێندنی باڵا

No:
Date



ژمارە : ١٩/٧/ ٥١٢
ڕێکەوت: ٢ / ٥ / ٢٠١٦ زایینی
/ / ٢٧١٦ کوردی

بۆ/ فەرمانگەی تەندروستی سلێمانی – سەنتەری چارەسەری نەخۆشیە دەروونیەکان
بابەت / ئاسانکاری

داواکارین لە بەڕێزتان ڕەزامەندی بفەرموون بە ئاسانکاری کردنی کارەکانی بەڕێز ( دیاری صابر احمد ) ,خوێندکاری خوێندنی باڵای کولێجەکەمان ( ماستەر ) بەمەبستی کۆکردنی زانیاری وداتا توێژینەوەکەی کە بە ناونیشانی
**(Assessment of Self-Esteem and Feeling of Loneliness in Patients with Major Depressive Disorder in Mental Health Center in Sulaimani City)**

هاوکاریتان جێگەی ڕێز وسوپاس

د. عطية كريم محمد
سەرۆکی سکوڵی پەرستاری
٢/٥/٢٠١٦

وێنەیەك بۆ/
- خوێندنی باڵا.
- خۆیی.
- دۆسیەی دەرچوو.

هـ ٢٠١٦/٤/٢٥ ـد

# Appendix B

# Ethical Committee Form

Name of the researcher : Diary Sabr Ahmad

Title of the study : Assessment of Self esteem and feeling of loneliness with Major Depressive disorder in Mental Health center / sulaimani city

Type of the study : Experimental     No experimental ✓

| Item No. | Ethical Consideration of research proposal | yes | No | Remarks |
|---|---|---|---|---|
| Part 1 | • Responsive to health needs | ✓ | | |
| | • Meets priorities of vulnerable population | ✓ | | |
| | • Based on Scientific Principles & Knowledge | ✓ | | |
| | • Protects human rights of subjects | ✓ | | |
| | • It dose not threat any agency medical organization & institutes | ✓ | | |
| | • It have great benefit that than cost | ✓ | | |
| Part 2 | • It should not threat subjects health | ✓ | | |
| | • It should not expose the subjects to risk | ✓ | | |
| | Pain | ✓ | | |
| | Discomfort | ✓ | | |
| | Injury | ✓ | | |
| | Critical situation | ✓ | | |
| | Moral Bothering | ✓ | | |
| Part 3 | • It should be Kept confidentiality | ✓ | | |
| | • It should gain informed consent assigned by them | ✓ | | |
| | • It should not cost the subjects money time spent any effort | ✓ | | |
| | • If the subjects pregnant no risk to child or pregnancy | — | | |
| | • If the subjects ( children or mental disorder ) or behavioral disorder | | | |
| | • It should assigned informed consent from parents or the husbands | ✓ | | |
| | • No injury to their health status | ✓ | | |
| | • Equitable selection, distributes of the groups subjects | — | | |
| Part 4 | • Subjects have to gain money if cost them-travel ,spent time | | ✓ | |
| | • Subjects have right to compensate or guaranteed | ✓ | | |
| | • Finding should be kept secret | ✓ | | |
| | • Subjects should be informed on finding if its related to their health | — | | |
| | • Legal representation should be from parents if the subjects (children or mental disorder) | ✓ | | |
| | • Subject have right to compensate or paid if they get-injury if death family will compensate | — | | |
| | • Subject have right to have free medical services or benefit financial from medical organization | | ✓ | researcher bases |

## Ethical Committee Approval Members

Chairman

Name prof. Dr Salwa Shaker

Signature

Member

Name Dr. Adiya K.

Signature

Member

Name Dr. Jalal. K. Rasheed

Signature

# Appendix C

**Questionnaire** **Pts No…..**

**Part one**: **A- Socio-Demographic Characteristics of the patient:**

**Age**: ☐ years

**Gender:** Male ☐ Female ☐

**Marital status**:

Single ☐ Married ☐ Widow/er ☐

Divorced ☐ Separated ☐

**Level of Education**:

Illiterate ☐ Primary school ☐

Secondary school ☐ Institute& University ☐

**Occupation**:

Employed ☐ unemployed ☐

**If unemployed which is duty? ……………………………**

**Economic status**:

Sufficient ☐ Barely Sufficient ☐ Insufficient ☐

**Residential area**:

Urban ☐ Suburban ☐ Rural ☐

**B-Psychiatric history of the patient:**

**Number of hospitalization:**

One time ☐

Two times ☐

More than two times ☐

**Have you received ECT?** Yes ☐ No ☐

**Have you take medication?** Yes ☐ No ☐

**Have you attempted suicide?** Yes ☐ No ☐

**<u>If yes</u>**, how many attempts?

One attempt ☐

Two attempts ☐

More than two attempts ☐

**<u>Methods of suicide:</u>**

Burn ☐

Hanging ☐

Gun ☐

Poison ☐

Overdose ☐ self-cut ☐

**Part two** **SELF-ESTEEM SCALE:-**

The next questions ask about your current feelings about yourself. For each of the following, please choice one response that corresponds with the best describes how you strongly agree or disagree with the statement about yourself now.

| No | Statement | Strongly Agree | agree | disagree | Strongly disagree |
|---|---|---|---|---|---|
| 1 | I feel that I am a person of worth, or at least on an equal plane with others. | | | | |
| 2 | I feel that I have a number of good qualities. | | | | |
| 3 | All in all, I'm inclined to feel that I am a failure. | | | | |
| 4 | I am able to do things as well as most other people. | | | | |
| 5 | I feel I do not have much to be proud of. | | | | |
| 6 | I take a positive attitude toward myself. | | | | |
| 7 | On the whole, I am satisfied with myself. | | | | |
| 8 | I wish I could have more respect for myself. | | | | |
| 9 | I certainly feel useless at times. | | | | |
| 10 | At times, I think I am no good at all. | | | | |
| | Total score | | | | |

**Part three** **Loneliness interview scale**

Instruction: please indicate how often each of the statements below is descriptive of you.

| | Statement | Never | rarely | Some time | Most of time |
|---|---|---|---|---|---|
| 1 | * How often do you feel that you are "in tune" with the people around you? | | | | |
| 2 | How often do you feel that you lack companionship? | | | | |
| 3 | How often do you feel that there is no one you can turn to? | | | | |
| 4 | How often do you feel alone? | | | | |
| 5 | * How often do you feel that you are a part of a group of friends? | | | | |
| 6 | * How often do you feel that you have a lot in common with the people around you? | | | | |
| 7 | How often do you feel that you are no longer close to anyone? | | | | |
| 8 | How often do you feel that your interests and ideas are not shared by those around you? | | | | |
| 9 | * How often do you feel outgoing and friendly? | | | | |
| 10 | * How often do you feel close to people? | | | | |
| 11 | How often do you feel left out? | | | | |
| 12 | How often do you feel that your relationships with others are not meaningful? | | | | |
| 13 | How often do you feel that no one really knows you well? | | | | |
| 14 | How often do you feel isolated from others? | | | | |
| 15 | * How often do you fee1 you can find companionship when you want it? | | | | |
| 16 | * How often do you feel that there are | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | people who really understand you? | | | | |
| 17 | How often do you feel shy? | | | | |
| 18 | How often do you feel that people are around you but not with you? | | | | |
| 19 | * How often do you feel that there are people you can talk to? | | | | |
| 20 | * How often do you feel that there are people you can turn to? | | | | |
| | Total score | | | | |

# Appendix D

# LIST OF EXPERTS

| No | expert | Scientific degree | Work place |
|---|---|---|---|
| **1** | Dr .Nezar Mohammed Amin | Professor | School of Medicine/Sulaimani University /consultant psychiatrist |
| **2** | Dr. A.Kareem Sharif A.Karachatani | Professor | Psychology/school of basic education /university of Sulaimani |
| **3** | Dr. Roshdi Jaff | Professor | Basic Education/Sulaimani University |
| **4** | Dr. Twana A.Rahim | Assistant Professor | School of Medicine/Sulaimani University |
| **5** | Dr. Atiya Karim Muhammed | Assistant Professor | Head of School of Nursing/Sulaimani University |
| **6** | Dr. Muhammed Rashid | Assistant Professor | College of Nursing/Sulaimani University |
| **7** | Dr. Saman Anwar Faraj | Lecturer | School of Medicine/Sulaimani University |
| **8** | Dr .Danial Saady | Psychiatrist | Directorate of Health / Sulaimani general teaching hospital |
| **9** | Dr .Bahar Nasradin | Lecturer | College of Nursing/Sulaimani University |
| **10** | Dr. Rebwar G. Hama | Lecturer | School of Medicine/Sulaimani University |
| **11** | Dr.Zamdar M.Rasul | Psychiatrist | Director of health /MHTC |
| **12** | Dr.Hassan faxradin | psychologist | Educational psychology /university of Sulaimani |

# Appendix E

**پرسیارنامە**

**بەشی ١: ١-١ زانیاری شوناس و کۆمەڵایەتی نەخۆش:**

**تەمەن:** ( ) ساڵ **ڕەگەز:** نێر: ( ) مێ: ( )

**باری خێزانی:** سەڵت: ( ) خێزاندار: ( ) جیابوونەوە: ( ) بێوەژن/ بێوەپیاو: ( ) تەڵاقدراو: ( )

**ئاستی خوێندن:** نەخوێندەوار: ( ) بنەڕەتی: ( ) ئامادەیی: ( ) پەیمانگایان زانکۆ : ( )

**پیشە:** دامەزراو لەدەزگای حکومی ( ) دانە مەزراو ( )

**باری ئابووری:** باش: ( ) مامناوەند: ( ) لاواز: ( )

**شوێنی نیشتەجێبوون:** شار: ( ) قەزا وناحیە: ( ) لادێ: ( )

**١-٢ : مێژووی نەخۆشی دەروونی:**

**ژمارەی داخڵ بوون :** ١جار ( ) ، ( )٢جار ( ) ، زیاترلە ٢جار( )

**ئایا (E.C.T) ت وەرگرتووە؟** بەڵێ: ( ) نەخێر: ( )

**ئایا دەرمانت وەر گرتووە؟** بەڵێ: ( ) نەخێر: ( )

**ئایا هەوڵی خۆکوشتنت داوە؟**

بەڵێ: ( ) ، نەخێر: ( ) ،ئەگەر بەڵێ یە ، چەند جار؟

١ جار( ) ، ٢جار ( ) ، زیاتر لە ٢جار( )

**بەچ ڕێگایەك؟** سوتان ( ) ، خنکاندن ( ) ،چەك ( ) ،ژەهراوی بوون ( )

زیادلە بیویست دەرمان خواردن ( ) ،خۆبرین ( )

بەشی ٢ : **پێوانەی خۆنرخاندن (بە های خود)**

| ژ. | ڕوونکردنەوە: تکایە دیاری بکە تا چەند لەگەڵ ئەم ڕوونکردنەوانەدایت. | زۆر بەباشی پەسەندی ئەکەم | پێم پەسەندە | پێم پەسەند نیە | بەتەواوی ڕەتی ئەکەمەوە |
|---|---|---|---|---|---|
| ١+ | *وا هەست ئەکەم کە کەسێکی بە بەهام،لا نی کەم یەکسانم لەگەڵ خەڵکی . | ٣ | ٢ | ١ | ٠ |
| ٢ | *وا هەست ئەکەم کە ژمارە یەک سیفاتی باشم هەیە. | | | | |
| ٣_ | بە گشتی واهە ست دە کەم شکستم هێناوە. | ٠ | ١ | ٢ | ٣ |
| ٤ | *من ئەتوانم ئەو کارانە ئەنجام بدەم کە کەسانی تر ئەتوانن ئەنجامی بدەن. | | | | |
| ٥ | وا هەست ئەکەم کە سیفاتێکی وام نیە شانازی پێوە بکەم. | | | | |
| ٦ | *هە ڵوێستی باشم هەیە سەبارەت بەخۆم . | | | | |
| ٧ | *بە شێوە یە کی گشتی من لەخۆم ڕازیم. | | | | |
| ٨ | هیوادارم بمتوانیایە ڕێزی خۆم زیاتر بگرم. | | | | |
| ٩ | هەندێک جار بە دڵنیایەوە خۆم بە بێ کەڵک ئەزانم. | | | | |
| ١٠ | هەندێک جار وا هەست ئەکەم کە هیچ باش نیم. | | | | |
| | ئەنجام | | | | |

## بەشی ٣ پێوانەی هەستی تەنیایی بۆچاوپێکە وتن

| ژمارە | ڕوونكردنەوە: تكایە دیاری بكە تا چەند لەگەڵ ئەم ڕوونكردنەوانەدایت. | هەرگیز | کەم | هەندێک جار | زۆرجار |
|---|---|---|---|---|---|
| +١ | * تا چ ڕادەیەک هەست دەکەیت کە دە گونجێیت لەگەڵ کەسا نی دەوروبەرت.؟ | ٤ | ٣ | ٢ | ١ |
| ٢_ | تا چ ڕادەیەک هەست بە نە بونی هاوڕێیەتی ئەکەیت.؟ | ١ | ٢ | ٣ | ٤ |
| ٣ | تا چ ڕادەیەک هەست دەکەیت کە کەسێک نیە ڕووی تێ بکەیت.؟ | | | | |
| ٤ | تا چ ڕادەیەک هەست بە تەنیای دەکەیت. | | | | |
| ٥ | *تا چ ڕادەیەک هەست دەکەیت کە تۆ بەشێکیت (ئە ندامێکیت )لە کۆمەڵێ هاوڕێ.؟ | | | | |
| ٦ | *تا چ ڕادەیەک خاڵی هاوبەشی زۆرت هەیە لەگەڵ کەسانی دەوروروبەرت؟ | | | | |
| ٧ | تا چ ڕادەیەک هەست دەکەیت کە چی تر لە کەسانی ترەوە نزیک نیت؟ | | | | |
| ٨ | تا چ ڕادەیەک هەست دەکەیت کە حەز و بۆچوونەکانت لە هی کەسانی تر دە چیت؟ | | | | |
| ٩ | *تا چ ڕادەیەک هەست بە وە دە کە یت کە کراوەیتوخۆشە ویستیت؟ | | | | |
| ١٠ | *تا چ ڕادەیەک هەست بە نزیکی دەکەیت لەگەڵ خەڵک؟ | | | | |
| ١١ | تا چ ڕادەیەک هەست بە بەجێماوی دەکەیت لە خەڵک؟ | | | | |
| ١٢ | تا چ ڕادەیەک هەست دەکەیت کە پەیوەندیەکانت لەگەڵ کەسانی تردا بێ مانان؟ | | | | |
| ١٣ | تا چ ڕادەیەک هەست دەکەیت کە کەسێ تۆ بە تەواوی ناناسێنیت؟ | | | | |
| ١٤ | تا چ ڕادەیەک هەست بە دوورەپەرێزی دەکەیت لە کەسانی تر؟ | | | | |
| ١٥ | *تا چ ڕادەیەک هەست دەکەیت کە دەتوانی هاوڕێیەتی دروست بکەیت هەر کاتێک کە بتەوێت؟ | | | | |
| ١٦ | *تا چ ڕادەیەک هەست دەکەیت کە کەسانێک هەن کە بە تەواوی لە تۆ دەگەن. | | | | |
| ١٧ | تا چ ڕادەیەک هەست بە شەرم کردن ئەکەیت؟ | | | | |
| ١٨ | تا چ ڕادەیەک هەست دەکەیت کە کەسانێک هەن لە دەوروبەرت، بەڵام لەگەڵ تۆدا نین. | | | | |
| ١٩ | *تا چ ڕادەیەک هەست دەکەیت کە کەسانێک هەن کە دەتوانیت لەگەڵیان بدوێیت؟ | | | | |
| ٢٠ | *تا چ ڕادەیەک هەست دەکەیت کە کەسانێک هەن کە دەتوانیت ڕوویان تێ بکەیت و پشتیان پێ ببەستی؟ | | | | |
| | ئە نجا م | | | | |

# پوختە

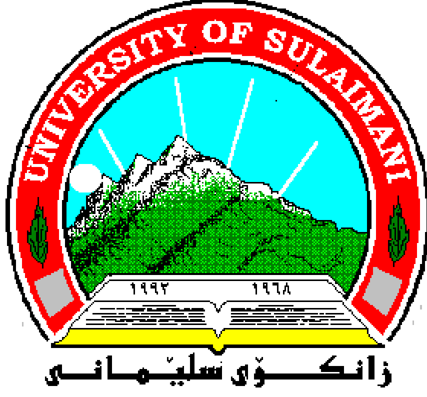
**پێشینە:** خۆبەکەم زانین و هەستی تەنیای، فشاری دەروونین کە دەبنە هۆی کەم بوونەوەی لەشساغی و کامەرانی ، کە ئەمەش پێدەچێ لە لایەن نەخۆشە خەمۆکەکانەوە هەستی پێ بکرێ.

**ئامانج** :بۆ هەڵسەنگاند نی ئاستی خۆنرخاندن و هەستی تەنیای لەو نەخۆشانەی خەمۆکی توند ییان هەیە .

**شێوازەکانی:** ئەم توێژینەوەیە، توێژینەوەیەکی وەسفی چەند ێتی زانستییە ، پەیوەندی کراوە بە سەنتەری چارەسەری نەخۆشییە دەروونییەکان (MHC) لە نەخۆشخانەی هەناوی فێرکاری لە شاری سلێمانی،لە بەرواری ٢٨ گوڵانی٢٠١٦ بۆ ٨ی ئەیلولی ٢٠١٦سەرجەم (٥٨) نەخۆش کە ئامانجی توێژینەوەکەبوون لە سەنتەری چارەسەری نەخۆشییە دەروونییەکان هەڵبژێردران ، ڕاپرسییەکە سازکراو پەرەی پێد را کە پێکهاتبوو لە سێ بەش ،بەشی یەکەم: فۆڕمی شوناس و کەسایەتی و زانیاری نەخۆشی دەروونی ،بەشی دووەم: پێوانەی ڕۆزنبێرگ بۆ پێوانی خۆنرخاندن(بەهای خود) و کۆتا بەشیش : پێوانەی رۆسێڵ بۆ پێوانی هەستی تەنیایی . نەخۆشەکان لەلایەن توێژەرەوە چاوپێکەوتنیان لەگەڵدا کراوە بەمەبەستی وەرگرتنی زانیاری ,زانیارییەکان شیکارکراون بەبەکارهێنانی پاکێجی ژمێریاری بۆ زانستە کۆمەڵایەتیەکان (ڤێر ژنی ٢١) .

**ئەنجام :** ئەنجامی توێژینەوەکە دەریخست نزیکەی هەموو نەخۆشە خەمۆکەکان هەستی تەنیاییان هەبوو لە نێوان زۆر دووبارە بووەوە (60.3٪) بۆ ئاستی بەرز (30.3٪) ،وە زۆربە ی هە رە زۆری(84.4٪) نەخۆشیەکان خۆنرخاندنیان لە ئاستێکی زۆر نزمدایە ( 8.51±3.02) . پێوانەی تەنیای وبەهای خود (خۆنرخاندن) ی گۆڕاوەکان دەری خست کە پێوانەی ڕۆستیل و ڕۆزنبیرگ بە شێوەیەکی تێبینی کراو پەیوەندیەکی پێچەوانەیان هەبوو ( P<.001,r=-.45 ).

**دەرئەنجام:** بە گوێرەی ئەم تۆژینەوە یە خۆ بەکەم زانین و هە ستی تە نیایی زۆر دووبارە بووەوە وەك گیروگرفت هەستی پێ کراوە لە ناو ئەو نەخۆشانەی کەخەمۆکیان هە یە.




حكومەتی هەرێمی کوردستان

وەزارەتی خوێندنی باڵاو توێژینەوەی زانستی

زانكۆی سلێمانی

كۆلیژی پەرستاری

# هەڵسەنگاندی خۆنرخاندن و هەستی تەنیایی لەو نەخۆشانەی خەمۆکی توندیان هەیە لە سەنتەری چارەسەری نەخۆشیە دەروونیەکان لە نەخۆشخانەی فێرکاری لە شاری سلێمانی

ئەم توێژینەوەیە پێشکەش کراوە بە ئەنجومەنی کۆلێژی پەرستاری /زانکۆی سلێمانی وەك بەشێك لە پێداویستیەکانی بەدەست هێنانی بروانامەی ماستەر لە پەرستاری زانستی دەروونی وتەندرووستی دەروونی

لەلایەن

دیاری سابرأحمد

بەکالۆریۆس لە زانستی پەرستاری2010

بەسەرپەرشتی

پرۆفیسۆر

د سلوى شاكر الكروى

| نەورۆز | نیسان |
|---|---|
| ٢٧١٧ | ٢٠١٧ |