Republic of Iraq
Ministry of Higher Education
and Scientific Research
University of Babylon
Collage of Nursing

Psychological Status among Elderly with Chronic Diseases

A Thesis Submitted

By

Hussein Yassin Hassan

To

College of Nursing, University of Babylon

in Partial Fulfillment of the Requirements for the Degree of

Master in Nursing Sciences

Academic Supervised by

Prof. Dr. Saja Hashem Mohammed,PhD

2022 A.D 1444 A.H

بِسْمِ اللهِ الرَّحْمَنِ الرَّحِيمِ

هُوَ الَّذِي جَعَلَ الشَّمْسَ ضِيَاءً وَالْقَمَرَ نُورًا وَقَدَّرَهُ مَنَازِلَ

لِتَعْلَمُوا عَدَدَ السِّنِينَ وَالْحِسَابَ مَا خَلَقَ اللَّهُ ذَٰلِكَ إِلَّا بِالْحَقِّ

يُفَصِّلُ الْآيَاتِ لِقَوْمٍ يَعْلَمُونَ

صدق الله العلي العظيم

سورة يونس

اية: 5

Supervisor Certification

I certify that this thesis, entitled **(Psychological Status among Elderly with Chronic Diseases)**, submitted by **Hussein Yassin Hassan** was prepared under my supervision and guidance at the Department of Psychiatric and Mental Health Nursing, College of Nursing, University of Babylon as a partial fulfillment of the requirement for the Degree of Master in Nursing Sciences.

Signature

Professor. Dr. Saja Hashem Mohammed.

Date: / / 2022

Signature

Professor. Dr. Salma Kadhim Jihad

Head of Psychiatric and Mental Health Nursing Department

College of Nursing / University of Babylon

Date: / / 2022

Certification

We, the examining committee, certify that we have read this dissertation **(Psychological Status among Elderly with Chronic Diseases)**, which is submitted by **Hussein Yassin Hassan** from the Department of Psychiatric and Mental Health Nursing, and we have examined the student in its contents, and what is related to it and we decide that it is adequate for awarding the degree of (Master) in nursing Sciences with specialty of (Psychiatric and Mental Health Nursing).

Signature:

Prof. Dr.

Nuhad Mohammad Kassim

Member

Date: / / 2022

Signature:

Assist. Prof. Dr.

Qahtan Qasim Mohammed

Member

Date: / / 2022

Professor. Dr. Amean A. Yasir

Chairman

Date: / / 2022

Approved by the council of the college of nursing

Signature

Professor. Dr. Amean A. Yasir

Dean of the College of Nursing/ University of Babylon

Date: / / 2022

Dedication

I dedicate this work to:

Our heroes on the battle field

The pure souls of our martyrs

Dear mother the source of love and inspiration

Dear father for his support

Dear sister for her support

Dear wife for her support

Dearer friends and relatives for their supports

Acknowledgement

Great thanks to Allah, the Glorious, the Merciful, and the Compassionate.

My thanks and gratitude to the Dean of the nursing College, University of Babylon. **Prof. Dr. Amean A. Yasir** .

I would like to express sincere thanks to my supervisor **Prof. Dr. Saja Hashem Mohammed**, for her constructive instructions, scientific guidance &encouragement throughout the time frame of the study.

I wish to thank all of the experts who reviewed and evaluated the questionnaire. Thanks are due to the employees in the Babylon Oncology Center, Imam Al-Sadiq Teaching Hospital and health centers in the Hilla city center for facilitating my research and completing the study. Finally, I would like to express my appreciation to all patients who participated in this study.

Abstract

Ageing is happening in different regions and in countries at various levels of development . Ageing is the natural process which happens gradually and continuously from the beginning of early adulthood . Multiple chronic medical disorders are connected with a loss in life quality, impaired functioning, and mobility decline. Chronic illness is linked to an increased risk of mental illness as well as hospitalizations and death. The purpose of this study was to assess the Psychological status for older people, determine the differences in Psychological status with regards socio-demographical data and find out the association between Psychological status and types of chronic disease. A descriptive analytical study using assessment technique to assess the psychosocial status among elderly with chronic diseases. The period of the study was from 9th of February 2022 to the 6th of July 2022 conducted in Hilla city center .Using purposive (non-probability) sample of 100 elderly suffering from chronic diseases were selected from health centers. This sample is distributed throughout(oncology centers, health centers and hospitals)in Hilla city center. The questionnaire consists of (21) items The findings revealed that most of the sample the mean age is 69, the age 60-69 years were records highest percentage. In regard gender, a fifty percent for male and female. There were a severe psychological status of elderly with chronic diseases. In addition, the study showed association between psychological status and elderly age with p.value <0.05, and indicates that association between chronic disease, depression and anxiety. Providing special programs in health centers to support the psychological status for the elderly with chronic diseases**.** Special agencies responsible for caring of elderly people as follow- up in application of activity daily living elderly People.

List of Contents

List of Tables

List of abbreviations

Abb.	Meaning
%	Percent
<	Less Than
>	More Than
Abb.	Abbreviation
ANOVA	Analysis of Variance
ASH	American Hypertension Association
BP	Blood Pressure
CAD	Coronary Artery Disease
COPD	Chronic Obstructive Pulmonary Disease
CVA	Cerebral Vascular Accident
Df	Degree of freedom
DM	Diabetes Mellitus
et. al.,	And others
F	Frequency
GI	Gastro-Intestinal
HTN	Hypertension
IARC	International Agency for Research on Cancer
IBS	Irritable Bowel Syndrome
ISH	International Association of Hypertension

MI	Myocardial Infarction
MS	Mean Score
NCDs	Non-Communicable Diseases
No.	Number
SPSS	Statistical Package for the Social Science
T	t- test
WHO	World Health Organization

List of appendices

Chapter One

Introduction

Chapter One

1.1. Introduction:

Ageing is occurring in different locations and in societies at varied stages of development . Ageing is the normal process that occurs gradually and continually from the beginnings of young adulthood *(Shree & S, 2021).*

Old age was inevitable that aging would bring about a range of physical, mental, endocrine, and changes in society (*Nations, 2011*).

One of the fastest-growing communities is that of the elderly, and this trend is occurring in every country on earth. There are approximately (600)million people in this world above 60 years of age and it is expected to grow four times by the year 2050(*Maheshwari et al., 2021*).

Elderly can now live longer Because to better diet, cleanliness, medical advancements, universal healthcare, learning, and financial well-being. The old age are now able to live longer. Individuals and society alike gain when can continue to have active and meaningful lives well into our senior years. due to an increase in the percentage of the elderly population that outpaces that of every other age group and is occurring in an increasingly wide variety of countries (*Thompson, 2017*).

Population aging rapidly due to longer lifespans and lower mortality rates (*Tarakci et al., 2015*).

Many physical processes begin to decline in early middle age. In order to become old, a person does not have to reach a certain age. In the past, the age of (65)has traditionally been considered the beginnings of old age (*Richard & Besdine , 2015*).

With rapid population ageing, knowledge of income related inequalities

in chronic disease and associated physical and mental health problems in later life will be important for designing appropriate health and welfare programs (*Korda et al., 2014*).

Chronic illnesses (NCDs) are become a serious public health problem as a result of environmental degradation. Chronic diseases such as diabetes, heart disease, and cancer are becoming more prevalent as people become more urbanized and adopt harmful lifestyle habits (such as smoking)(*Feng et al., 2014).*

Age-related degeneration in all of the body's systems causes numerous chronic diseases to develop, including CVA , HTN , CAD, musculoskeletal disease (e.g. arthritis and osteoporosis) and psychiatric illnesses (such as anxiety and depression). The patient's mental health might have a negative impact on all of these disorders, preventing him or her from taking the necessary steps to enhance their health. Proper care, on the other hand, can significantly lessen the negative consequences of growing older. When the patient is encouraged to be more physically, cognitively, and socially active, the greatest improvement frequently occurs (*Kazeminia et al.,2020*).

The elderly are the primary victims of these debilitating conditions. As a result, it has a significant impact on senior people's quality of life and is the leading cause of death worldwide, particularly when the illness is not caught and managed early on (*Vathesatogkit et al.,2012*).

However the health conditions and the impact of chronic diseases experienced by the elderly become one of the risk factors for increased psychosocial health problems in the elderly, such as anxiety, feeling of worthlessness, depression, despair, social isolation and loneliness (*Kozier et al.,2010).*

Once some behaviors are identified as being indicative of old age, it is important to view aging as a whole because it is both a biological and a psychological process. Old age has an ontological aspect that alters people's relationships with time and their relationships with the universe and their own stories, as in every individual scenario. As a result, the term "old age" must be taken as a complete, as well as a cultural truth (*Meaning et al., 2010)* .

1.2. Importance of the study:

Life expectancy has increased over the world. Most people nowadays can life expectancy well into their sixties or even seventies. As the world's population ages, the population of elderly people in the population grows as well*(Kasai,2021)*.

The human body changes in many noticeable ways with age, and aging is often accompanied by decline in bodily functions. However, a decline in function is different from loss of function that results from disease(*Chalise, 2019*).

According to the Iraqi Ministry of Health's annual national bureau of statistics, old individuals over (60) years of age are anticipated to rise from(3.40 percent in(2010) to(5) percent in (2015) and (7.2) percent in (2050) (*Al-Abedi et al,.2020*) .

Physiologically aging is distinguished by decreasing of bodily functions , Increased risk of chronic disease and care reliance for older adults occurs as physiological changes occur with aging. Aging-related hearing, sighting and movement loss, as well as illnesses like dementia, heart illness and CVA and severe respiratory disease, diabetes or osteoarthritis are the leading causes of disability or death in those over (60) (*Agyemang-Duah et al,.2019*).

In general, many elderly people experience a variety of health and mobility issues in their latter years. If the structural, economic, and social factors of ill health are managed at an early stage, chronic condition, mental health disorders, disability, and impairment can be decreased *(Debén et al., 2014).*

Multiple chronic medical disorders are connected with a loss in life quality, impaired functioning, and mobility decline. People with mental illness or cardiovascular disease, as well as those who have numerous chronic health disorders, tend to have worse health and much more difficulty doing the activities of daily living. Chronic illness is linked to an increased risk of mental illness as well as hospitalizations and death. Three to four medical illnesses have a 25% increased death risk, whereas individuals with five or more chronic health conditions have an 80% increased mortality risk(*Caughey et al.,2013*).

People who suffer from a number of long-term health issues have very high and intricate medical care requirements. They are heavy users of healthcare and see a wide variety of health care professionals, indicating that aged care becomes a significant social, financial, and governmental issue (*Roughead et al,.2011*).

As the world's population ages, the proportion and total number of people in need of long-term care will rise rapidly. Since women have traditionally provided most of the care for their families, this will happen at a time when younger individuals are less likely to be available to do so. To improve global health responses to the aging population, an approach to preventing and reversing functional disability and care dependency is essential. An essential need exists for this type of strategy. Several studies

have been conducted by researchers to examine the health and relevant issues associated with aging, which necessitates more investigation, with the current study focusing on Psychological state among seniors with chronic conditions(*De Vries et al., 2011*).

1.3. Statement of the problem:

Psychological Status among Elderly with Chronic Diseases.

Older people face a variety of challenges as a result of physical and psychological changes that occur as a result of the aging process. Although many people regard these changes in the elderly as normal and acceptable, there are some aspects of mental health that are pathological and must be recognized and addressed early, particularly those that lead to emotional instability and various degrees of depression. It should also be noted that mental health affects physical health and vice versa.

Multiple underlying physiological changes as people age, raising the chances of getting chronic disease and becoming dependent on others. People who have several chronic health issues have extensive and complex care requirements. The primary causes of impairment and death in adults over 60 are age-related hearing, vision, and mobility losses, as well as illnesses such as dementia, heart disease, stroke, chronic respiratory disorder, diabetes, and osteoarthritis .

The rising prevalence of chronic diseases among the elderly will be one of the most significant concerns confronting global health systems in the twenty-first century. Greater longevity, "modernization" of lifestyles with increased exposure to many chronic disease risk factors, and the expanding ability to intervene to keep people alive who would otherwise have perished

have all contributed to a shift in the disease burden confronting health-care systems.

In most places, socioeconomic improvement has been accompanied by substantial declines in fertility and equally dramatic increases in life expectancy over the last 50 years. This process has resulted in fast aging populations around the world, with the number of individuals over 60 anticipated to more than triple, from 46 million in 2015 to 147 million in 2050.

1.4. Objectives of the study are to:

1. To assess the severity of Psychological status for older people.
2. To determine the differences in Psychological status with regards socio-demographical data.
3. To find out the association between Psychological status and types of chronic disease.

1.5. Definition of Terms:

1.5.1. Chronic disease :

Theoretical Definition:

Chronic diseases are defined as long-term conditions that can usually be managed but not cured *(WHO,2014).*

Operational Definition:

Chronic diseases are long-term health conditions or problems that may last for several years and limit daily activities, and they share characteristics and symptoms that cannot usually be treated.

1.5.2. Psychological statue:

Theoretical Definition:

Psychological statue (psychology) a psychiatric disorder where the characteristics of a state are approximately unchanged although the state on its own could be lively; "a manic state" *(Free Dictionary,2022).*

Operational Definition:

Psychological statue is a state of mind in which the attributes of the state are relatively static, despite the fact that the state itself may be dynamic.

1.5.3 Elderly:

Theoretical Definition:

Elderly are individuals over 65 years old who have functional impairments*(Free Dictionary,2022).*

Operational Definition:

Persons who are 65 years old and older; who suffers from chronic disease and attending hospitals and centers**.**

Chapter Two

Review of Literatures

Chapter Two

Review of Literatures

2.1.Concept of Elderly

Aging is defined as progressive decline in homeostasis following the reproductive phase of life, resulting in increased risk of disease or death(*Lee et al.,2012*).

The older society implies significant changes at multiple levels. From of the ancient period to the19th generation, human average lifespan trebled from 20 years to 40 years. But even so, this average lifespan trebled fast to 80 years from of the 19th century to the 20th century as well as increased steadily in the 21st (*Estapé,2017*) .

The World Health Organization (WHO) defines old age (old age) starting after retirement, Those from 65 and 75 years old. WHO classifies of the age of the elderly into 4 groups, namely: middle age is 45-59 years, elderly (elderly) is 60-74 years, old age is 75-90 years and very old age over 90 years(*Kirca & Pasinlioglu, 2019*).

Healthy ageing is a concept promoted by WHO, that considers the ability of people of all ages to live a healthy, safe and socially inclusive lifestyle(*Age UK, 2010*).

According to the (WHO) old age is fixed at (60) years old for developing countries and the third world, and at 65 for developed countries, a classification that involves the economic and social situation in each country*(Meaning et al., 2010*).

Today, because of advancements in education, technology, medicine, food distribution circumstances, and health, there are more old people than

ever before. As a result, meeting folks in their 70s, 80s, 90s, and even close to (100) years old is not uncommon nowadays(*Chalise, 2019*).

However, their demand for the care and helping grows. Indeed, almost (20) percent of male and (30) percent of female in the age category now requires assisting an everyday activity is a must functions, In the near future, it is expected that there will be an increase in the numbers, and projections indicate that by the year (2035) the total number of elderly people who suffer from the consequences of aging will increase to a 3rd, posing a significant defiance to meet their support and care needs; this fact implies significant socioeconomic and health implications(*Kingston & Jagger, 2018*).

Gerontology, in general survey of the process of aging, and geriatrics, a specialization focusing on the medicinal concerns connected with growing of elderly, are two academic studies of the aging process. In an effort to comprehend all elements of the complicated process of ageing, gerontology includes interdisciplinary concepts and methodologies. Three academic fields have typically made significant contributions to gerontology. Biological aging, which is concerned with lifespan and how (and why) the body changes as it ages; psychological aging, which is concerned with adaptive qualities ,memory, intelligence, and how individuals cope with their own aging are examples of perceptual aging; and social aging The roles in society and preconceptions for older individuals in a particular society or culture are addressed by aging(*Touhy, 2012*).

With rapid aging population, understanding of income related disparities in chronic illness and related psychiatric conditions of the quality of life will be crucial in developing health care plans that are effective. and wellbeing projects. so far, whereas many research findings on Social and

economic disparities in the incidence of chronic illness involve elderly adults, Usually the data accumulated for the elderly respondents more than (65) year, (with the some exceptions, and there is very little guide of disparities particularly between the elderly age more than (80) year. moreover, few finding provide data on the absolute imbalances(*Korda et al., 2014*).

The growing prevalence of chronic diseases in the elderly will be one of the most significant concerns confronting global health systems in the twenty-first century. Greater longevity, "modernization" of lifestyles with greater exposure to many chronic illnesses, and the expanding capacity to intervene to keep individuals alive who would otherwise have perished have all contributed to a shift in the disease burden confronting health systems (*Nolte & McKee,. 2008).*

Therefore, an approach to prevent and reverse functional decline and care dependency in older age is critical to improving public health responses to population ageing. Such an approach is needed urgently(*WHO,2017*).

2.1.1. The Aging Process and Ageism:

As Humans go through different phases or stages of life as they age. Understanding aging in the perspective of these stages is beneficial since aging is more than just a physiological functions. A life It is the period from an individual's birth until his death, which includes several stages of life that can be predicted including physical growth and progression to age-related roles such as child , parents , adults ,adolescents, the elderly, etc. At each point in life, as an individual sheds previous roles and assumes new ones, new institutions or situations are involved, which require both learning and a revised self-definition. The fact that age-related roles and identities vary according to social

determinations mean that the process of aging is much more significantly a social phenomenon than a biological phenomenon (*Little, 2014*).

Aging caused by the combination of processes that happen throughout time, such as period, genes, illness, and behavioral and environmental variables. It is also linked to a slew of physiological, physiologic, psychological, and intellectual changes and declines, though there is no set order in which they manifest(*Matud & Concepci, 2019*).

Understanding mechanisms of healthy aging in humans is important because early detection of deviations from a healthy aging trajectory could be used to promote longevity by delaying, avoiding, or preventing the development of age-related diseases (*Alpert et al., 2019*).

Ageism is a set of concepts and beliefs connected with discriminatory attitudes against older persons (*Quadagno, 2011*).

Despite social and professional demographics, ageism manifests as social and interpersonal discrimination and as stereotypes based on advancing age. (*Kagan et al.,2015*).

❖ Types of Age:

- Chronologic age

Chronological age is expressed in units of time (months and years) since birth. Although only an indicator of time, chronological age is by far the most commonly used metric of later return. Age, on the other hand, can be defined biologically, physiologically, psychologically, and socially. Chronological age often does not precisely predict where a person falls on each of these aspects (*Séguy et al.,2019*).

- .Biological age

The biological age of a person is determined by the systems of organs and the external appearance of the body. The different components of biological functions and personality traits must be evaluated independently even within the same person because they can vary. In terms of blood pressure, and most likely cardiovascular function, Marge is physiologically older than her peers. On the other hand, her gray curls are an indication of physical aging, which puts her in line with the age of other (*Rose, 2013*).

- Functional age

Functional age refers to a person's ability to perform specified duties. Functional age, like biological age, entails compassion for chronological age peers. When an individual's competency in some aspect of functioning compares to that of chronological age peers, he or she is deemed functionally youthful. For instance, an 85-year-old guy who drives at night is functionally young than his chronologically younger peers who have stopped driving at night (*Soto-Perez-de-Celis et al.,2018*).

- Psychological age

Psychological age is often defined as how effectively an individual adapts to changing circumstances. To what extent may an individual use cognitive, personal, or social abilities to adapt to new situations or engage in new activities or experiences? Individuals who can adjust to new conditions are deemed mentally younger than others who find it difficult to do so and prefer to repeat the same actions (*Mitina et al.,2020*).

❖ Social age

The majority of a society's ideas on what persons in a given chronological age category should be doing and how they ought to act are

referred to as social age. People may be expected to finish their schooling by their early twenties, marry by their late twenties or early thirties, have children by their early to mid-thirties, and be established in their careers by the age of 40. Individuals who do not marry until the age of 40 and live with their parents until then are considered socially younger than those who leave their parents' house at the age of 22 and married at the age of 25 (*Erber,2012*).

2.1.2. Category of older individual:

During the increased the average life expectancy and the number of persons in the (60+) group growing by the day, age (60) and above is further segmented for demographic data gathering and other uses. In Western and affluent countries, (65) years is considered the start of aging, and aging can be characterized as follows:

a-Young old: year (65 to 74).

b- Middle old year (from 75 year to 84 year) .

c-Old-old years (more than 85year) (*Chalise, 2019*).

2.1.3. Changes related to Aging:

People change biologically, emotionally, and culturally as they age. The changing are normal, and the many objects that could be done to assist old age persons in adjusting to and compensating for them.

- Biological Changing

External Alterations: External changes are among the most visible effects of aging. Changes to one's hair, nails, and skin are examples of this.

❖ Changes in the Sensory

Alterations in taste, odor, sight, and perception are examples of sensory changes.

❖ Psychological Changing

People get slower in "recalling" facts as they age. It takes them longer to "respond" to events. They may, however, be quite functional if given enough time. Learning might be difficult for seniors who have hearing or vision difficulties. If the setting is noisy, inconvenient, or unpleasant, learning and memory can suffer. Illness, overmedication, depression, and stress can all affect learning and memory(*Farley et al.,2006*).

❖ Social Changes

Many losses befall the elderly. They retire after their children have left the house. from employment, they are suffer bodily deterioration, and Losing their oldest best friend. The majority of the elderly are on fixed incomes. When elderly people are unable live alone, they must live with others, like family, friends, or in a nursing home. Lonely and vulnerable elderly people can become victims of deception and abuse (*Chalise, 2019*).

2.1.4. Theories of Aging:

There is no agreement on quite why aging process occurs, and while various hypotheses have been offered, no single hypothesis is suitable for explaining the complicated of the aging. Because the majority of the existing research in this field has featured nonhuman creatures, extrapolation to humans are tricky (*Jett, 2012*).

2.1.4.a Random Theories

Consider aging to be produced by a sequence of negative alterations in the cells that result in replicative mistakes. These changes happen at random and build up over time. In this theory, This type of theory includes the error theory, the cross-linking, or connective, theory, and the free radical theory(*Davidovic et al .,2010).*

- ❖ Wear and tear theory.

The first tries to explain physiological aging process was the wear and tear idea. It is predicated on the premise that continual use results in worn out or damaged body organs. It is apparently influenced moreover as a result of accumulation of byproducts that are harmful to the normal functioning of cells and tissues over time (*Jin, 2010*).

- ❖ Error theory.

This theory is largely concerned with the accumulation of errors in DNA (deoxyribonucleic) and RNA as we age. When arbitrary errors occur in RNA's "copying" capabilities, erroneous genetic information gets copied and conveyed, compromising cell function. The causes of aging and mortality are thought to be faults that arise and are propagated at the molecular level (Tiedt, 2015).

- ❖ Cross-linking, or connective tissue, theory.

Cross-linking, or connective tissue, The hypothesis asserts that elastin and collagen (the two connective tissue proteins that support and connect the body's organs and structures). Cross-linking can be seen in age-related alterations in skin tissue. Cross-linking research is ongoing, although it is unclear how to prevent it and what effect it has on aging (*Jin, 2010*).

- Free radical theory .

They are biochemical byproduct of regular oxygen-based cellular metabolism.. They may also be produced by ozone, pesticides, radiation, and possibly gasoline and byproducts of plastic production. They are incredibly unstable and barely last the second or minimal however they are capable of reacting biologically in conjunction with the other molecules, particularly unsaturated fatty acids. The body is trying to neutralize free radicals declines with age (*Saxon et al., 2015*).

2.1.4.b Non- random Theories

This category includes theories such as programmed aging hypothesis and immunologic or resistance theory.

- The Programmed of aging theory.

Hayflick and Moorehead proposed that aging process could be governed by a biological or genetic clock. They determined that it is a sort of controlled At the molecular level, aging after observing that human embryonic fibroblastic cells grown in cultured cells out of the body may divided about fifty times before degrading(*Cui et al.,2013*).

- Immunological theory, or immunity theory.

Because the Immunity system is a complicated physical system that is interconnected It may be a cause of ageing in other complex structures. Immune changes can determine survival/mortality either alone or in comparison to less inflammatory process to the chronic illness although they do not appear to influence all elements of the process of aging universally. The immune system, Which is associated with neuro-endocrine system, is the one causes that behind aging, as evidenced by lifespan. If we consider inflammatory response as the

causes of aging in relation to the theory of evolution and the oxidative theory of aging, The immunity may be the primary cause of getting older once more (*Robert,2014*).

2.1.4.c Psychosocial Theories.

- Maslow(Human Needs).

Maslow established a basic human needs that human behavior leadership. The most fundamental require are those required for survival, according to the hierarchy. The following are:

1- Survival demands that must be addressed in order to live (food, water, and oxygen).

2. Safety and security needs. Once physiological needs are met, the individual is motivated to seek safety and security.

3. Demands for connection or affiliation become significant once physiological and security needs are addressed..

4. The hierarchy continues with esteem requirements. Individuals must build a feeling of self, or self-worth, after their basic needs have been addressed.

5. The urge for self-actualization is the last and greatest level in Maslow's hierarchy. This means realizing one's full potential and being the best one can be.

Maslow's hierarchy of needs could be effective in developing services and programs for older individuals (*Heinz et al.,2017*).

- Erikson’s Theory

Erik Erikson was a pioneer in proposing a psychological process take to the full life span . He hypothesized a succession of developmental crises

that the person solves at a primarily good or primarily negative path.

- Ego Integrity vs. Despair in Late Later life.

The basic growth goal in old age is to reflect on one's life, reconcile triumphs and disappointments, and bring it all into context(*Agronin ,2014*).

❖ Peck's Tasks of Old Age.

Erikson's final two stages were broken into seven distinct tasks by Peck. Erikson and Peck's viewpoints diverge in that Peck offered four particular activities for middle age and three for later adults. The tasks for every age group can be completed concurrently rather than sequentially. Sequencing is not required (*Rathus, 2011).*

<u>The three tasks are follows:</u>

A. Ego Differentiation vs. Work Role Preoccupation.

If the old age are removed from certain lifestyle duties or are unable to fulfill them adequately, older persons who are clinging to former lives or the job responsibilities as indicators of their self-respect consider these standard unsatisfactory. However, older persons who regard themselves as valuable can boost their self-respect out of with a group of ongoing pleasant contacts with the others (*Craig & Dunn, 2007*).

B. Body Spirituality vs. Body Obsession.

Those older individuals who can rise above preoccupations with their health or the body effects associated with their own aging process are more likely to retain an attention in and derive self- satisfaction from living in their later years than those who become preoccupied with or infatuated with evidence of poor wellbeing or body changes.

C. Self-Transcendence vs. Self-Preoccupation.

Senior citizens who see beyond oneself and have an invested role in society. culture are more impressive to have a positive outlook on themselves and their lives (*Eliopoulos, 2014*).

2.2. Chronic diseases.

Chronic diseases are ailments that persist another year or more and necessitate continuing medical treatment or impede everyday activities. Hypertension, cardiovascular disease, and diabetic are examples of common chronic diseases. Most chronic diseases can be treated, but they can be managed in methods that lessen the disease's daily burden and/or the likelihood that it will develop to more severe symptoms. *(Aspen Health Strategy Group, 2019)*.

Chronic diseases, also known as non-communicable diseases, are the leading cause of mortality and disability globally, and include Alzheimer's disease, arthritis, cancer, heart disease , diabetes, and Parkinson's disease (*Prasad et al.,2012*).

The main risk factors for these diseases include unhealthy lifestyle choices such as a lack of exercise, a poor diet, stress, and excess tobacco and alcohol intake (*Kunnumakkara et al.,2018*).

Health conditions and the impact of chronic diseases on the elderly become risk factors for increased psycho - social health problems in the older adults, such as anxiety, unworthiness, depressed mood, despair, social loneliness and isolation, alcoholism, fear of becoming a burden to family and society, and even suicidal behavior (*Zulfitri et al.,2019*).

2.2.1. Age-related changes in Cardiovascular system:

Cardiovascular disease are the overall leading causes of death, and they are especially high reasons for death in middle and late adults(*Xu et al.,2016*).

The heart changes with age, and some of these changes may increase a person's risk of cardiovascular disease. These include blood vessel and valve stiffness, which can lead to leaks or difficulty pushing blood from the heart (*NIA, 2012*).

- Heart disease .

It is the leading cause of mortality among the elderly. Age-related changes diminish cardiac efficiency and contribute to lower heart muscle compliance. Myocardial enlargement, which affects left ventricle strength and function; increasing fibro and calcification tissues that infiltrate muscle and conductive tissues, creating valve stenosis; and reduced pacemaker cells are among the changes (*Capriotti & Frizzell, 2015*).

Many people, however, are unaware that they have cardiovascular disease. A sudden heart condition, properly known as a myocardial infarction, is often the first sign of a problem in middle life. Sudden heart attacks are frequently caused by the rupture of an accumulation of plaque that provide oxygen to the heart muscles over time (a disease condition known as atherosclerosis)(*Kalyanasundaram & Shirani, 2010*).

- Hypertension

The American Hypertension Association (ASH) and the International Association of Hypertension (ISH) determine the presence of hypertension based on (SBP) of the (140 mm Hg) or greater and (DBP) of (90 mm Hg). or greater , based on the mean of (1-2) or more CBPs that it takes health care

providers (1-4) weeks to complete (*weber et al., 2014*).

- ❖ Contributing factors.
  - o Advance in adulthood.
  - o Drink a lot of alcohol (more than two drinks per day for men and more than one drink per day for women).
  - o The history of family.
  - o Gender:
  - o Men are at a higher risk till the age of 45.
  - o Gender hazards are roughly equal between the ages of 45 and 64.
  - o Women are at a higher risk at 65 years of age and later .
  - o Overweight.
  - o Poor dietary habits, especially if they include an excessive amount of salt (*American Heart Association, 2016*).

2.2.2. Cancer

Cancer is a huge public health issue around the world, and the burden cause of cancer - related is increasing (*Hong et al., 2015*).

Age is a risk factor for cancer, with more than half of cancer patients over the age of (65) year (*Brighi et al.,2014*).

Older people with cancer often suffer from comorbidities, geriatric syndromes, social isolation, and functional disability (*Soto-Perez-de-Celis et al.,2018*).

According to the Worldwide World cancer Research fund (IARC), the world had (11) million cases of cancer in (2002), with people (65) and older accounting for (45) percent of cases. This number has increased to (14) million in (2012), with the elderly accounting for (47) percent of all cases. According to

predictions, three out of every five cancer cases will occur among elderly by (2050) (*Esdras,2019*).

2.2.3. Age-related changes in Musculoskeletal System.

The major and most significant age-related skeletal system alteration is the steady loss of calcium from bone. Bone mass peaks around the age of 35, followed by a steady decline of bone density and density (osteopenia). Genetics, smoking, excessive drinking, and hormonal factors are all factors that influence bone loss(*Linton, 2007*).

In aging, the balance between new bone formation and bone resorption is disturbed and bone resorption begins to exceed bone formation, resulting in a loss of both bone mass and bone density. Consequently, bone strength declines with age. Loss of bone mass varies both between and within individuals, These changes also contribute to decreased strength and mobility in the skeletal system (*Marieb & Hoehn, 2013*).

2.2.4 Respiratory changes with age

This changes that occurs in the respiratory are frequently indistinguishable from changes in the system caused by variables including such air quality, ergonomic accidents, smoking, and other lifestyle and environment. However, respiratory efficiency declines with aging (*Tabloski, 2014*).

The quantity of alveoli does not vary greatly as we get older, but their structure does. The number of capillaries available for gas exchange decreases with age. Overall, the functional alveolar area decreases when alveoli walls thin, alveoli increase, and the surface available for oxygen-carbon dioxide exchange diminishes. Overall, with age, less oxygen is given to body cells, resulting in a reduced spare capacity in the respiratory when facing high conditions. Most

older people are more fatigable as a result of these changes (*Davies & Bolton, 2010*)**.**

- Asthma

Asthma is a heterogeneous disease, usually characterized by chronic airway inflammation (*Global Initiative for Asthma, 2015*).

According to the World Health Organization, the number of people over the age of 65 is predicted to rise to up to 17% of the total global population between 2000 and 2050. Asthma has a significant prevalence in the elderly, affecting more than 10% of people over the age of 60 (*WHO,2007*) .

Asthma in the old age is not an uncommon condition. Furthermore, due to unusual presentation, age-related decline in dyspnea perception, and concomitant comorbidities, it is commonly underdiagnosed or misdiagnosed. Asthma, in particular, may overlap and converge in the elderly; many older persons with asthma exhibit persistent blockage on pulmonary function testing, making it difficult to distinguish asthma from COPD.(*Diaz-Guzman & Mannino,2010*).

2.2.5. Changes related to age in the endocrine system.

Changes related to age in glands can result in critical health problems associated with metabolism of electrolytes, glucose, water, and minerals, but this is highly individualized and the concentrations of major hormones necessary for homeostatic equilibrium are not universally changed with aging. It does appear that aging in the endocrine system contributes to increased difficulties in regulating various mechanisms that ultimately result in lessened vitality in older adults (*Hill, 2006*).

Older adults' symptoms of endocrine disorders are often atypical, nonspecific, or muted, or they may mimic other disorders such as depression or fatigue. Sometimes in this age group there are no presenting symptoms even when disease is present. In addition, signs or symptoms of endocrine disease may be changed or masked by concomitant illnesses or medications. Endocrine pathologies are classified as those based on hyposecretion , hypersecretion, and hyporesponsiveness of various glands*(Tabloski, 2014*).

- Diabetes mellitus

It is a class of metabolic illnesses defined by elevated blood glucose levels (hyperglycemia) caused by abnormalities in insulin production, insulin action, or both (*American Diabetes Association , 2016*).

Diabetes was estimated to affect 422 million people worldwide in 2014, and this figure is anticipated to rise to even more than 642 million by 2040 (*WH O , 2015*).

Age is one of the most important risk factors in the development of prediabetes and diabetes (*Mordarska & Godziejewska,2017*)

Diabetes is predicted to become more prevalent as the population ages and lifestyles change, particularly among people aged 75 and up. Diabetes is a debilitating disease in elderly adults due to its vascular consequences and associated morbidities. Diabetes triples the likelihood of nursing home admission. Diabetes management and care to elderly persons are especially complex of the illness in old age and the heterogeneity of this age group (*Abdelhafiz et al.,2019*).

- Risk factors of Diabetes
  - The history of Family to diabetes
  - Obesity .

- Race/ethnicity (e.g., African Americans, Hispanic Americans, Native Americans, Asian Americans, Pacific Islanders).
- Age greater than 45 years .
- A history of impaired glucose tolerance or poor glucose tolerance.
- Hypertension more than (≥140/90 mm Hg).
- The antecedents of gestational diabetes(*American Diabetes Association,2016*).

2.2.6 Changes related to age in the gastrointestinal system.

Changes related to age have been identified of the various components of the GI system, they evidently exert relatively little effect on overall functioning of the GI tract. The process of digestion slows with age and may become somewhat less efficient, but marked changes are not common and the system usually remains adequate to meet most reasonable demands imposed on it. In spite of this resilience, many older adults' complaints center around various gastrointestinal problems. Over the years, folklore and misconceptions about digestive functioning and age have played a considerable part in encouraging older adults to attribute various signs and symptoms of digestive malfunctions to age alone. It is much more likely that lifestyle factors such as poor dietary choices, lack of adequate fluid intake, lack of bulk in the diet, excessive straining when defecating, and lack of exercise are more responsible for many of the common GI complaints than age(*Tabloski, 2014*).

- Irritable bowel syndrome **.**

Irritable Bowel Syndrome(IBS) is a chronic functional condition characterized by recurring stomach pain and irregular bowel movements, which can include (diarrhea, constipation), or both(*Skrastins & Fletcher, 2016*).

Irritable Bowel Syndrome caused by a functional defect in intestinal

motility. Motility alterations may be caused by neuroendocrine dysregulation, particularly changes in serotonin transmission, infection, inflammation, or a vascular or metabolic imbalance. The intensity with which the peristaltic waves move the fecal matter forward is modified at particular parts of the gut. The gut mucosa shows no signs of irritation or tissue alterations (*Grossman & Porth, 2014)*.

❖ The main symptom

- Constipation.
- Diarrhea.
- Abdominal distention.
- Changes in bowel pattern.
- Abdominal pain.
- Chronic fatigue syndrome.
- Chronic pelvic pain.
- Migraine headaches.
- Anxiety.
- Depression (*Lacy et al., 2016*)

The age at which IBS manifests itself varies. An start after the age of 65 year (elderly) is highly rare, as most cases increase throughout youth and early adulthood. However, because aging is connected with a higher risk of having any physical abnormalities, managing IBS in the elderly people is more difficult and complex than managing IBS in younger populations(*Kurniawan & Kolopaking,2016*).

2.3. Psychological status.

An individual who is mentally healthy may make and maintain close friendships with other people, participate in the societal standards of their community, and notice pleasant thoughts but also control emotions like despair. A person's internal and external functioning can be more understood and valued when they have good mental health (*Bhugra & Sartorius,2013*).

Mental state has several elements and is affected by a combination of factors. The individual's psychological health is a complex, or ever-changing, condition as a consequence of these interactions. A person's mental health is motivated by individual, interpersonal, and social/cultural factors. Individual characteristics include a ’s genetic make-up, autonomy and independence, self-esteem, growth potential, vitality, capacity to achieve long - term goals, moral fortitude or hardiness, feeling of connection, accurate solution, and coping or stress management skills (*Wortzel, 2013*).

In the elderly a good psychological aging shown in their ability to adapt to physiological, social and Psychological casualties that achieve life gratification. In order to variations in lifestyles are unavoidable over the course of a life span , elderly require resilience and acclimatization abilities when faced with stress ,and changing . A positive self-concept encourages risk - taking and trying something new, unproven positions (*Pender& Parsons, 2014*).

If older people are allowed to engage and appropriate society support facilities are offered, they are more likely to preserve good functional capacity independence(*Miller, 2015*).

2.3.1 Depression.

It usually consists of two or more weeks of sadness or lack of interest in living activities. Depression affects twice as many women as men and is (1.5 – 3) times more likely in first-degree relatives than in the overall population. In women, the prevalence of depression decreases with age while it rises in men(*Black & Anreasen, 2014*).

Depression is one of main ailments among the elderly. Chronic illness , limited movement , disinheritance, senior addict, loneliness, and decrease the source of income are of contributed factors for depression among the elderly, and the major contributed factors seen in all age categories(*Pilania et al.,2019*).

In the elderly the depression can manifest in a variety of ways and can be difficult to identify(*Mehra et al.,2017*).

It is linked to an increased illness risk, decreased physical, cognitive, and social performance, and increase in self (*Sözeri-Varma, 2012*).

- Symptoms of Depression:
  - Sad mood.
  - Sleep pattern disturbances.
  - Increased fatigue.
  - Increased agitation.
  - Feelings of guilt or worthlessness.
  - Weight loss or gain .
  - Decreased interest in pleasurable activities (anhedonia).
  - Decreased ability to think, remember, or concentrate.
  - Having frequent thoughts of death and suicide (Townsend & Morgan,2017).

- Causes of depression in elderly.

The fact that at least half of older persons who come with depression have no prior history suggests that different pathogenic mechanisms may be at work than in those who have previously had depression *(Ortman et al., 2014*).

❖ Contributed factors**.**

The etiology of depression is sometimes ambiguous, making it difficult to establish which symptoms are caused by depression but which are caused by other factors, these include:

- Long-term medical conditions.
- Multi-pharmacy.
- Several losses.
- Functional deterioration (physical, cognitive, or both).
- A family or personal history of depression.
- Societal exclusion.
- Drug abuse or addiction (*Wilkinson et al., 2018*).

2.3.2Anxiety.

Anxiety is defined as a mysterious feeling of fear or dread; the reaction of anxiety to environmental stimuli that can manifest as behavioral, psychological, and physical symptoms. Anxiety differs from fear in that fear is caused by obviously identified outside triggers to implies a risk for the individual (*Bandelow et al., 2014*).

Anxiety affects people of all ages; the prevalent of anxiety during the aging , particularly severe in the old age society .Anxiety symptoms are prevalent in 15-52 percent of the elderly, while anxiety disorders affect 3-15

percent of adults, with chronic conditions being the most common(*Ryan et al., 2011*).

In elderly decline of self-respect, loss of activity and stimulation, loss of friends and relatives, loss of physical independence and chronic illnesses, changes in daily life or living environment, fear of death, and lack of social support make them more vulnerable to stress and anxiety(*Alipour et al., 2009*).

2.3.2.a Causes of anxiety in older adults:

- Long-term medical conditions.
- A general sense of ill health.
- Sleep deprivation.
- Medication side effects .
- Misuse or abuse of alcohol or prescription medications.
- Physical restrictions in daily activities.
- Upsetting life events.
- Negative or traumatic childhood experiences.
- Excessive concern or obsession with physical health issues (*Pary et al., 2019*).

2.3.2.b Signs and symptoms of anxiety in older adults.

- Feelings of restlessness.
- Difficulty concentrating.
- Decrease in memory.
- Insomnia .
- Fatigue and Nausea.
- Changes in appetite.
- Irritability.
- Social withdrawal .

- Chest pain, palpitations and Shortness of breath .
- Headaches (*Yarze & Rounds, 2021*).

2.3.3 Stress.

❖ Overview of Stress.

Every person operates at a particular degree of adaptation and is subjected to a certain number of changes on a regular basis. Such change is to be expected; it promotes growth and improves quality of life. This homeostasis can be disturbed by a stressor. A stressor is an internal or external event or scenario that can cause physical, psychological, or behavioral alterations (*Greenberg et al., 2014*).

Stress is defined as an uncomfortable state of mental and physiological arousal that people have experienced when they believe a situation to be harmful or threatening to their well-being. Some people define stress as an incident or scenario that makes people feel tense, pressured, or negative emotions like anxiety or rage. Stress is the exhilaration, worry, and/or physical strain that comes when an individual's demands are perceived to surpass his capacity to adapt. This most typical interpretation of stress is referred to as anguish or negative stress (*Tandon, 2017*).

Stress in the elderly can cause health problems, the higher the stress level of the elderly the more often they experience recurrence of the disease(*Keramane et al.,2019*).

It is also one of the psychological elements that influence the overall health of the aged. They are subjected to numerous types of stress as a result of changes in the family hierarchy, physiological condition, and physical health degradation. Retired, the loss of friends, and fewer social activities are all common sources of additional stress(*Gholamzadeh et al., 2019*).

2.3.3.a Types of Stressors

Stressors come in a variety of shapes and sizes. They might be classified as physical, physiological, or psychological. Cold, heat, and chemical agents are examples of physical stressors; pain and exhaustion are examples of physiologic stressors. Fear is An instance of a stressful event (e.g., fear of not passing the test, losing work, or waiting for a result to diagnose an illness). also can the Stressors develop as a result of typical life transitions, such as transitioning from childhood to adolescence, getting married, or birthing *(Greenberg et al., 2014*).

Frustration or everyday troubles, significant complicated repetitions including big numbers, and stressors that happen fewer frequently and impact fewer people have all been classed as stressors. Day-to-day stressors include everyday occurrences such as getting stuck in traffic, experiencing computer outages, and arguing with a spouse or roommate. The impact of these encounters varies. For example, witnessing a downpour while on vacation will be at the beach almost certainly elicit a more passive reaction from would at next time. Due to the obvious cumulative effect they have over time, these minor inconveniences It has been found to has a bigger health effects of life calamities*(Schonfels et al., 2015*).

- Duration can also be used to classify stresses, as seen below:

1- Acute, time-limited stress factor, such as final test preparation.

2- Stressor sequential series of traumatic situations that follow a single stressful event, such as job loss or divorce.

3- Intermittent chronic stressors, such as daily annoyances.

4- A long-term lasting stressor, such as serious disease, a disability, or poverty. (Gallo et al., 2014).

2.3.3.b Sources of stress in old age :

1. Change in lifestyle and financial situation following retirement.
2. Taking care of grandchildren.
3. Taking care of a sick spouse.
4. Death of relatives, loved ones, or close friends
5. Physical abilities deterioration and chronic illness
6. Concerns about being not able to be independent.
7. Concerns about institutionalization (*Okoye, 2015*).

2.3.3.c Common signs and symptoms of stress:

A- Physiological symptoms:

1. inability to sleep, nightmares, loss of appetite, palpitation, and frequent urine.
2. muscular aches and fatigue.

B- Emotional and psychological:

1. Anxiety, fear, irritability, and sadness.
2. agitation, poor concentration, and forgetfulness (*Aldwin, 2018*).

2.4. Previous studies.

The first study: A study conducted by Lotfy et al., 2021 which was titled as (Depression and Generalized Anxiety disorders among Middle and Older Adults with Chronically Ill in Saudi Arabia) the study aimed to assess the severity of depression and anxiety. In this study the findings highlight the significance of offering suitable customized therapies to support the psychological health of older persons with chronic conditions.

The second study: A study conducted by Azam et al.,2021 which was titled as (Prevalence of Mental Health Disorders among Elderly Diabetics and

Associated Risk Factors in Indonesia) This study's goal was to identify the prevalence for the mental disorders (MHD) between many elderly diabetes patients in Indonesia. In this study the researcher suggested the MHD incidence between old diabetic in Indonesia was (19.3) percent, indicating the importance of screening for psychological issues and teaching elderly diabetic patients. MHD was more common among unmarried female senior diabetics with less educational and a history of stroke.

The third study: A study conducted by Ibrahim et al.,2019 which was titled as (Mental disorders among elderly people in Baghdad, Iraq, 2017) The purpose of this study was to evaluate the frequency and predictors of psychological illnesses (MDs) among older persons living in care homes also with their relatives in Baghdad, Iraq, in 2017A cross-sectional study has been undertaken on all elderly people living in Baghdad's NHs and an equal number of old people living in WF. In this study the multivariate revealed numerous factors linked to MD. Low income, reliance on others, and neglect were higher predictors of MD among older individuals living in WF. The incidence of MDs in the NH is much more than double the incidence in the population. We advocated for improved aged mental health care services, comprising curative, prevention, and promotional initiatives.

The fourth study: A study conducted by Zhu et al., 2018 which was titled as (Chronic Disease, Disability, Psychological Distress and Suicide Ideation among Rural Elderly: Results from a Population Survey in Shandong) The goal of this study was to look at the impact of chronic illness and physical impairment on suicide ideation in rural old people in Shandong Province, China, while accounting for mental trauma. In this study the researcher suggested that the Psychological anguish was the most influential factor in rural elderly suicide

ideation, followed by chronic sickness and disability. Effective intervention methods should be implemented in medical care among the rural elderly to allow the early diagnosis of mental distress).

The fifth study: A study conducted by Hong et al ., 2015 which was titled (Psychological distress in elderly cancer patients) The goal of this study is to look at the frequency and particular symptoms of psychological discomfort in older cancer patients. A number of 67 individuals (43.8 percent) reported some level of mental disturbance.The researcher concluded that compared to single patients, those who have lower education monthly income, marriage respondents, those with higher education, and those with greater monthly salary had substantially lower subjective stress scores (p 0.05).In the study the researcher suggested Psychological distress is common among older cancer patients and should be recognized by healthcare workers serving these individuals

.

Chapter Three

Methodology

Chapter Three

Methodology

This chapter discusses the components and strategies employed in this study include the study's design, managerial and ethical considerations, the study's setting, the target group, the sample of the study, the study's a tool, the accuracy of the questionnaire, the pilot study, the questionnaire accuracy, data collection Techniques, and data process.

3.1. Study Design:

A descriptive analytical study using assessment technique to assess the psychosocial status among elderly with chronic diseases. The period of the study was from 9th of February 2022 to the 6th of July 2022.

3.2.Administrative Arrangements:

Administrative arrangements procedure for conducting the present study an official permission is obtained before collecting data from relevant authorities in Appendix(B) as follow:

- Approval from the higher studies scientific committee and Research Ethical Committee at the College of Nursing, University of Babylon.
- Official permissions were obtained from the Babylon Health Directorate in order to access the Hospitals and Health Centers formally.
- The permission was presented to hospitals and Health centers , which includes:

  -Babylon Oncology Center.

  -Imam AL-Sadiq Teaching Hospital .

  -The first sector of Hilla and The Second Sector of Hilla .

3.3. Setting of the study:

The study was conducted in Hilla city center (oncology centers, health centers and hospitals). The hospital is Imam Al-Sadiq Teaching Hospital, Al-Murjan Teaching Hospital (Babylon Oncology Center) and health centers It includes the first and second sectors of Hilla**.**

3.3.1. Babylon Oncology Center

It is a center that provides health services to people with malignant diseases. Its located at Marjan City Hospital. It contains several beds with a private ward at a capacity of four beds as well as specialized medical and nursing staff. The center receives patients from different regions of Iraq and is not restricting to residents of Babylon province.

3.3.2. Imam AL-Sadiq Hospital:

The hospital is considered the master hospitals of Babylon province. It follows the Iraqi Ministry of Health. The hospital Capacity (492) beds, several clinics and centers, and (18) operating halls. The hospital can accommodate (400) beds on the land of (40) dunums, and it's six floors to provide preventive, medical, and therapeutic services to citizens.

3.3.3. The First sector of Hilla:

It is includes several Health centers in the Hilla city , the researcher select the four health centers (Shahid AL-Islam Health center, Mohandessin Health Center, AL-Nahda Health Center, AL-Quds Health Center) these centers located in the center of Hilla city.

3.3.4.The Second Sector of Hilla:

The second sector, which includes many health centers located in the city of Hilla, and health centers located in center of Hilla city these were(AL-Qazia Health Center, Morgan Health Center, Babylon Health Center and AL-Imam Quarter Health Center. The first and second sectors of Hilla contain many centers that provide primary health care, , for all age groups not for the elderly only.

3.4.Study Sample:

A purposeful and non-probability sample of 100 elderly suffering from chronic diseases were selected from health centers, Imam Al-Sadiq Hospital and Babel Cancer Center in Hilla city center, Iraq.

Table (3-1) The distribution of study sample according to the setting

Setting	Number of the sample
Imam AL-Sadiq Teaching Hospital	40 patients
Babylon Oncology Center	5 patients
Health centers	55 patients
Total(n)	100 patients

n: size of sample

3.4.1. Inclusion Criteria:

Choosing the sample based on this consideration:

1- Elderly people who visit health centers and suffer from chronic diseases in the city center of Hilla. They were diagnosed by doctors they have chronic disease.

2-The age of elderly was more than 60 year and more of age.

3- Elderly who are free from psychological problems.

3.5.Study Instruments:

For the purpose of the present study; a questionnaire was developed based on the study objectives. The questionnaire elements for this study were based on (Appendix A) :

1-Thorough review of related research and publications.

2- The following are the scales:the DAS-scale (21)(Depression, Anxiety and Stress) It is a well-established measurement tool for emotional states of depression, anxiety and stress(Oei et al.,2013).

The final questionnaire consist of four parts as follows :

Part 1: covering letters to acquire caregivers' permission to participate in a study **.**

Part 2: This section is composed of demographical characteristics, which include "age, gender, Residence, Type of Occupation, Past working Status, Educational level, marital status, Monthly income ,Source for income, Having children , and Living ".

Part 3: This section is composed of chronic diseases, which includes "cardiovascular diseases, diabetes, cancer, arthritis , asthma, irreparable bowel syndrome".

Part 4: The section is divided into three sections, each of which comprises twenty-one items, which are distributed as follows.:

1- **Anxiety:** This section was including (7) items using three Likert rating level (always), (sometimes) and (neve r), this scale have been rating and scoring (3) to always(2) to sometimes and (1) to (never) the total sum of all scoring (21).

2- **Depression:** This section was including (7) items using three Likert rating level scale (always), (sometimes) and (never), this scale have been rating and scoring (3) to(always), (2) to(sometimes) and (1) to (never) the total sum of all scoring (21).

3- **Stress:** This section was including (7) items using three Likert rating level scale (always), (sometimes) and (never), this scale have been rating and scoring (3) to(always), (2) to(sometimes) and (1) to (never) the total sum of all scoring (21).

Each section using three - Likert rating level scale [(always),(sometime), never)] they were have been rating and scoring always = (3), sometimes = (2), and never =(1), To each one of psychological statues (depression, anxiety , stress)score was (21).

3.6.Validity of the Questionnaire:

Validity (content)is considered from the main aspects of the research , because of that the researcher want to examine the accuracy of the questionnaire, A group of experts was shown the tool. from various disciplines related to the field of study to make it more valid . The questionnaire contents was show on a panel of 11 experts from different disciplines who specialized in related field and have years of experience in their specialty these experts were(Appendix C):

- From the University of Baghdad (College of Nursing) (2) (Psychiatry specialty) .
- From the University of Babylon (College of Nursing) (2) (Community Health Nursing specialty).
- From the University of Kufa(College of) (1) (Psychiatry Medicine specialty)

- From the University of Kufa(College of Nursing) (2) (Psychiatry specialty)
- From the University of Karbala(College of Nursing). (2) (Psychiatry and Mental Health specialty)
- From the University of Babylon (College of Nursing) (1) (Psychiatry specialty)

The experts' observations implicitly included that they all agreed that (21) items of the DAS_ scale questionnaire were clear and sufficient to measure the phenomena underlying the study. Amendments were made to some items as stated in the experts' suggestions.

3.7.Pilot Study:

After making the administrative arrangements and before starting data collection a pilot study was conducted on 10 patients (n =10) from both genders were selected from Babylon Oncology Center, Imam AL-Sadiq Hospital and Health center in Hilla city(10%from total sample). The pilot study was conducted from March 1st to March 16th, 2022, and the elderly were eliminated from the study's main group.

3.7.A The following objectives were set for a pilot study:

1- Determine the assessment tool's clarity and content adequacy.
2- To calculate the mean time required for data gathering for each participant throughout the study interviews
3- To assess questionnaire reliability by evaluating internal consistency among items.
4- To identify any roadblocks that may arise during the process of data collection.

5- Data collection period.

3.7.C The finding of the pilot study including that:

1. The questionnaire items were clear and understandable

2. Each respondent needs between(15 – 25) minutes to complete the instrument.

3.7.D. Reliability of the Questionnaire:

The dependability of the research instrument entails ensuring that the result will be almost identical if it is administered repeatedly to the same persons at different periods. After establishing the apparent validity of the research tool, the researcher used it to a randomized exploratory sample of 10 older persons, roughly equal to 10% of the original population. Members of this group were later excluded from the initial sample on which the ultimate research was undertaken out. The reliability coefficient is calculated using the Alpha Cronbach test coefficient, as shown below.

Table3-2:Reliability of the Studied Questionnaire (*n=10*)

Reliability	
DAS-21	0.86

The questionnaire's items were reliable. The time required for answering the questionnaire ranged from (15-25) minutes. In addition, the instrument items were clarified and understood the psychological status of elderly people with chronic diseases in the center of Hilla city.

3.8.Data Collection Methods:

After permission were obtained from all centers and hospitals, and completed Piot study The data was collected by using the questionnaire from April 23th, 2022 to May 15th, 2022.

For gathered data personally administered the questionnaire to the elderly. after explaining the purpose of the study to respondents.

Been questioned each old person individually after asking if he or she was available for questions and assist in this research; the majority of them were agreeable with the interviewer. The average amount of time necessary for each responder to the elderly interview was around (15-25) minutes. The data was gathered through daily visits to the health centers between the hours of(8 a.m.),(12:30 p.m.), five days a week.

3.9.Methods of Statistics Data Analysis:

Data were prepared, organized, and input into a computer file before being analyzed using a statistical tool for he data processing that follows the social sciences (Microsoft Excel 2010 with spss Version 26). The next data analysis methodologies are utilized to examine and evaluation the Study findings.

3.9.1.Descriptive approach:

Descriptive statistics includes a set of mathematical and statistical methods that are adopted to describe the main features of a data quantitatively by using tables and charts. Descriptive statistics always aim to present and describe the data which is required to be processed, organized, summarized and categorized, as well as presenting them in a simple and clear manner that makes it easier for the recipient to recognize and understand its content. The analysis performed through use:

3.9.1.a. Statistical tables Frequency and percentage .

3.10.1.b. Mean of scores *M*±.

The overall responses of Psychological Status according to total mean of score which follow:

$$\textbf{total mean of scores} = \frac{\textbf{Maximum total sores} - \textbf{munimum total sores}}{\mathbf{3}}$$

$$\textbf{Psychological Status} = \frac{\mathbf{63 - 21}}{\mathbf{3}}$$

$$= \frac{\mathbf{63 - 21}}{\mathbf{3}} = \mathbf{14}$$

M= 21-35 refers to High Psychological Status.

M=36-49 refers to Moderate Psychological Status.

M=50-63 refers to Psychological Status.

3.10.1.c. Standard Deviation test ±*SD*.

3.10.2.Inferential approach:

3.10.2.a. One Way ANOVA:

For equality of Means, is use (ANOVA test when the mean's parameter is different).

3.10.2.b. Sample Independent t-test:

The t Test examines the mean of two independent groups to see if the related population means differ significantly statistically.

The level:

(1) **NS**: *Non significantly at probability-value>0.05*.

(2) **S**: *Significantly at probability-value <0.05*.

Chapter Four

Results of the Study

Chapter Four

Results of the Study

Under the objectives of current study findings, the descriptive and inferential statistic approach organized in tables and figures that including:

4-1.Descriptive Statistic of Socio-Demographic Variables (n:100)

SDVs	Classification	Freq.	%
Age/years (*M ± SD= 69±7.24*)	(60-69) years	49	49.0
	(70-79) years	33	33.0
	(80) years and more	18	18.0
Gender	Male	50	50.0
	Female	50	50.0
Residents	Urban	48	48.0
	Rural	52	52.0
Occupation	Retired	47	47.0
	Unemployment	53	53.0
Past working Status	Employed	29	29.0
	Free business	51	51.0
	Unemployed	20	20.0
Level of Education	Illiterate	36	36.0
	Read and write	8	8.0
	Elementary school	20	20.0
	Middle school	9	9.0
	Secondary education	10	10.0
	College degree	17	17.0
Marital status	Married	52	52.0
	Divorced	10	10.0
	Widower	38	38.0
Income/month	Adequate	24	24.0
	Barely adequate	44	44.0
	Inadequate	32	32.0
Sources of income	Pension	52	52.0
	Social Insurance	18	18.0
	Relatives	30	30.0
Number of sons	Not have	5	5.0
	1-2	7	7.0
	>2	88	88.0
Living status	With family	68	68.0
	With son	20	20.0
	Live alone	12	12.0

Finding show participants demographic information, the mean age is (69), the age 60-69 years were records highest percentage (49%). In regard gender, a fifty percent for male and female. Concerning residents, most of elderly (52%) from rural areas. Occupation related findings, elderly expressed unemployment with previously a free business (53% and 51) respectively. Education associated findings, a thirty-six percent were illiterate. In terms of income and its sources, forty-four percent were barely adequate and mostly depends on pension. Eighty-eight percent were have >2 sons and (68%) of them live within their families.

4-2.Descriptive Statistic of Chronic Diseases

Variables	Classification	Freq.	%
Chronic Diseases	HTN	24	24.0
	DM	11	11.0
	Asthma	2	2.0
	IBS	2	2.0
	Cancer	7	7.0
	HTN & DM	7	7.0
	DM, Asthma	4	4.0
	Asthma, IBS	1	1.0
	HTN,DM,IBS	4	4.0
	HTN,DM, Arthritis	3	3.0
	DM, Arthritis	15	15.0
	HTN,IBS, Cancer	8	8.0
	IBS, Cancer	6	6.0
	HTN, IBS	3	3.0
	HTN, Arthritis	3	3.0
Duration of Diseases	1 year	8	8.0
	2-5years	35	35.0
	6-10 years	30	30.0
	>10 years	27	27.0

Finding show participants Chronic diseases and its associated. Out of 100 elderly included in current study were have hypertension (HTN) (24%) as a mostly. Most of participants on chronic diseases for 2-5 years as a duration of chronic diseases.

4.3.Psychological Status among Elderly with Chronic Diseases

Table 4-3-1.Psychological Status in terms of Depression

List	Depression Items	Class	Freq.	%	*M.s ± SD*
1	I was unable to become enthusiastic about anything	Always	31	31.0	*1.89±0.709*
		Sometime	49	49.0	
		Never	20	20.0	
		Total	100	100.0	
2	I felt that life was meaningless	Always	24	24.0	*2.07±0.742*
		Sometime	45	45.0	
		Never	31	31.0	
		Total	100	100.0	
3	I don't feel positive at all	Always	28	28.0	*1.93±0.700*
		Sometime	51	51.0	
		Never	21	21.0	
		Total	100	100.0	
4	I feel sad and blue	Always	47	47.0	*1.62±0.647*
		Sometime	44	44.0	
		Never	9	9.0	
		Total	100	100.0	
5	t was tough for me to get the motivation to get things done	Always	37	37.0	*1.73±0.633*
		Sometime	53	53.0	
		Never	10	10.0	
		Total	100	100.0	
6	I thought I didn't have much value as a person.	Always	22	22.0	*2.21±0.782*
		Sometime	35	35.0	
		Never	43	43.0	
		Total	100	100.0	
7	I feel I have nothing to look forward to.	Always	30	30.0	*1.93±0.728*
		Sometime	47	47.0	
		Never	23	23.0	
		Total	100	100.0	

"(M.s) Mean of Scores, (SD) Standard deviation, Level of Assessment (High≤1.66, Moderate=1.67-2.33, Low≥2.34)"

In terms of statistical mean and standard deviation, this table illustrated that the elderly with chronic diseases expressed a moderate responses regards psychological status associated depression at all items of the scale as indicated by moderate mean of scores (*M.s= 1.67-2.33*) except, the elderly expressed a high depression in terms of (*felt down-hearted and blue*) as indicated by low mean of scores (*M.s ≤1.66*).

Table 4-3-2:Overall Psychological Status Associated Depression

Depression Level	*Freq.*	*%*	*M ± SD*
Sever (*M=7-11*)	24	24.0	*13.83 ± 3.85*
Moderate (*M=12-16*)	53	53.0	
Mild (*M=17-21*)	23	23.0	
Total	100	100.0	

This table show it is the (53%) of elderly with chronic diseases exhibited a moderate psychological status related to depression as described by moderate average which equal to *13.83* (±*3.85*).

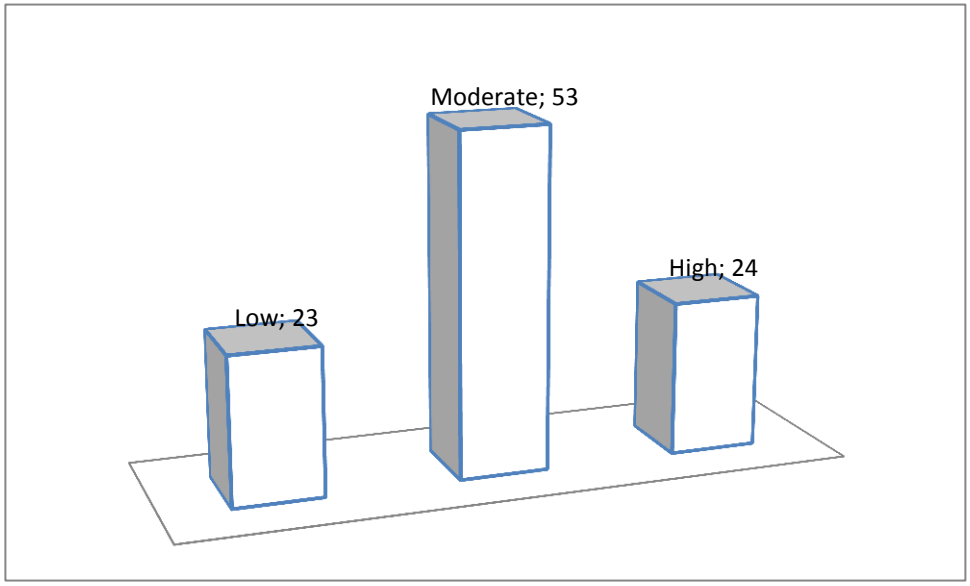


Figure4-1:Depression Level among Elderly

Table 4-3-3.Psychological Status in terms of Anxiety

List	Anxiety Items	Class	Freq.	%	*M.s ± SD*
1	I was terrified for no apparent reason	Always	52	52.0	*1.67±0.779*
		Sometime	29	29.0	
		Never	19	19.0	
		Total	100	100.0	
2	I am concerned about circumstances in which I would yell and embarrass myself..	Always	54	54.0	*1.50±0.577*
		Sometime	42	42.0	
		Never	4	4.0	
		Total	100	100.0	
3	I felt I was close to panic	Always	57	57.0	*1.66±0.831*
		Sometime	20	20.0	
		Never	23	23.0	
		Total	100	100.0	
4	I became conscious of the dryness in my mouth.	Always	66	66.0	*1.40±0.603*
		Sometime	28	28.0	
		Never	6	6.0	
		Total	100	100.0	
5	I began shaking (e.g. in my hands)	Always	59	59.0	*1.58±0.767*
		Sometime	24	24.0	
		Never	17	17.0	
		Total	100	100.0	
6	In the lack of effort, I was conscious of the activity of my heart	Always	56	56.0	*1.53±0.658*
		Sometime	35	35.0	
		Never	9	9.0	
		Total	100	100.0	
7	I was having trouble breathing	Always	55	55.0	*1.51±0.611*
		Sometime	39	39.0	
		Never	6	6.0	
		Total	100	100.0	

"(M.s) Mean of Scores, (SD) Standard deviation, Level of Assessment (High≤1.66, Moderate=1.67-2.33, Low≥2.34)"

In terms of statistical mean and standard deviation, this table illustrated that the elderly with chronic diseases expressed a highly psychological status associated anxiety at all items of the scale as indicated by low mean of scores (*M.s≤ 1.66*) except, the elderly expressed a moderate level of anxiety in terms of (*felt scared without any good reason*) as indicated by moderate mean of scores (*M.s= 1.67-2.33*).

Table 4-3-4:Overall Psychological Status Associated Anxiety

Anxiety Level	*Freq.*	*%*	*M ± SD*
Sever (*M=7-11*)	55	55.0	*10.85 ± 4.21*
Moderate (*M=12-16*)	30	30.0	
Mild (*M=17-21*)	15	15.0	
Total	100	100.0	

This table show that the (55%) of elderly with chronic diseases exhibited a severe psychological status related to anxiety as described by low average which equal to *10.85* (*±4.21*).

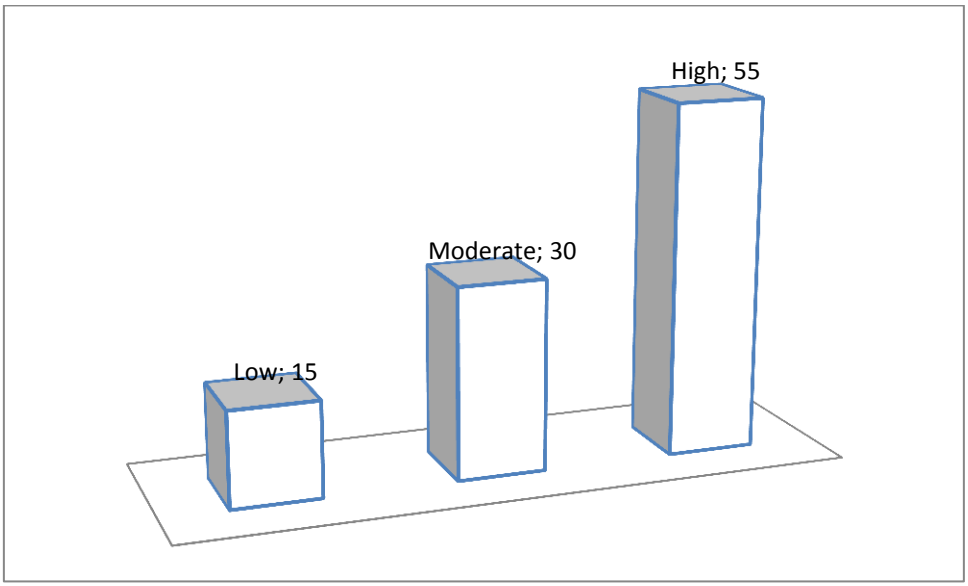


Figure4-2:Anxiety Level among Elderly

Table 4-3-5.Psychological Status in terms of Stress

List	Stress Items	Class	Freq.	%	*M.s ± SD*
1	I had the impression that I was very sensitive.	Always	51	51.0	*1.54±0.593*
		Sometime	44	44.0	
		Never	5	5.0	
		Total	100	100.0	
2	I was irritated by anything that prevented me from going on with my work	Always	60	60.0	*1.58±0.780*
		Sometime	22	22.0	
		Never	18	18.0	
		Total	100	100.0	
3	It was tough for me to unwind.	Always	75	75.0	*1.30±0.559*
		Sometime	20	20.0	
		Never	5	5.0	
		Total	100	100.0	
4	I began to get irritated	Always	61	61.0	*1.56±0.769*
		Sometime	22	22.0	
		Never	17	17.0	
		Total	100	100.0	
5	I had the impression that I had been actually spending a lot of nervous energy.	Always	66	66.0	*1.44±0.671*
		Sometime	24	24.0	
		Never	10	10.0	
		Total	100	100.0	
6	It was difficult for me to relax	Always	77	77.0	*1.29±0.573*
		Sometime	17	17.0	
		Never	6	6.0	
		Total	100	100.0	
7	I tended to over-react to situations	Always	63	63.0	*1.50±0.717*
		Sometime	24	24.0	
		Never	13	13.0	
		Total	100	100.0	

"(M.s) Mean of Scores, (SD) Standard deviation, Level of Assessment (High≤1.66, Moderate=1.67-2.33, Low≥2.34)"

In terms of statistical mean and standard deviation, this table illustrated that the elderly with chronic diseases expressed a highly psychological status associated stress at all items of the scale as indicated by low mean of scores (*M.s≤ 1.66*).

Table 4-3-6:Overall Psychological Status Associated Stress

Stress Level	*Freq.*	*%*	*M ± SD*
Sever (*M=7-11*)	65	65.0	*10.21 ± 3.39*
Moderate (*M=12-16*)	31	31.0	
Mild (*M=17-21*)	4	4.0	
Total	100	100.0	

This table show that the (65%) of elderly with chronic diseases exhibited a severe psychological status related to stress as described by low average which equal to *10.21* (*±3.39*).

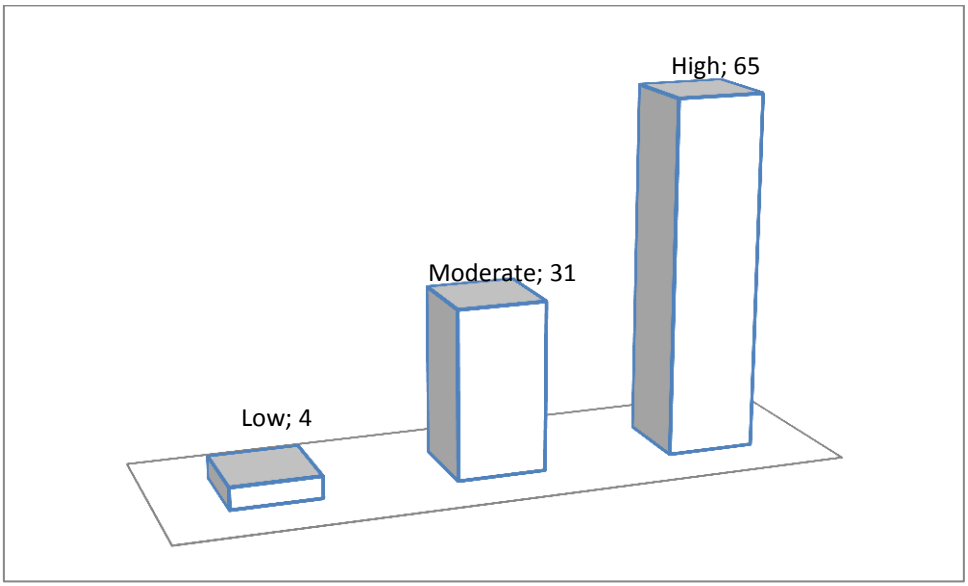


Figure4-3:Stress Level among Elderly

Table 4-4:Overall Psychological Status among Elderly with Chronic Diseases

Psychological Status	*Freq.*	*%*	*M ± SD*
Sever (*M=21-35*)	53	53.0	*34.44 ± 8.55*
Moderate (*M=36-49*)	43	43.0	
Mild (*M=50-63*)	4	4.0	
Total	100	100.0	

According to study criteria, findings demonstrated that the (53%) of elderly with chronic diseases exhibited a sever psychological status as described by low average which equal to *34.44* (*±8.55*). Figure (4-4) show that the stress were considered a most common factors related psychological status (*M=1.45*), followed by anxiety (*M=1.55*) and depression (*M=1.91*).

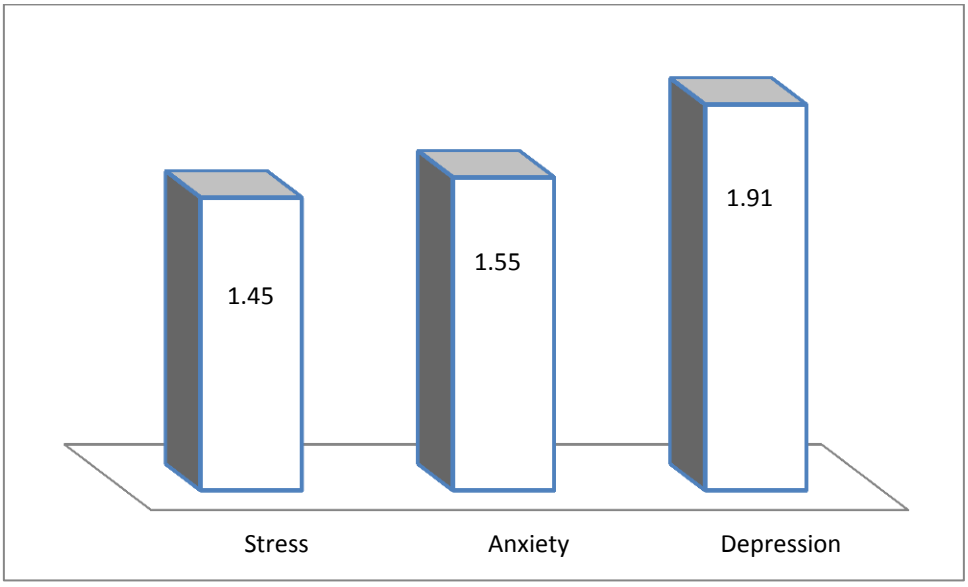


Figure 4-4:Psychological Status among Elderly with Chronic Diseases

4.5.Statistical Differences in Psychological Status with regard their Elderly Socio-Demographic Variables.

Table 4-5-1:Statistical Differences in Psychological Status with regards Elderly Age (*n=100*)

	Classification	Mean	SD	*p-value*
Psychological Status *Vs.* Age	(60-69) years	1.82	.365	.001
	(70-79) years	1.58	.326	
	[(80) years and, more	1.23	.325	

The findings revealed that there were substantial disparities in psychological state based on elderly age (*p=0.001*). It was observed that the introduced ages (80 and older) is significantly associated higher psychological status (lower average) unlike those who are aged 60-69 years (higher average) (Fig. 4-5). (Appendix E_5)

Table 4-5-2:Statistical Differences in Psychological Status with regards Elderly Gender (*n=100*)

	Gender	Mean	Sd	T-value	D.F	P-*value*
Psychological Status	Male	1.66	.392	.606	98	*.549*
	Female	1.61	.424			

In this study the result found no significant differences in psychological status with regards gender at (*t=0.606*; *p=0.549*).

Table 4-5-3:Statistical Differences in Psychological Status with regards Elderly Residents (*n=100*)

	Resident	Mean	Sd	T-value	D.F	P-*value*
Psychological Status	Urban	1.88	.251	1.807	98	*.074*
	Rural	1.61	.412			

The finding in this study show no significant differences in psychological status with regards those who are residents in urban (*M=1.88*) and those who are residents in rural (*M=1.61*) at (*t=1.807*; *p=0.074*).

Table 4-5-4:Statistical Differences in Psychological Status with regards Elderly Occupation (*n=100*)

Psychological Status	Occupation	Mean	Sd	T-value	D.F	P-*value*
	Retired	1.68	.384	.991	98	.*324*
	Unemployment	1.60	.427			

According the result no significant differences in psychological status with regards those who are retired (*M=1.68*) and those who are unemployment (*M=1.60*) at (*t=0.991*; *p=0.324*).

Table 4-5-5:Statistical Differences in Psychological Status with regards Elderly Past working (*n=100*)

Psychological Status *Vs.* Status	Classification	Mean	SD	*p-value*
	Employed	1.72	.410	.354
	Free business	1.62	.396	
	Unemployed	1.55	.429	

The outcome of the study that no significant differences in psychological status and elderly previous work status (*p=0.354*).

Table 4-5-6:Statistical Differences in Psychological Status with regards Elderly Education (*n=100*)

	Classification	Mean	SD	*p-value*
Psychological Status *Vs.* Level Of Education	Unlettered	1.37	.344	.001
	Read and write	1.16	.179	
	Elementary school	1.82	.216	
	Middle school	1.79	.226	
	Secondary education	1.66	.283	
	College degree	2.09	.277	

The findings revealed that there were considerable disparities in psychological state when it came to older education (*p=0.354*). As being the uneducated or informal educated is significantly associated higher psychological status (lower average) unlike those who are college (higher average) (Fig. 4-6).(Appendix E_1).

Table 4-5-7:Statistical Differences in Psychological Status with regards Elderly Marital Status (*n=100*)

	Classification	Mean	SD	*p-value*
Psychological Status *Vs.* Marital Status	Single	1.70	.454	.431
	Married	1.50	.464	
	Divorced	1.55	.399	
	Separated	1.58	.325	

The findings revealed that there were no considerable disparities in psychological state when it came to older marital status (*p=0.431*).

Table 4-5-8:Statistical Differences in Psychological Status with regards Elderly Income (*n=100*)

	Classification	Mean	SD	*p-value*
Psychological Status *Vs.* Income	Adequate	1.80	.367	.002
	Barely adequate	1.74	.321	
	Inadequate	1.37	.423	

The findings revealed that there were considerable disparities in psychological state when it came to older income (*p=0.002*). Inadequate income is significantly higher psychological status (Fig. 4-7).(Appendix E_2)

Table 4-5-9:Statistical Differences in Psychological Status with regards Elderly Sources of Income (*n=100*)

	Classification	Mean	SD	*p-value*
Psychological Status *Vs.* Sources of Income	Pension	1.63	.418	.352
	Social Insurance	1.53	.412	
	Relatives	1.71	.382	

The findings revealed that there were no considerable disparities in psychological state when it came to older sources of income (*p=0.352*).

Table 4-5-10:Statistical Differences in Psychological Status with regards Elderly Number of Sons (*n=100*)

	Classification	Mean	SD	*p-value*
Psychological Status *Vs.* No, sons	Not have	1.46	.440	.335
	1-2	1.48	.410	
	>2	1.66	.405	

The findings revealed that there were no considerable disparities in psychological state when it came to older their number of sons (*p=0.335*).

Table 4-5-11:Statistical Differences in Psychological Status with regards Elderly Living Status (*n=100*)

	Classification	Mean	SD	*p-value*
Psychological Status *Vs.* Living Status	With family	1.77	.366	.000
	With son	1.48	.311	
	Live alone	1.15	.330	

The findings revealed that there were considerable disparities in psychological state when it came to older their number of sons (*p=0.000*). It was see that the elderly who are independent living (alone) is significantly higher psychological status, unlike those who are living with their families or sons (Fig. 4-8).(Appendix E_3**)**

Table 4-5-12:Statistical Differences in Psychological Status with regards Elderly tier Chronic Diseases (*n=100*)

	Classification	Mean	SD	*p-value*
Psychological Status *Vs.* Chronic Diseases	HTN	1.72	.384	.002
	DM	1.83	.202	
	Asthma	1.97	.101	
	IBS	2.14	.471	
	Cancer	1.00	.000	
	HTN & DM	1.78	.212	
	DM, Asthma	1.71	.160	
	Asthma, IBS	1.95	.201	
	HTN,DM,IBS	1.69	.234	
	HTN,DM, Arthritis	1.85	.380	
	DM, Arthritis	1.37	.428	
	HTN,IBS, Cancer	1.29	.348	
	IBS, Cancer	1.33	.103	
	HTN, IBS	1.95	.501	
	HTN, Arthritis	1.71	.125	

The findings revealed that there were no considerable disparities in psychological state when it came to older their chronic of diseases (*p=0.002*). It was see that the elderly who had cancers and cancer associated hypertension and irritable bowel syndrome is significantly higher psychological status.

4.6.Association between Psychological Status among Elderly and Duration of Diseases

Correlation Coefficient	1	2	3	4	5
1.Psychological Status	-	.003	.221*	-.607**	-.609**
2. 1 year	.003	-	.128	-.012	-.121*
3. 2-5 years	.221*	.128	-	.014	-.020
4. 6-10 years	-.607**	-.012	-.121*	-	.001
5. >10 years	-.609**	.014	-.020	.001	-

Findings indicate that the psychological status among elderly were significantly increased as a duration of diseases increased.

Table(4-7): Statistic Variations in Depression Among the Older Based on Chronic Illnesses (*n=100*)

Chronic Diseases	source of the difference	Sum of Boxes	D.F	Average Square	*F-statistic*	*p-value*
Depression	Between Groups	12.271	14	.876	4.195	.000
	Within Groups	17.761	85	.209		
	Total	30.032	99			

The findings revealed that there were considerable disparities in psychological state when it came to older their chronic diseases (*p=0.000*). It was see that the elderly who had cancers were mostly significant higher psychological status in terms of Depression (Fig. 4-9).(Appendix E_4)

Table 4-8: Statistic Variations in anxiety Among the Older Based on Chronic Illnesses (*n=100*)

Chronic Diseases	source of the difference	Sum of Boxes	D.F	Average Square	*F-statistic*	*p-value*
Anxiety	Between Groups	12.278	14	.877	3.151	.001
	Within Groups	23.656	85	.278		
	Total	35.934	99			

The findings revealed that there were considerable disparities in psychological state when it came to older chronic diseases (*p=0.001*). It was see that the elderly who had cancers were mostly significant higher psychological status in terms of (Fig. 4-10).(Appendix E_4)

Table 4-9: Statistic Variations in Stress Among the Older Based on Chronic Illnesses (*n=100*)

Chronic Diseases	source of the difference	Sum of Boxes	D.F	Average Square	F-*statistic*	P-*value*
Stress	Between Groups	4.939	14	.353	1.632	.087
	Within Groups	18.379	85	.216		
	Total	23.318	99			

The findings revealed that there were no considerable disparities in psychological state when it came to older their chronic diseases (*p=0.087*).

Figure 4-9. (Appendix E_6**).**

Chapter Five

Discussion

Chapter Five

Discussion

This chapter deals with the systematic illustration and discussion of the findings, which resulted reasonably from the literature and studies on the psychological status among elderly with chronic diseases .

5.1 Demographic characteristics of elderly with chronic diseases (Table4-1).

Age :

The findings of the study shows that Thirty-four percent of the sample were from the age group (60-69) years, and Thirty-three percent of them from age group(70-79) years , and the results also shows that Eighteen percent of them were from the age group 80 and older (80 years and older) .

Gender:

In regard to gender the same percentage for female and male . The half of the sample were female and half were male,.

Residential area:

Regarding the residential area, the result shows that Fifty –Tow percent of elderly were living in rural area while Forty-Eight percent of the elderly people living in Urban area.

Occupation :

According to occupation , Current work during the sampling period the result shows that Fifty-Three percent of the sample they were unemployment , While Forty-Seven percent of them were retired. While the Previous Work, this result shows that the percentage Fifty-One percent of elderly work in free business and Employed Twenty –Nine percent and the Unemployed were Twenty percent.

Educational level:

Regarding the educational level, the results shows that Thirty-Six percent of the sample were illiterate and Twenty percent of them were primary school graduation , while eight percent of them read and write , ten percent secondary school graduation, nine percent intermediate school graduation and seventeen percent of the sample were College graduation .

Marital status:

The marital status of the present sample revealed that Fifty-Tow percent of the elderly were married, ten percent divorced, Thirty- Nine percent widower.

Monthly income

According to the monthly income of the sample the results show that Forty-Four percent of the elderly their income were barely enough, and Twenty-Four percent from elderly income is adequate Thirty-Tow percent of them their income were inadequate and mostly depends on pension.

Have son :

Eighty-eight percent were have >2 sons and Sixty- Eight percent of them live within their families.

5.2 Descriptive the samples according to chronic disease table (4-2)

The participants of this study (the sample of the study) were 100 elderly people who suffer from chronic disease , Twenty-Four percent of the sample have HTN , and eleven percent of them have diabetes mellitus, seven percent of them have cancer, and Tow percent have asthma and Tow percent suffer from irritable bowel syndrome.

However, there are elderly people who have more than one chronic illness (Fifteen percent of them has DM, Arthritis, Eight percent from the sample has HTN,IBS, Cancer) According to duration of the chronic disease most of elderly they have the disease from 2- 5 years.

5.3 Psychological Status among Elderly with Chronic Diseases.

5.3.1. Table (4-3-1)

The result of the study show that Forty-Nine percent of the sample they answer (sometime) to the question N.o1 (I was unable to become enthusiastic about anything)) at M.s (1.89). while Forty-Five percent from the participants answer (sometime) to the question No 2 (I felt that life was meaningless) at M.s(2.07), Fifty-Three percent from the participant answer (sometime) about the a question No 3 (I couldn't seem to experience any positive feeling at all) with M.s (1.93), and Forty-Four percent from the participant answer (always) to the question No 4 (I felt down-hearted and blue) at(M.s (1.62), Fifty-Three percent from respondents answer (sometime) to the question N.o 5(I found it difficult to work up the initiative to do things), with M.s (1.73), Fory-Three percent from respondents answer(never) to the question N.o 6(I felt I wasn't worth much as a person) with M.s (2.21), Forty-Seven percent from the respondents answers (sometime) to the question N.o 7(I felt that I had nothing to look forward to) at M.s (1.93).

5.3.2 Levels of depression Table(4-3-2)

The result indicates that most of the sample Fifty-Three percent of the elderly people with chronic disease have moderate level of depression as described by moderate average which equal to *13.83* (*±3.85*). the finding show

that Twenty-Four percent of them have severe psychological status related to depression while Twenty-Three percent have low psychological status related to depression . These results were supported by (*Sherina el at.,2005*.) this study under the title (prevalence of depression among elderly in an urban area of Selangor, Malaysia.) who found that Fifty-Six percent of the sample have moderate level of depression . this result Perhaps because the elderly people suffer from depression but they accepted what happened and believed in Allah judgment and considered it is Allah will **.**

5.3. 3 Anxiety. Table (4-3-3)

The result of the study show that most of the sample Fifty-Three percent of them they answer (always) to the question no.1 (I felt scared without any good reason) at M.s*(1.67)*. Fifty-Four percent from the participants answer (always) to the question no 2(I was worried about situations in which I might panic and make a fool of myself) with M.s(*1.50)* , Fifty-Seven percent about the a question no 3(I felt I was close to panic) were answers (Always) with M. s(*1.66±)*, Sixty-Six percent from the participant answer (always) *to the question no 4* (I was aware of dryness of my mouth*)at M.s (1.40)*, Fifty-Nine percent from the sample answers(Always) to the question N.o 5(I experienced trembling (e.g. in the hands)) with *M.s* (*1.58*), Fifty-Six percent from the participants answer(Always) to the question no 6(I was aware of the action of my heart in the absence of exertion(e.g. sense of heart rate increase, heart missing a beat)) with *M.s* (*1.53*), Fifty-Five percent from respondents answers to the question N.o 7(I experienced breathing difficulty (e.g. excessively rapid Breathing, breathlessness in the absence of physical exertion) were (Always), *at M.s (1.51).*

5.3.4 Levels of Anxiety. Table (4-3-4)

The result of the study showed that Fifty-Five percent of elderly with chronic diseases exhibited a severe psychological status related to anxiety , while Thirty percent of them have moderate psychological status related to anxiety ,and Fifteen percent mild psychological status average which equal to *10.85* (*±4.21*.). This result maybe because most of the elderly were exposed to anxiety ,Because of effort they are exposed to as a result of adherence to treatment and diet to avoid symptoms resulting from chronic diseases.. this finding were supported by(*Shakir& Mohammed, 2017*) who found that the most of the sample a Fifty percent have moderate anxiety level, Fifty-Four percent Thirty-Seven percent of the sample have severe anxiety level .

5.3.5. Stress. Table (4-3-5).

The result of the study show that most of the sample Fifty-One percent of them they answer (always) to the question no.1 (I felt that I was rather touchy) at M.s*(1.54)*. Sixty-One percent from the participants answer (always) to the question no 2(I was intolerant of anything that kept me from getting on with what I was doing) with M.s(*1.58)* , Seventy-Five percent about the a question no 3(I found it difficult to relax) were answers (Always) with M. s(*1.30)*, Sixty-One percent from the participant answer (always) *to the question no 4* (I found myself getting agitated*)at M.s (1.56)*, Sixty-Six percent from the sample answers(Always) to the question N.o 5(I felt that I was using a lot of nervous energy) with *M.s* (*1.44*), (77.0%)from the participants answer(Always) to the question no 6(I found it hard to wind down) with *M.s* (*1.29*), Sixty-Three percent from respondents answers to the question N.o 7(I tended to over-react to situations) were Sixty-Three percent (Always) were (Always), *at M.s (1.50)*.

5.3.6 Levels of Stress. Table(4-3-6)

Findings demonstrated that Sixty-Five percent of elderly people with chronic diseases exhibited a severe psychological status related to stress ,and Thirty-One percent of elderly with chronic diseases exhibited a moderate psychological status related to stress and a Four percent low psychological status . In the this result Perhaps because the elderly adapted to the presence of the chronic disease due to the use of medicines and adherence to some medical and health guidelines for the disease. These results were against the result found by (*Lotfy et al., 2021*) which found that 81.5% (n=163) of participants had mild anxiety and 18.5% (n=37) had moderate-to-severe anxiety.

5.4 The Overall Psychological Status among Elderly with Chronic Diseases.

In the study criteria, findings demonstrated that the Fifty-Three percent of elderly with chronic diseases exhibited a severe psychological status as described by mild average which equal to *34.44* (±*8.55*), Forty-Three percent , moderate psychological status and a Four percent low psychological status . The result show that the stress were considered a most common factors related psychological status (*M=1.45*), followed by anxiety (*M=1.55*) and depression (*M=1.91*). this result may be the elderly with chronic diseases they are affected by symptoms resulting from severe illness, social status, and changes that occur in their lives as a result of chronic disease, and therefore all of these factors lead to increase the stress. this finding agree with (*Katekaew et al.,2019*) who found that common factors affecting stress among the elderly are family relationship, financial status, social or community environment, physical health and chronic illness.

5.5. Discussion the Distribution levels of psychological status According to Demographic characteristics.

5.5.1 Elderly Age. Table(4-5-1)

The findings of the study indicates that there is a significant relationship between psychological status and age with regards elderly age (*p=0.001*). It was observed that the introduced ages (80 and older) is significantly associated with higher psychological status (lower average) unlike those who are aged 60-69 years (higher average).During aging, psychological problems increases as a result of changing that occur with age, such as physical disability , chronic disease or the inability to carry out daily duties. This is agree with the study by(*Najafi et al.,2014*) who found that during aging the chance of mental health problems increased (P<0.01).

5.5.2 Education level. Table(4-5-6)

The study about educational level indicates that there is a significant relationship between psychological status and educational level of elderly people (*p=0.001*). As being the uneducated is significantly associated with higher psychological status (lower average) unlike those who are college (higher average)**.** Because people with a low level of education face difficulty in their interactions in society and even in terms of group relations, which negatively affects the psychological state. This result supported by (*Motalebi & Shahbadery,2021*)who found that the Education level was significantly correlated with psychological status (R = 0.19; p < 0.001) and moderate correlation was found between education and psychological status(R = 0.26; p < 0.001).

5.5.3 Elderly Income. Table (4-5-8)

The study result indicates that income have a significant relationship between psychological status and elderly income (*p=0.002*). Inadequate income is significantly with a severe psychological status . Because elderly people with limited income find it difficult to work and meet the basic requirements of life as a result of aging in addition to stressful physical changes such as disability or chronic diseases, and all of these factors affect the psychological state. This finding agree with the study by (*Assari, 2020*). His finding That Higher incomes have been associated with higher odds of good mental health in older adults. However, there is less protective effect of higher income on the psychological state of the elderly.

5.5.4 Elderly Living Status. Table(4-5-11)

Concerning with Living Status he findings of the study shows that there is significant relationship between psychological status and Living Status of elderly people with their number of sons (*p=0.000*). It was see that the elderly who are independent living (alone) is significantly severe psychological status, unlike those who are living with their families or sons. Because the elderly in old age are exposed to psychological problems resulting from physical changes or as a result of complications of chronic diseases, so they need psychological support from a family member or to help them carry out daily activities. So we see the psychological problems of elderly people who live alone or do not have sons higher than those who live with their families and have someone to help them in their daily lives. These results were supported by *(Ibrahim et al., 2019)*The study revealed high prevalence rates of depression(Thirty- Five percent in NH group and Sixteen

percent with family group) and anxiety disorders (Twenty-Three percent in nursing home group and Ten percent in WF group) among elderly.

5.6 Statistical differences in the psychological state with regard to chronic diseases of the elderly group. Table(4-5-12)

The result of the study showed that chronic disease indicates there is a significant relationship between psychological status of elderly people and their chronic diseases (*p=0.002*). It was seen that the elderly who had cancers and cancer associated hypertension and irritable bowel syndrome was significantly higher psychological status. This was because the side effects of chronic diseases cause disabilities for the elderly, and as a result of these disabilities, it is difficult for the elderly to perform leisure activities, and this negatively affects the psychological state, this result agree with the study by (*Chen et al.,2017*)the results of this study found that both chronic diseases and mental health disorders, the goodness-of-fit statistics were poor, respectively model, which provided an acceptable fit to the data, also indicated that mental health disorder showed a significant concomitant effect on chronic diseases development. The study findings also suggest that pre-existing mental health disorders can significantly contribute to the development of chronic disease over time'

5.7 Discussion Association between Psychological Status among Elderly and Duration of Diseases.

The study result about the psychological status indicates that there was a significant relationship between the psychological status and the Duration of Diseases in elderly people. Because the longer the duration of the chronic disease increases, the greater its complications. Thus, many elderly people

find it difficult to adapt to these complications, and these factors increase their psychological problems. this result goes with the study by (*Busija & Sanders 2017*) This study reports the associations between Health-related quality of life (HRQOL) and duration of illness in eight common chronic health conditions, specifically asthma, heart disease, arthritis, diabetes, stroke, bipolar disorder, depression, and anxiety.

5.8. Statistical Differences in Depression among Elderly with regards their Chronic Diseases Table (4-7).

In current study the findings indicate that there were significant differences in depression with regards elderly their chronic diseases (*p=0.000*). It was seen that the elderly who had cancers their was a significant higher psychological status in terms of Depression. This was because the elderly have physical disabilities as a result of chronic illness, which makes it difficult for them to carry out the simplest daily activities, and this increases their sense of the end of their life and the approach of death, this result comes with the study of (*Seo et al .,2017*) This study found higher significantly in elderly in the middle-aged population ($p < 0.001$). Approximately One percent of the middle aged population and Nine percent of the elderly population had 4 or more chronic diseases ($p < 0.001$). The prevalence of depressive symptoms in the elderly population Seventeen percent was significantly higher than that in the middle-aged population (9.59%) ($p < 0.001$).

5.9 Statistical Differences in Anxiety among Elderly with regards their Chronic Diseases Table (4-8).

In regard to Anxiety among elderly with Chronic Diseases indicates that there is a significant relationship between the anxiety and Chronic Diseases of elderly people (*p=0.001*). It was seen that the elderly who had cancers were mostly higher significant relationship with psychological status in terms of anxiety. This result may be because they must adhere to treatment and diet to reduce side effects resulting from chronic disease, this result agree with the study by (*Yang et al .,2022*) who found that The number of chronic diseases was a positive factor associated with anxiety. Compared with participants without chronic diseases.

As people age, the prevalence of chronic diseases is increasing, challenging the health system to provide accessible services to meet the growing needs of managing chronic diseases, reducing risks, promoting healthy lifestyles, and improving the quality of life of the elderly population.

Chapter six

Conclusion and Recommendations

Chapter six

Conclusion and Recommendations

6.1.Conclusion:

Based on the study results and discussion, the study concluded the following:

6.1.1 Most of the participants were married , males with ages range from(60 to 69) years old and Fifty-Tow percent from rural areas, most of them unemployed and illiterate. Eighty-eight percent were have >2 sons and Sixty-Eight percent live within their families.

6.1.2. According to The levels of psychological statues it conclude (anxiety severe level , depression moderate level and stress severe level).

6.1.3. Psychological status of people who are 80 and older is significantly associated with higher psychological status than those who are aged 60-69 years, they were significant differences in psychological status with regards elderly age at (p=0.001) and regards elderly education (p=0.354), were significant differences.

6.1.4. Psychological status regards elderly income at (p=0.002) were significant differences, psychological status of elderly with number of sons (p=0.000) and the elderly who are independent living (alone) is significantly higher psychological status, compared to those who are living with their family members or sons.

6.1.5. Most of the elderly who had cancers and cancer with hypertension and irritable bowel syndrome is significantly higher psychological status than the rest of the elderly.

6.1.6. The psychological status among elderly were significantly increased as a duration of diseases increased.

6.1.7. Elderly who had cancers were mostly significant higher psychological status in terms of Depression and the elderly who had cancers were mostly significant higher psychological status in terms of anxiety(*p=0.001*).

6.2. Recommendations:

According to the findings and conclusions of the study the researcher has recommended that:

6.2.1 Develop educational programs for families on how to take care of the elderly and conduct periodic examinations for them to detect early any disease and provide the necessary treatment.

6.2.2. Using educational programs and awareness that encourage the elderly people to interesting for elderly socially and economically.

6.2.3. Provide a programed system to follow-up a health status for old age.

6.2.4. Psychological educational programs for the elderly can be used to increase their knowledge of psychological problems and provide psychological support to improve their psychological state.

6.2.5. Providing special programs in health centers to support the psychological status for the elderly with chronic diseases.

6.2.6. Special agencies responsible for caring of elderly people as follow- up in application of activity daily living elderly People, such as transportation and medical care.

6.2.7. Preparing educational programs for families about healthy nutrition for the elderly who suffer from chronic diseases throw the mass media

References

❖ المصادر العربية

القرآن الكريم سورة يونس : آية 5

❖ Abdelhafiz, A. H., & Sinclair, A. J. (2019). Diabetes in the elderly. *Medicine*, *47*(2), 119-122.

❖ Adapted from American Heart Association, Inc. (2016). Know your risk factors for high blood pressure. Retrieved on 10/29/2016 at: *www.heart.org/HEARTORG/Conditions/HighBloodPressure/UnderstandYourRiskforHighBloodPrYour-Risk-for-High*-BloodPressure_UCM_002052_Article.jsp#.WBUWC1u3BK9

❖ Age UK. (2010). Healthy Ageing Evidence Review. *Healthy Ageing Evidence Review*, 1–30. http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Health-and-wellbeing/Evidence Review Healthy Ageing.pdf?dtrk=true

❖ Agyemang-Duah, W., Owusu-Ansah, J. K., & Peprah, C. (2019). Factors influencing healthcare use among poor older females under the livelihood empowerment against poverty programme in Atwima Nwabiagya District, Ghana. *BMC Research Notes*, *12*(1), 1-6.

❖ AlAbedi, G. A. H., & Naji, A. B. (2020). Impact of Physical Activity Program upon Elderly Quality of Life at Al-Amara city/Iraq. *Prof.(Dr) RK Sharma*, *20*(3), (6).

❖ Aldwin, C. M. (2018). The elders life stress inventory: Egocentric and nonegocentric stress. In *Stress and coping in later-life families* (pp. 49-69). Taylor & Francis.

❖ Agronin, M. E. (2014). From Cicero to Cohen: Developmental theories of aging, from antiquity to the present. *The Gerontologist*, *54*(1), 30-39.

- Alipour, F., Sajadi, H., Forouzan, A., Nabavi, H., & Khedmati, E. (2009). The role of social support in the anxiety and depression of elderly. *Iranian Journal of Ageing*, *4*(1), 0-0.
- American Diabetes Association (ADA). (2016). Standards of medical care in diabetes —2016. Classification and diagnosis of diabetes. Diabetes Care, 39(Suppl 1), S13– S24.
- Aspen Health Strategy Group. (2019). *A Report of the Aspen Health Strategy Group: A Report of the Aspen Health Strategy Group*. 1–146.
- Assari, S. (2020). Income and mental well-being of middle-aged and older Americans: Immigrants' diminished returns. *International Journal of Travel Medicine and Global Health*, *8*(1), 37-43.
- Azam, M., Sulistiana, R., Fibriana, A. I., Savitri, S., & Aljunid, S. M. (2021). Prevalence of Mental Health Disorders among Elderly Diabetics and Associated Risk Factors in Indonesia. *International journal of environmental research and public health*, *18*(19), 10301.
- Bandelow, B., Lichte, T., Rudolf, S., Wiltink, J., & Beutel, E. M. (2014). The diagnosis of and treatment recommendations for anxiety disorders. *Deutsches Ärzteblatt International*, *111*(27-28), 473.
- Bhugra, D., Till, A., & Sartorius, N. (2013). What is mental health?. *International Journal of Social Psychiatry*, *59*(1), 3-4
- Black, D. W., & Andreasen, N. C. (2014). *Introductory textbook of psychiatry*. American Psychiatric Pub.
- Brighi, N., Balducci, L., & Biasco, G. (2014). Cancer in the elderly: is it time for palliative care in geriatric oncology?. *Journal of geriatric oncology*, *5*(2), 197-203.
- Busija, L., Tan, J., & Sanders, K. M. (2017). Associations between illness duration and health-related quality of life in specified mental and physical

chronic health conditions: results from a population-based survey. *Quality of Life Research*, *26*(10), 2671-2681.

- Capriotti, T., & Frizzell, J. P. (2015). Pathophysiology: Introductory concepts and clinical perspectives. Philadelphia, PA: FA Davis.
- Caughey, G., Gilbert, A., Roughead, L., McDermott, R., Ryan, P., & Esterman, A. (2013). Multiple chronic health conditions in older people. *Implications for health policy planning, practitioners and patients*.
- Cui, Y. H., Jing, C. X., & Pan, H. W. (2013). Association of blood antioxidants and vitamins with risk of age-related cataract: A meta-analysis of observational studies. American Journal of Clinical Nutrition, 98(3), 778–786. doi: 10.3945/ajcn.112.053835
- Craig, G. J., & Dunn, W. L. (2007). Understanding human development. Upper Saddle River, NJ: Pearson Education.
- Chalise, H. N. (2019). Aging: Basic Concept. *American Journal of Biomedical Science & Research*, *1*(1), 8–10. https://doi.org/10.34297/ajbsr.2019.01.000503
- Chalise, H. N. (2019). Aging: basic concept. *Am J Biomed Sci & Res*, *1*(1), 8-10.
- Chen, C. M., Lee, I. C., Su, Y. Y., Mullan, J., & Chiu, H. C. (2017). The longitudinal relationship between mental health disorders and chronic disease for older adults: a population-based study. *International Journal of Geriatric Psychiatry*, *32*(9), 1017-1026.
- Davidovic, M., Sevo, G., Svorcan, P., Milosevic, D. P., Despotovic, N., & Erceg, P. (2010). Old age as a privilege of the "selfish ones." Aging and Disease, 1(2), 139–146.

- Davies, G., & Bolton, C. (2010). Age-related changes in the respiratory system. In H. Fillit, K. Rockwood, & K. Woodhouse (Eds.), *Brocklehurst's textbook of geriatric medicine and gerontology* (7th ed., pp. 97–100). Philadelphia, PA: Saunders Elsevier.
- De Vries, N. M., Staal, J. B., Van Ravensberg, C. D., Hobbelen, J. S. M., Rikkert, M. O., & Nijhuis-van der Sanden, M. (2011). Outcome instruments to measure frailty: a systematic review. *Ageing research reviews*, *10*(1), 104-114.
- Debén, E., Gallego, T., Perez, M., Gomez, M., Serra, J., Ramirez, E., Ibañez, A., Martinez, C., Alañon, E., & Morell, A. (2014). DI-024 Cetuximab in the treatment of advanced metastatic colorectal cancer. *European Journal of Hospital Pharmacy*, *21*(Suppl 1), A79.2-A80. https://doi.org/10.1136/ejhpharm-2013-000436.195
- Diaz-Guzman and D. M. Mannino, "Airway obstructive diseases in older adults: from detection to treatment," Journal of Allergy and Clinical Immunology, vol. 126, no. 4, pp. 702– 709, 2010.
- Eliopoulos, C. (2014). *Gerontological nursing* (8th ed.). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.
- Erber, J. T. (2012). *Aging and older adulthood*. John Wiley & Sons.
- Esdras Edgar Batista Pereira. Functional Capacity Assessment in Oncogeriatric. Am J Biomed Sci & Res. 2019 - 5(6). AJBSR. MS.ID.000965. DOI: 10.34297/AJBSR.2019.05.000965
- Estape, T. (2018). Cancer in the elderly: challenges and barriers. *Asia-Pacific journal of oncology nursing*, *5*(1), 40-42.
- Farley, A., McLafferty, E., & Hendry, C. (2006). The physiological effects of ageing on the activities of living. *Nursing standard*, *20*(45), 46-54.

- FreeDictionary,2022 https://www.thefreedictionary.com/psychological+state
- Gallo, L. C., Roesch, S. C., Fortmann, A. L., et al. (2014). Associations of chronic stress burden, perceived stress, and traumatic stress with cardiovascular disease prevalence and risk factors in the Hispanic community health study/study of Latinos sociocultural ancillary study. *Journal of Biobehavioral Medicine*, 76(6), 401–475.
- Gholamzadeh, S., Pourjam, E., & Kalyani, M. N. (2019). Effects of continuous care model on depression, anxiety, and stress in Iranian elderly in Shiraz. *International Journal of Community Based Nursing and Midwifery*, *7*(1), 13.
- Global Strategy for Asthma Management and Prevention, Global Initiative for Asthma (GINA). (2015). Retrieved on 1/25/2015 at: www.ginasthma.org/local/uploads/files/GINA_Report_2015_Aug11.pdf
- Goodman, R. A., Posner, S. F., Huang, E. S., et al. (2013). Defining and measuring chronic conditions: Imperatives for research, policy, program, and practice. *Preventing Chronic Disease*, 10, E66.
- Greenberg, M. S., Tanev, K., Marin, M., et al. (2014). Stress, PTSD, and dementia. Alzheimer's & Dementia, 10, S155–S165.
- Grossman, S. C., & Porth, C. M. (2014). Porth's pathophysiology: Concepts of altered health states (9th ed.). Philadelphia, PA: Wolters Kluwer.
- Heinz, M., Cone, N., Da Rosa, G., Bishop, A. J., & Finchum, T. (2017). Examining supportive evidence for psychosocial theories of aging within the oral history narratives of centenarians. *Societies*, *7*(2), 8.
- Hill, C. (2006). Endocrine function. In S. E. Meiner & A. G. Lueckenotte (Eds.), *Gerontological nursing* (3rd ed., pp. 535–560). St. Louis, MO:

Mosby Elsevier.

- Hong, J. F., Zhang, W., Song, Y. X., Xie, L. F., & Wang, W. L. (2015). Psychological distress in elderly cancer patients. *International Journal of Nursing Sciences*, *2*(1), 23-27.
- Hong, J. F., Zhang, W., Song, Y. X., Xie, L. F., & Wang, W. L. (2015). Psychological distress in elderly cancer patients. *International Journal of Nursing Sciences*, *2*(1), 23-27.
- Ibrahim, A. A., Ai-Lami, F., Al-Rudainy, R., & Khader, Y. S. (2019). Mental disorders among elderly people in Baghdad, Iraq, 2017. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, *56*, 0046958019845960.
- Jin, K. (2010). Modern biological theories of aging. *Aging and disease*, *1*(2), 72.
- Jeamamornrat, R., & Howharn, C. (2019). Health Status among Elderly in One Region of Thailand. Mokslines leidybos deimantas, MB. https://doi.org/10.33422/ics21.2019.07
- Jett, K. (2012). Theories of aging. In T. A. Touhy & K. Jett (Eds.), Ebersole & Hess' toward healthy aging (8th ed., pp. 33–43). St. Louis, MO: Mosby Elsevier.
- Kalyanasumdaram, A., & Shirani, J. (2010). Acute coronary syndromes. Retrieved August 27, 2010 from http://emedicine.medscape.com/article/164525-overview.
- Kasai, T. (2021). Preparing for population ageing in the Western Pacific Region. *The Lancet Regional Health–Western Pacific*, *6*.
- Katekaew, S., Nisarat, A., Kumar, R., Ratana, S., Prakasit, T., & Pitakpong, P. (2019). Stress and associated risk factors among the elderly:

a cross-sectional study from rural area of Thailand. *F1000Research*, *8*.

- Kazeminia, M., Salari, N., Vaisi-Raygani, A., Jalali, R., Abdi, A., Mohammadi, M., ... & Shohaimi, S. (2020). The effect of exercise on anxiety in the elderly worldwide: a systematic review and meta-analysis. *Health and quality of life outcomes*, *18*(1), 1-8.
- Keraman, B., Triana, N., & Amelia, A. (2019). The Relationship of Coping Mechanism with Incidence of Stress on Elderly in BPPLU Pagar Dewa Bengkulu City. *Jurnal Sains Kesehatan*, *26*(3), 1-8.
- Kim, E. S., Tkatch, R., Martin, D., MacLeod, S., Sandy, L., & Yeh, C. (2021). Resilient aging: psychological well-being and social well-being as targets for the promotion of healthy aging. *Gerontology and Geriatric Medicine*, *7*, 23337214211002951.
- Korda, R. J., Paige, E., Yiengprugsawan, V., Latz, I., & Friel, S. (2014). Income-related inequalities in chronic conditions, physical functioning and psychological distress among older people in Australia: Cross-sectional findings from the 45 and up study. *BMC Public Health*, *14*(1), 1–11. https://doi.org/10.1186/1471-2458-14-741
- Kozier, B., Erb, G., Berman, A., & Snyder, S. J. (2010). Buku Ajar Fundamental Keperawatan 1. EGC.
- Kunnumakkara, A. B., Sailo, B. L., Banik, K., Harsha, C25. Kunnumakkara, Ajaikumar B.; Sailo, Bethsebie L.; Banik, Kishore; Harsha, Choudhary; Prasad, Sahdeo; Gupta, Subash Chandra; Bharti, Alok Chandra; Aggarwal, Bharat B. (2018). Chronic diseases, inflammation, and spices: how are they linked?. *Journal of Translational Medicine*, 16(1), 14–. doi:10.1186/s12967-018-1381-2.
- Kurniawan, I., & Kolopaking, M. S. (2016). Management of irritable bowel syndrome in the elderly. *Acta Medica Indonesiana*, *46*(2).

- Kagan, S. H., & Melendez-Torres, G. J. (2015). Ageism in nursing. *Journal of Nursing Management*, *23*(5), 644-650.
- Lacy, B. E., Mearin, F., Chang, L., Chey, W. D., Lembo, A. J., Simren, M., & Spiller, R. (2016). Bowel disorders. *Gastroenterology*, *150*(6), 1393-1407.
- Linton, A. D. (2007). Respiratory system. In A. D. Linton, & H. W. Lach (Eds.), *Matteson& McConnell's gerontological nursing* (3rd ed., pp. 353–405). St. Louis, MO: Saunders Elsevier
- Little, W. (2014). Introduction to Sociology – 1st Canadian Edition. Victoria, B.C.: BCcampus. https://opentextbc.ca/ introductiontosociology/https://www.msdmanuals.com/home/older-people%E2%80%99s-health-issues/the-aging-body/overview-of-aging2019.
- Lotfy, A. M. M., Alharbi, B. S. D., Alharbi, W. S. D., & Abd-Ellatif, E. E. (2021). Depression and Generalized Anxiety disorders among Chronically Ill Middle and Older Adults in Saudi Arabia. *Global Journal of Health Science*, *13*(12), 1-25.
- Mitina, M., Young, S., & Zhavoronkov, A. (2020). Psychological aging, depression, and well-being. *Aging (Albany NY)*, *12*(18), 18765.
- Maheshwari, S. K., Chaturvedi, R., & Sharma, P. (2021). Effectiveness of psycho-educational intervention on psychological distress and self-esteem among resident elderly: A study from old age homes of Punjab, India. *Clinical Epidemiology and Global Health*, *11*, 100733.
- Marieb, E. N., & Hoehn, K. (2013). *Human anatomy and physiology* (9th ed.). San Francisco, CA: Pearson Benjamin Cummings.

- Matud, M. P., & Concepci, M. (2019). Psychological Distress and Social Functioning in Elderly Spanish People : *A Gender Analysis. https://doi.org/10.3390/ijerph16030341*
- Meaning, T. H. E., Old, O. F., Aging, A., Ofthe, E., Significado, E., Vejez, D. E. L. A., Experiencia, D. E. L. A., Para, D. E. E., Maria, L. O. S. A., Queiroz, T. A., & Aur, J. (2010). *A RTIGO O RIGINAL de envelhecer para os idosos THE MEANING OF OLD AGE AND THE AGING EXPERIENCE OF IN THE ELDERLY*. *44*(2), 407–412.
- Mehra, A., Grover, S., Chakrabarti, S., & Avasthi, A. (2017). Symptom profile of depression in elderly: Is assessment with geriatric depression rating scale enough?. *Journal of Geriatric Mental Health*, *4*(1), 18
- Miller, C. A. (2015). Nursing for wellness in older adults (7th ed.). Philadelphia, PA: Wolters Kluwer.
- Mordarska, K., & Godziejewska-Zawada, M. (2017). Diabetes in the elderly. *Przeglad menopauzalny= Menopause review*, *16*(2), 38.
- Motalebi, S. A., & Shahbadery, P. (2021). Relationship Between Mental Health and The Education Level in Elderly People: Mediation of Leisure Attitude.
- Najafi, B., Arzaghi, M., Fakhrzadeh, H., Sharifi, F., Shoaei, S., Alizadeh, M., ... & Mehrdad, N. (2014). Mental health status and related factors in aged population: Urban health equity assessment and response tool (Urban-HEART) study in Tehran. *Iranian Journal of Diabetes and Metabolism*, *13*(1), 62-73.
- National Institute on Aging. (2012). *Heart Health*. Retrieved from https://www.nia.nih.gov/health/publication/heart-health
- Nolte, E., & McKee, M. (2008). *EBOOK: Caring for People with Chronic Conditions: A Health System Perspective*. McGraw-Hill Education (UK).

- Nolte, E., & McKee, M. (2008). *EBOOK: Caring for People with Chronic Conditions: A Health System Perspective*. McGraw-Hill Education (UK).
- Okoye, C. A. (2015). Stress in The elderly. *Practicum Psychologia*, *5*(1).
- Ortman, J. M., Velkoff, V. a., & Hogan, H. (2014). An aging nation: The older population in the United States. *Economics and Statistics Administration, US Department of* Wilkinso, P.
- Paralikas, T., Maria, M., Dimitrios, T., Christina, B., Nikolaos, C., Antigoni, F., ... & Stiliani, K. (2021). Physical and Mental Health Level of the Elderly Living in Central Greece. *Materia Socio-Medica*, *33*(1), 16.
- Pary, R., Sarai, S. K., Sumner, R., & Lippmann, S. (2019). Anxiety in geriatrics. *Postgraduate Medicine*, *131*(5), 330-332.
- Pender, N. J., Murdaugh, C. L., & Parsons, M. A. (Eds.). (2014). Health promotion in nursing practice (7th ed.). Upper Saddle River, NJ: Prentice Hall Health.
- Pilania, M., Yadav, V., Bairwa, M., Behera, P., Gupta, S. D., Khurana, H., ... & Poongothai, S. J. B. P. H. (2019). Prevalence of depression among the elderly (60 years and above) population in India, 1997–2016: a systematic review and meta-analysis. *BMC public health*, *19*(1), 1-18.
- Prasad, S., Sung, B., & Aggarwal, B. B. (2012). Age-associated chronic diseases require age-old medicine: role of chronic inflammation. *Preventive medicine*, *54*, S29-S37.
- Quadagno, J. (2013). *Aging and the life course: An introduction to social gerontology*. McGraw-Hill Higher Education.
- Rose, N. (2013). The human sciences in a biological age. *Theory, culture & society*, *30*(1), 3-34.

- Richard, W. and Besdine, MD.: Overview of Aging. The United State of America, Merck Sharp and Dohme Corp., 2015.
- Robert, L.; Fulop, T. (2014). [Interdisciplinary Topics in Gerontology] Aging Volume 39 (Facts and Theories) || On the Immunological Theory of Aging. , (), 163–176. doi:10.1159/000358904.
- Roughead, E. E., Vitry, A. I., Caughey, G. E., & Gilbert, A. L. (2011). Multimorbidity, care complexity and prescribing for the elderly. *Aging health*, *7*(5), 695-705.
- Rathus, S. (2011). Psychology: Concepts and connections (10th ed). Belmont, CA: Wadsworth Cengage Learning.
- Ryan, J., Scali, J., Carrière, I., Scarabin, P. Y., Ritchie, K., & Ancelin, M. L. (2011). Estrogen receptor gene variants are associated with anxiety disorders in older women. *Psychoneuroendocrinology*, *36*(10), 1582-1586.
- Saxon, S. V., Etten, M. J., & Perkins, E. A. (2015). Physical change & aging : a guide for the helping professions (Sixth). Springer Publishing Company, LLC. Retrieved March 7, 2022, from INSERT-MISSING-URL.
- Soto-Perez-de-Celis, E., Li, D., Yuan, Y., Lau, Y. M., & Hurria, A. (2018). Functional versus chronological age: geriatric assessments to guide decision making in older patients with cancer. *The Lancet Oncology*, *19*(6), e305-e316.
- Schonfels, P., Brailovskaia, J. Bieda, A., et al. (2015). The effects of daily stress on positive and negative mental health: Mediation through self-efficacy. *International Journal of Clinical and Health Psychology*, 28(3), 256–266.

- Seo, J., Choi, B., Kim, S., Lee, H., & Oh, D. (2017). The relationship between multiple chronic diseases and depressive symptoms among middle-aged and elderly populations: results of a 2009 korean community health survey of 156,747 participants. *BMC public health*, *17*(1), 1-10.
- Shakir, W. A., & Mohammed, S. H. (2017). Social problems among Elderly people at Geriatric homes in the Middle Euphrates Governorates. *Research Journal of Pharmacy and Technology*, *10*(7), 2122-2126.
- Sherina, M., Rampal, L., Aini, M., & Norhidayati, H. (2005). The prevalence of depression among elderly in an urban area of Selangor, Malaysia. *The International medical journal*, *4*(2), 57-63.
- Shree, M. S. K. C. R., & S, M. S. P. (2021). An examination on causes for anxiety and depression among elderly people. *Journal of Contemporary Issues in Business and Government*, *26*(02). https://doi.org/10.47750/cibg.2020.26.02.117
- Sözeri-Varma, G. (2012). Depression in the elderly: clinical features and risk factors. Aging and disease, 3(6), 465.
- Tabloski, P. (2014). *Gerontological nursing* (3rd ed.). Upper Saddle River NJ: Pearson Education.
- Tandon, M. (2017). Assessment of the level of stress among elderly. *Int J Home Sci*, *3*, 31-33.
- Tiedt, J. A. (2015). Theoretical perspectives on aging and physical changes. *The gerontology nurse's guide to the community-based health network*, 57-76.

- Tang, M., Wang, S. H., Li, H. L., Chen, H., Sun, X. Y., Bian, W. W., ... & Ma, S. J. (2021). Mental health status and quality of life in elderly patients with coronary heart disease. *PeerJ*, *9*, e10903.
- Tarakci, E., Zenginler, Y. & Mutlu, E. K. 2015. Chronic pain, depression symptoms and daily living independency level among geriatrics in nursing home Huzurevinde yaşayan. J. Tur. Soc. Algol. 1, 35-41. doi: https://doi.org/10.5505/agri.2015.14238
- Thompson, B. (2017). Setting the Scene. In *Palgrave Studies in Gender and Education*. https://doi.org/10.1057/978-1-137-49051-3_1
- Touhy, T. A. (2012). Gerontological nursing and an aging society. In T. A. Touhy & K. Jett(Eds.), *Toward healthy aging: Human needs and nursing response* (8th ed., pp. 1–18). St. Louis, MO: Elsevier Mosby.
- Townsend, M. C., & Morgan, K. I. (2017). *Psychiatric mental health nursing: Concepts of care in evidence-based practice*. FA Davis.
- United Nations. (2015). Department of Economic and Social Affairs; Population Division. World Population Ageing 2015.
- Vathesatogkit, P., Sritara, P., Kimman, M., Hengprasith, B., E-Shyong, T., Wee, H. L., & Woodward, M. (2012). Associations of lifestyle factors, disease history and awareness with health-related quality of life in a Thai population. *PloS one*, *7*(11), e49921.
- Vocabulary,2022 https://www.vocabulary.com/dictionary/psychological%20state
- Weber, M. A, Schiffrin, E. L., White, W. B., et al. (2014). Clinical practice guidelines for the management of hypertension in the community: A statement by the American Society of Hypertension and the International Society of Hypertension. The Journal of Clinical Hypertension (Greenwich), 16(1), 14–26.

- Wilkinson, P., Ruane, C., & Tempest, K. (2018). Depression in older adults. *BMJ (Online)*, *363*(11). https://doi.org/10.1136/bmj.k4922
- World Health Organization (WHO). (2015). Diabetes. Fact Sheet No. 312. Retrieved on 6/17/16 at: www.who.int/mediacentre/factsheets/fs312/en/
- World Health Organization, Global Surveillance, Prevention and Control of Chronic Respiratory Diseases: A Comprehensive Approach, WHO Press, Geneva, Switzerland, 2007.
- World Health Organization. (2014). *Global status report on non-communicable diseases 2014*. Geneva, Switzerland: Author
- World Health Organization. (2015). *World report on ageing and health*.
- World Health Organization. (2017). Integrated care for older people: guidelines on community-level interventions to manage declines in intrinsic capacity.
- Wortzel, H. S. (2013). The DSM-5 and forensic psychiatry. *Journal of Psychiatric Practice®*, *19*(3), 238-241.
- Xu, J., Murphy, S. L., Kochanek, K. D., & Bastian, B. A. (2016). Deaths: Final data for 2013. *National Vital Statistics Report, 64*(2), 1-119.
- Yang, G., Tian, L., Wang, Y., Li, J., Qiu, P., Rao, S., & Kuang, W. (2022). Prevalence and relative factors of health anxiety of elders in community healthcare centers. *International Psychogeriatrics*, 1-8.
- Yarze, N., & Rounds, G. G. (2021). Anxiety in Older Adults
- Yoda, T., Saengrut, B., Suksatit, B., Kanda, K., Suzuki, H., Rattanasathien, R., ... & Katsuyama, H. (2021). Quality of life and mental health status of Japanese older people living in Chiang Mai, Thailand. *Geriatrics*, *6*(2), 35.

- Zhou, R., Chen, H., Zhu, L., Chen, Y., Chen, B., Li, Y., ... & Wang, H. (2021). Mental health status of the elderly Chinese population during COVID-19: An online cross-sectional study. *Frontiers in psychiatry*, *12*.
- Zhu, J., Xu, L., Sun, L., Li, J., Qin, W., Ding, G., ... & Yu, Z. (2018). Chronic disease, disability, psychological distress and suicide ideation among rural elderly: results from a population survey in Shandong. *International journal of environmental research and public health*, *15*(8), 1604.
- Zulfitri, R., & Sabrian, F. (2019). Sociodemographic characteristics and psychosocial wellbeing of elderly with chronic illnesses who live with family at home. *Enfermeria clinica*, 29, 34-37.

Appendices

Appendix A

الاستبيان

الجزء الأول : المعلومات الديموغرافية

1- الجنس: ذكر ☐ أنثى ☐

2 - العمر : ☐ سنة

3- السكن : ريف ☐ مدينة ☐

4- المهنة حاليا : متقاعد ☐

ربة بيت ☐

5- المهنة سابقا: اعمال حرة ☐ موظف ☐

عاطل عن العمل ☐

6- المستوى التعليمي:

لا يقرأ ولا يكتب ☐

يقرأ و يكتب ☐

ابتدائية ☐

متوسطة ☐

اعدادية ☐

جامعة ☐

7- الحالة الزوجية:

متزوج ☐

اعزب ☐

مطلق ☐

ارمل ☐

Appendix A

منفصل ☐

8- الدخل الشهري: يكفي ☐

بالكاد يكفي ☐

غير كافي ☐

9- مصدر الدخل: راتب تقاعد ☐

التأمينات الاجتماعية ☐

الاهل او الأقارب ☐

10- لديك اولاد : نعم ☐ ☐

عدد الاولاد ☐

11- السكن : تسكن مع الاسرة ☐ الابن ☐

مع الابنة ☐

اخرى تذكر ☐

Appendix A

الجزء الثاني: الامراض المزمنة

1- ضغط الدم ☐

2- داء السكر ☐

3- الربو ☐

4- القولون العصبي ☐

5- السرطان ☐

6-التهاب المفاصل ☐

7-اخرى تذكر ☐

مدة الاصابة بالمرض المزمن (تشخيص المرض) ☐ **سنة**

Appendix A

الجزء الثالث: مقياس الاكتئاب والقلق والتوتر - 21 عنصرًا

أ- الاكتئاب	ابدا	نادرا	دائما
1- فقدت الشعور بالحماس لأي شيء.			
2- اشعر بأن الحياة ليس لها معنى.			
3- ليس بإمكاني الإحساس بمشاعر إيجابية على الإطلاق.			
4- اشعر بالحزن والغم.			
5- اجد صعوبة في العمل على المبادرة للقيام بالأشياء.			
6- اشعر بأن قيمتي قليلة كشخص.			
7- اشعر أنه ليس لدي أي شيء أتطلع إليه مستقبلا.			
ب- القلق	ابدا	نادرا	دائما
1- اشعر بالخوف دون أي سبب وجيه.			
2- اجد نفسي في مواقف جعلتني قلق جدا وكنت مرتاحا للغاية لزوالها.			
3- اشعر باني على وشك الوصول الى حالة من الرعب بدون سبب.			
4- اشعر بجفاف فمي.			
5- اشعر بارتجاف (في اليدين على سبيل المثال)			
6- اشعر بضربات قلبي بدون مجهود جسدي (زيادة في معدل الضربات، أو غياب ضربات القلب، مثلا)			
7- اعاني من صعوبة في التنفس (مثل سرعة التنفس بشكل مفرط ، وضيق في التنفس في غياب مجهود بدني).			
ج- الإجهاد	ابدا	نادرا	دائما
1- اشعر بأني اغضب بسرعة.			
2- كنت غير متسامح مع أي شيء يمنعني من متابعة ما كنت أفعله.			
3- اجد صعوبة في الاسْتِلْقَاءِ والراحة(التَمَدُّد)			
4- وجدت نفسي مضطربًا.			
5- اشعر أنني أستهلك الكثير من الطاقة العصبية.			
6- اجد صعوبة في الاسترخاء.			
7- أميل إلى المبالغة في الرد على المواقف			

Appendix A

Questionnaire

Part I: Demographical data:

1- Age : ☐ **Years**

2- Gender:

Male ☐ **Female** ☐

3-Residence:

Urban ☐ **rural** ☐

4- Type of Occupation:

Retired ☐ **Housewife** ☐

5-Past working Status:

Employee ☐ **Free business** ☐

Unemployed ☐

6- Educational level:

Illiterate ☐ **Read and write** ☐

Primary ☐ **Intermediate** ☐

Secondary ☐

College ☐

Appendix A

7- Marital status:

Single	☐	**Married**	☐
Divorced	☐	**Widow**	☐
Separated	☐		

8- Monthly income:

Adequate	☐	**Barely adequate**	☐
Not adequate	☐		

9- Source for income:

Pension	☐	**Social Insurance**	☐
Relatives	☐		

10- Having children:

Yes	☐	**No**	☐
Number of Children	☐		

11- Living

with the family	☐	**with the son**	☐
with the daughter	☐		
Other	☐		

Appendix A

Part II: <u>Chronic diseases:</u>

1-blood pressure ☐

2- diabetes mellitus ☐

☐

3- Asthma

4- Irritable Bowel Syndrome ☐

5- Cancer ☐

6- Arthritis ☐

7-Others ☐

The duration of the chronic disease (diagnosis of the disease)

☐ **year**

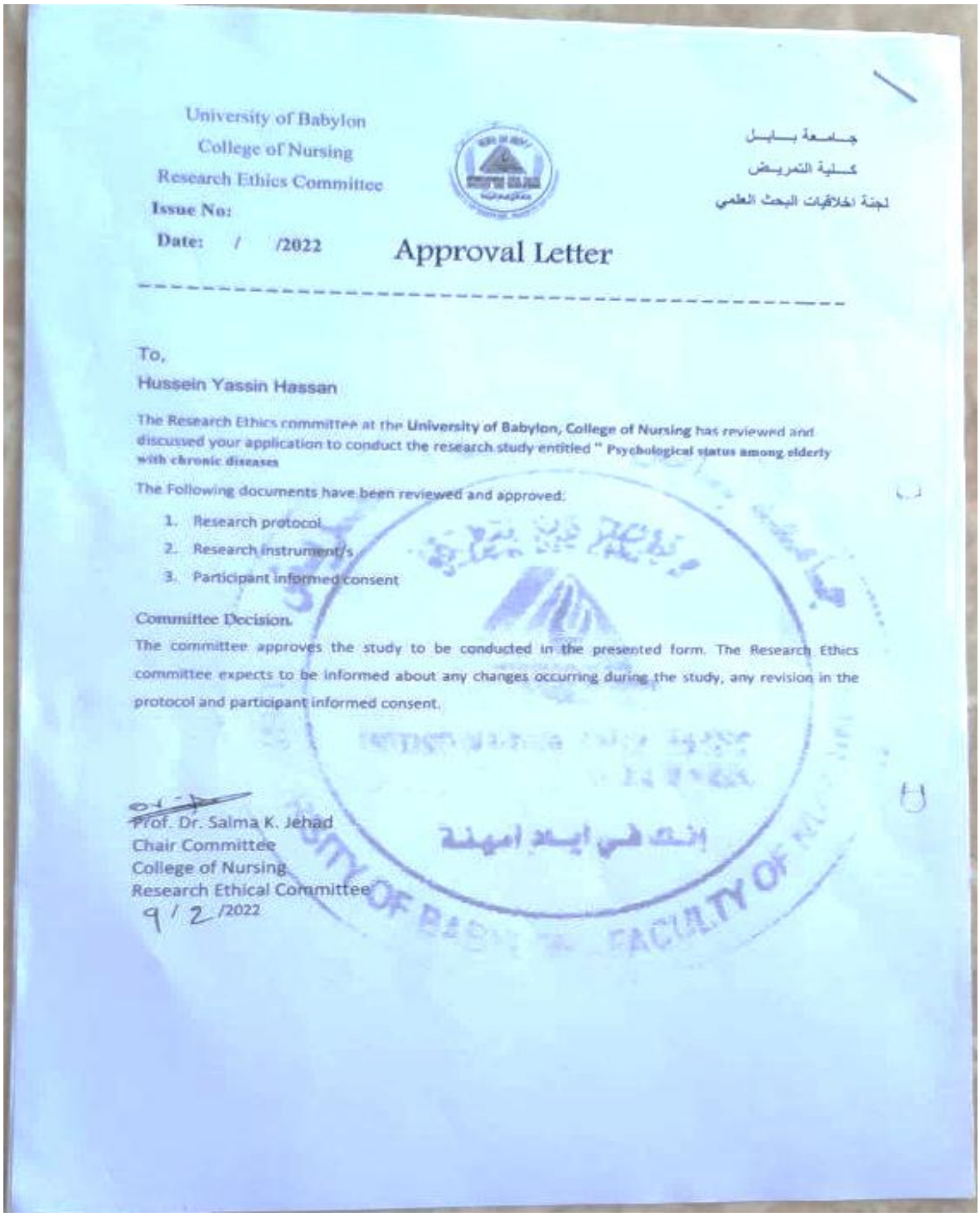
Appendix A

Part III: Depression, Anxiety and Stress Scale - 21 Items (DASS-21)

A- Depression	Never	sometimes	always
1- I was unable to become enthusiastic about anything .			
2- I felt that life was meaningless.			
3- I couldn't seem to experience any positive feeling at all.			
4-) I felt down-hearted and blue .			
5- I found it difficult to work up the initiative to do things.			
6- I felt I wasn't worth much as a person.			
7-I felt that I had nothing to look forward to.			
B- Anxiety	**Never**	**sometimes**	**always**
1. I felt scared without any good reason.			
2- I was worried about situations in which I might panic and make a fool of myself.			
3- I felt I was close to panic			
4- I was aware of dryness of my mouth.			
5- I experienced trembling (e.g. in the hands).			
6- I was aware of the action of my heart in the absence of exertion(e.g. sense of heart rate increase, heart missing a beat)			
7- I experienced breathing difficulty (e.g. excessively rapid Breathing, breathlessness in the absence of physical exertion).			
C- Stress	**Never**	**sometimes**	**always**
1- I felt that I was rather touchy			
2- I was intolerant of anything that kept me from getting on with what I was doing.			
3- I found it difficult to relax.			
4- I found myself getting agitated.			
5- I felt that I was using a lot of nervous energy.			
6- I found it hard to wind down.			
7- I tended to over-react to situations			

Appendix B

Administrative agreements



University of Babylon
College of Nursing
Research Ethics Committee
Issue No:
Date: / /2022

جامعة بابل
كلية التمريض
لجنة اخلاقيات البحث العلمي

Approval Letter

To,
Hussein Yassin Hassan

The Research Ethics committee at the University of Babylon, College of Nursing has reviewed and discussed your application to conduct the research study entitled " Psychological status among elderly with chronic diseases

The Following documents have been reviewed and approved:

1. Research protocol
2. Research instrument/s
3. Participant informed consent

Committee Decision.

The committee approves the study to be conducted in the presented form. The Research Ethics committee expects to be informed about any changes occurring during the study, any revision in the protocol and participant informed consent.

Prof. Dr. Salma K. Jehad
Chair Committee
College of Nursing
Research Ethical Committee
9 / 2 /2022

Appendix B

Ministry of Higher Education and Scientific Research
وزارة التعليم العالي والبحث العلمي
جمهورية العراق
University of Babylon
College of Nursing
جامعة بابل
كلية التمريض
لجنة الدراسات العليا

العدد : ٧٨٤
التاريخ : ١٠ / ٢ / ٢٠٢٢

Ref. No. :
Date: / /

إلى / دائرة صحة بابل
م/ تسهيل مهمة

تحية طيبة :

يطيب لنا حسن التواصل معكم ويرجى تفضلكم بتسهيل مهمة طالب الماجستير (حسين ياسين حسن) لغرض جمع عينة دراسة الماجستير والخاصة بالبحث الموسوم :

الحالة النفسية لكبار السن المصابين بأمراض مزمنة

Psychological Status among Elderly with Chronic Diseases

مع الاحترام ...

المرفقات //
- بروتوكول.
- استبانة.

ا.م . د. نهاد محمد قاسم الدوري
معاون العميد للشؤون العلمية والدراسات العليا
2022 /2/ ١٠

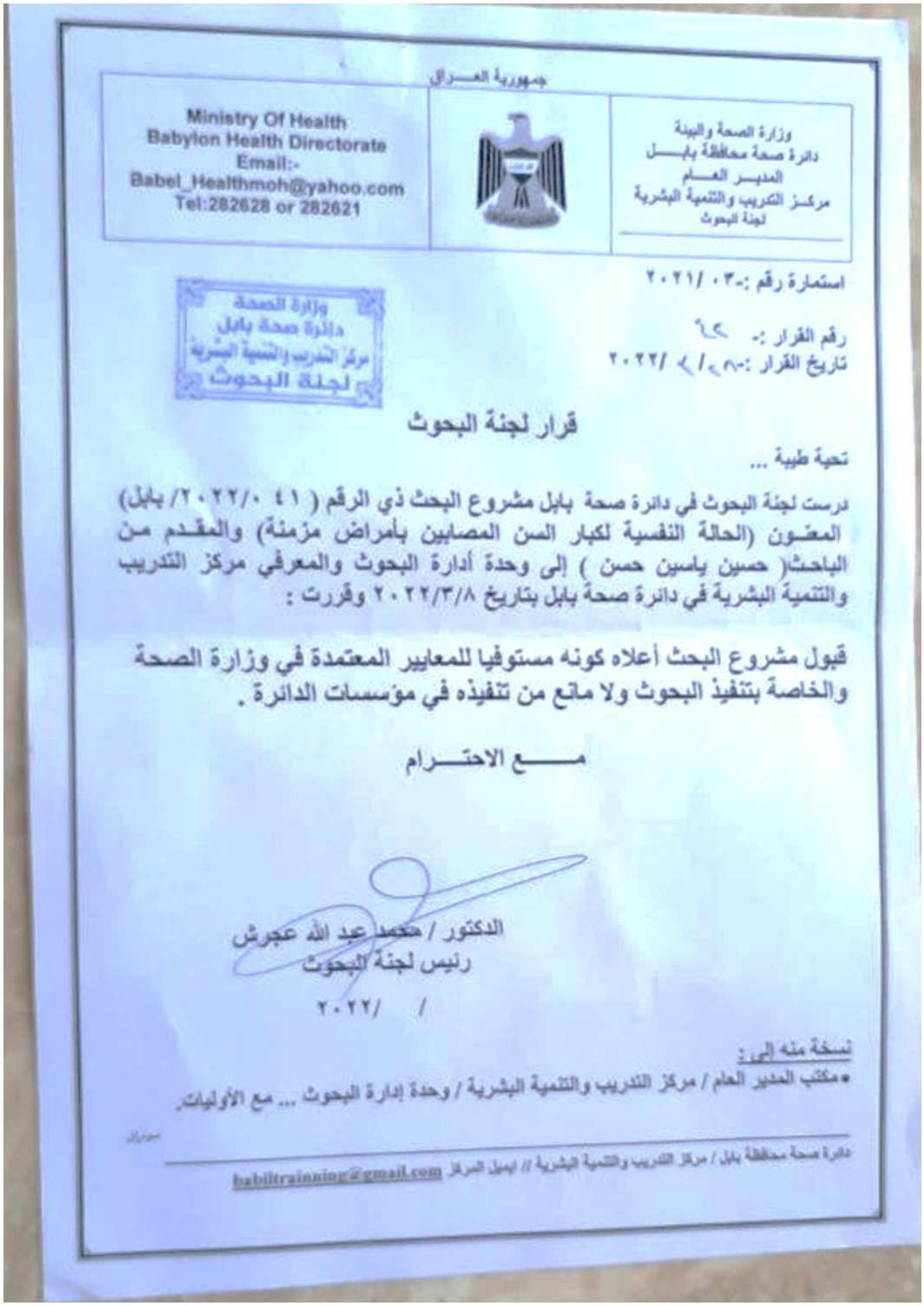
صورة عنه الى //
- مكتب السيد العميد للتفضل بالاطلاع مع الاحترام .
- لجنة الدراسات العليا
- الصادرة .

E-mail:nursing@uobabylon.edu.iq

وطني 07711632208
المكتب 009647711632208

www.uobabylon.edu.iq

Appendix B



جمهورية العـــراق

Ministry Of Health
Babylon Health Directorate
Email:-
Babel_Healthmoh@yahoo.com
Tel:282628 or 282621

وزارة الصحة والبيئة
دائرة صحة محافظة بابـــل
المديـر العـــام
مركـز التدريب والتنمية البشرية
لجنة البحوث

استمارة رقم :-٠٣٠ /٢٠٢١

وزارة الصحة
دائرة صحة بابل
مركز التدريب والتنمية البشرية
لجنة البحوث

رقم القرار :- ٤٢
تاريخ القرار :-٨/٣/ ٢٠٢٢

قرار لجنة البحوث

تحية طيبة ...

درست لجنة البحوث في دائرة صحة بابل مشروع البحث ذي الرقم (٤١ /٢٠٢٢/٠ بابل) المعنون (الحالة النفسية لكبار السن المصابين بأمراض مزمنة) والمقدم من الباحث(حسين ياسين حسن) إلى وحدة أدارة البحوث والمعرفي مركز التدريب والتنمية البشرية في دائرة صحة بابل بتاريخ ٢٠٢٢/٣/٨ وقررت :

قبول مشروع البحث أعلاه كونه مستوفيا للمعايير المعتمدة في وزارة الصحة والخاصة بتنفيذ البحوث ولا مانع من تنفيذه في مؤسسات الدائرة .

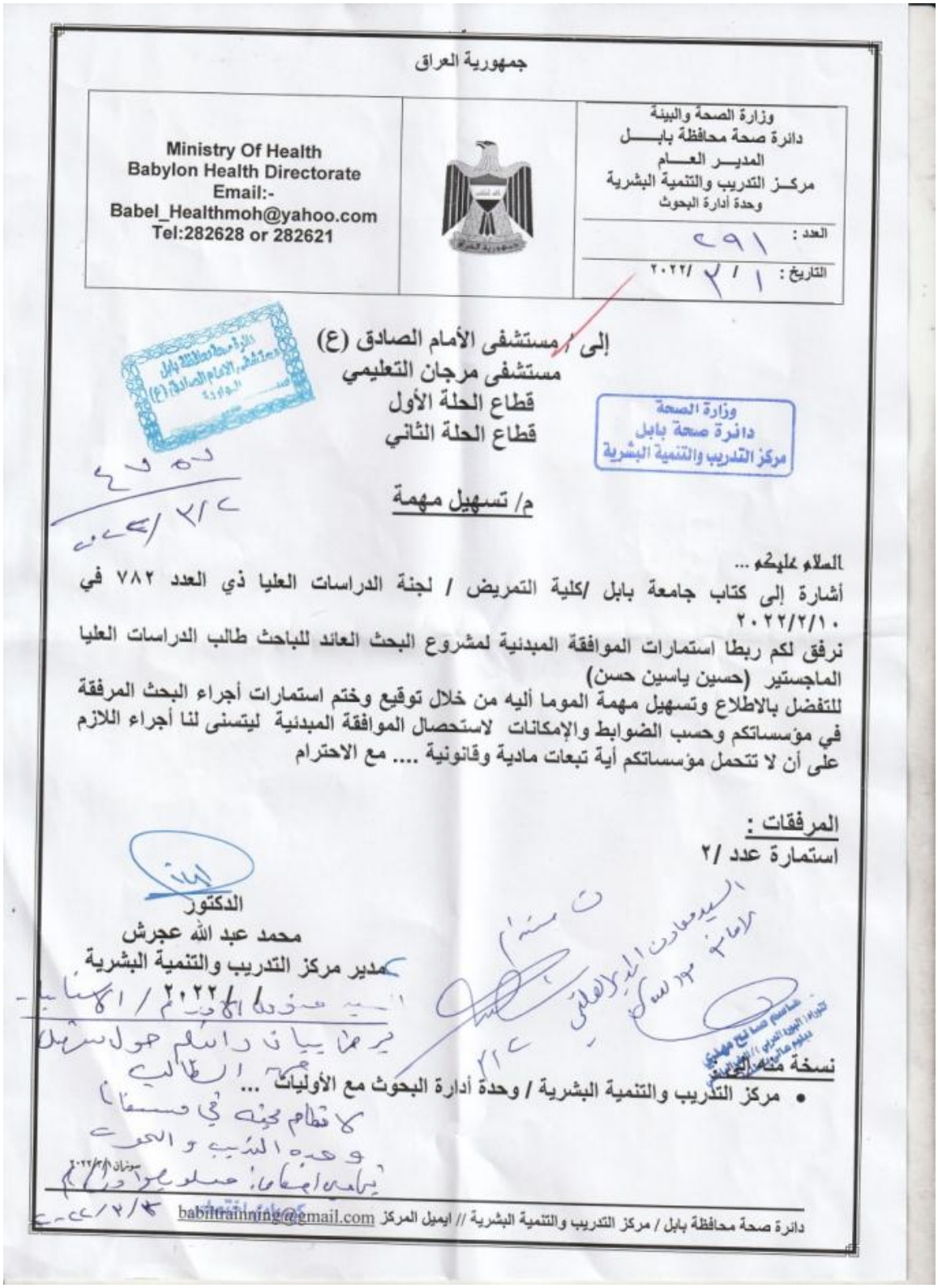
مـــــع الاحتـــرام

الدكتور / محمد عبد الله عجرش
رئيس لجنة البحوث
٢٠٢٢/ /

نسخة منه إلى :
• مكتب المدير العام / مركز التدريب والتنمية البشرية / وحدة إدارة البحوث ... مع الأوليات.

دائرة صحة محافظة بابل / مركز التدريب والتنمية البشرية // ايميل المركز babiltraining@gmail.com

Appendix B



جمهورية العراق

وزارة الصحة والبيئة
دائرة صحة محافظة بابـــل
المديـــر العـــام
مركـز التدريب والتنمية البشرية
وحدة أدارة البحوث

العدد : ٤٩١
التاريخ : ٢٠٢٢/ ٢/ ١

Ministry Of Health
Babylon Health Directorate
Email:-
Babel_Healthmoh@yahoo.com
Tel:282628 or 282621

إلى / مستشفى الأمام الصادق (ع)
مستشفى مرجان التعليمي
قطاع الحلة الأول
قطاع الحلة الثاني

وزارة الصحة
دائرة صحة بابل
مركز التدريب والتنمية البشرية

م/ تسهيل مهمة

السلام عليكم ...
أشارة إلى كتاب جامعة بابل /كلية التمريض / لجنة الدراسات العليا ذي العدد ٧٨٢ في ٢٠٢٢/٢/١٠
نرفق لكم ربطا استمارات الموافقة المبدئية لمشروع البحث العائد للباحث طالب الدراسات العليا الماجستير (حسين ياسين حسن)
للتفضل بالاطلاع وتسهيل مهمة الموما أليه من خلال توقيع وختم استمارات أجراء البحث المرفقة في مؤسساتكم وحسب الضوابط والإمكانات لاستحصال الموافقة المبدئية ليتسنى لنا أجراء اللازم على أن لا تتحمل مؤسساتكم أية تبعات مادية وقانونية .... مع الاحترام

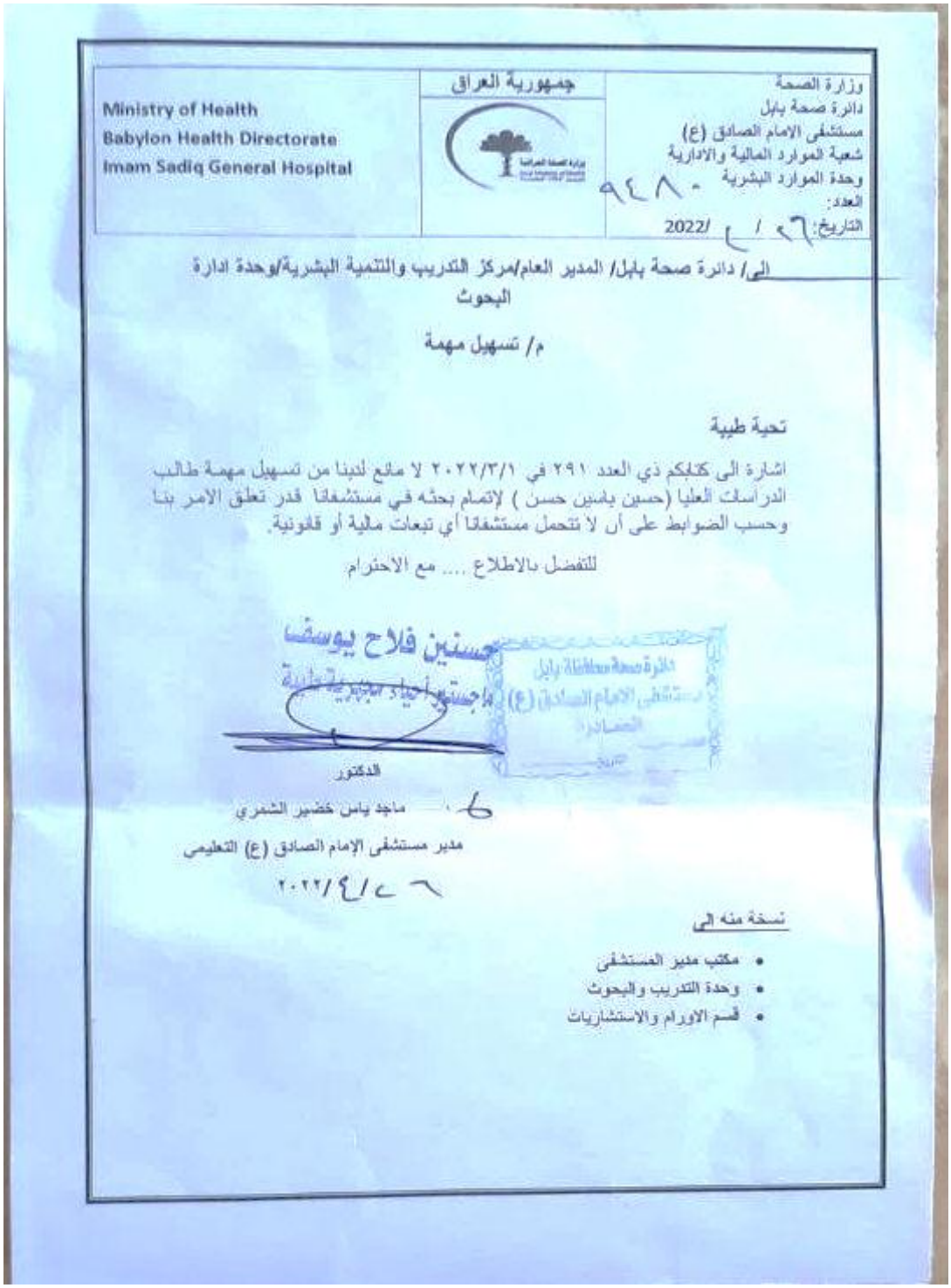
المرفقات :
استمارة عدد /٢

الدكتور
محمد عبد الله عجرش
مدير مركز التدريب والتنمية البشرية

نسخة منه الى :
- مركز التدريب والتنمية البشرية / وحدة أدارة البحوث مع الأوليات ...

دائرة صحة محافظة بابل / مركز التدريب والتنمية البشرية // ايميل المركز babiltraining@gmail.com

Appendix B



Ministry of Health Babylon Health Directorate Imam Sadiq General Hospital	جمهورية العراق	وزارة الصحة دائرة صحة بابل مستشفى الامام الصادق (ع) شعبة الموارد المالية والادارية وحدة الموارد البشرية العدد: ٩٤٨٠ التاريخ: ٢٦ / ٤ /2022

الى/ دائرة صحة بابل/ المدير العام/مركز التدريب والتنمية البشرية/وحدة ادارة البحوث

م/ تسهيل مهمة

تحية طيبة

اشارة الى كتابكم ذي العدد ٢٩١ في ٢٠٢٢/٣/١ لا مانع لدينا من تسهيل مهمة طالب الدراسات العليا (حسين ياسين حسن) لإتمام بحثه في مستشفانا قدر تعلق الامر بنا وحسب الضوابط على أن لا تتحمل مستشفانا أي تبعات مالية أو قانونية.

للتفضل بالاطلاع .... مع الاحترام

حسنين فلاح يوسف

دائرة صحة محافظة بابل
مستشفى الامام الصادق (ع)
الصادر

الدكتور

ماجد ياسن خضير الشمري

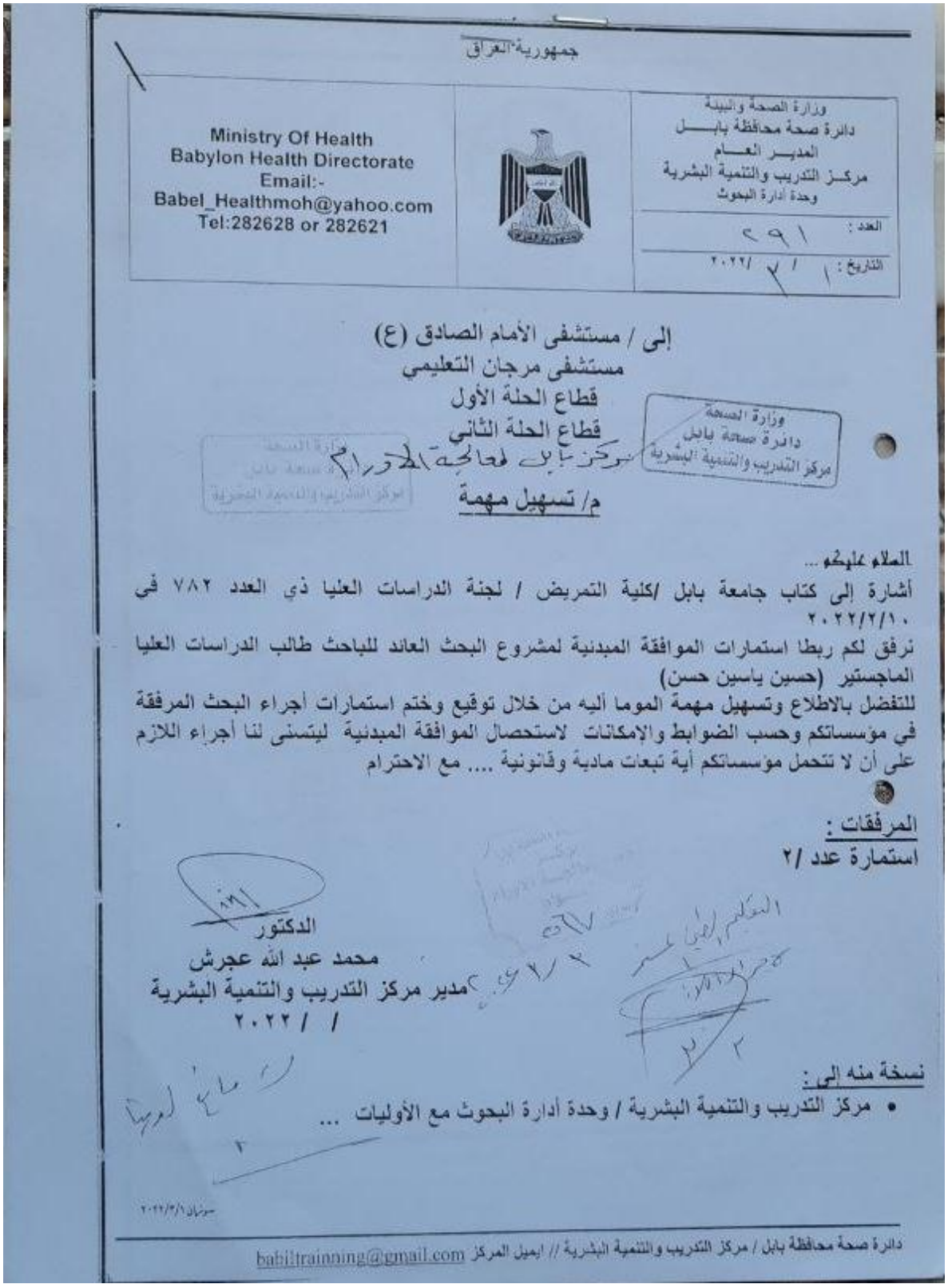
مدير مستشفى الإمام الصادق (ع) التعليمي

٢٠٢٢/٤/٢٦

نسخة منه الى

- مكتب مدير المستشفى
- وحدة التدريب والبحوث
- قسم الاورام والاستشاريات

Appendix B



جمهورية العراق

وزارة الصحة والبيئة
دائرة صحة محافظة بابـــل
المديـــر العـــام
مركـــز التدريب والتنمية البشرية
وحدة ادارة البحوث

العدد : ٢٩١
التاريخ : ١ / ٢ / ٢٠٢٢

Ministry Of Health
Babylon Health Directorate
Email:-
Babel_Healthmoh@yahoo.com
Tel:282628 or 282621

إلى / مستشفى الأمام الصادق (ع)
مستشفى مرجان التعليمي
قطاع الحلة الأول
قطاع الحلة الثاني
مركز بابل لمعالجة الاورام

وزارة الصحة
دائرة صحة بابل
مركز التدريب والتنمية البشرية

م/ تسهيل مهمة

السلام عليكم ...
أشارة إلى كتاب جامعة بابل /كلية التمريض / لجنة الدراسات العليا ذي العدد ٧٨٢ في ٢٠٢٢/٢/١٠
نرفق لكم ربطا استمارات الموافقة المبدئية لمشروع البحث العائد للباحث طالب الدراسات العليا الماجستير (حسين ياسين حسن)
للتفضل بالاطلاع وتسهيل مهمة الموما أليه من خلال توقيع وختم استمارات أجراء البحث المرفقة في مؤسساتكم وحسب الضوابط والإمكانات لاستحصال الموافقة المبدئية ليتسنى لنا أجراء اللازم على أن لا تتحمل مؤسساتكم أية تبعات مادية وقانونية .... مع الاحترام

المرفقات :
استمارة عدد /٢

الدكتور
محمد عبد الله عجرش
مدير مركز التدريب والتنمية البشرية
٢٠٢٢/ /

نسخة منه الى :
- مركز التدريب والتنمية البشرية / وحدة أدارة البحوث مع الأوليات ...

نيسان ٢٠٢٢/٣/١

دائرة صحة محافظة بابل / مركز التدريب والتنمية البشرية // ايميل المركز babiltrainning@gmail.com

Appendix B

Republic of Iraq
Babylon Governorate
Babylon Health Directorate
The first sector of Hilla

٤١٩٠ / ٢٠٢٢ / ٣٦

الى/المراكز الصحية الرئيسية كافة

م/تسهيل مهمة

ترفق طيا كتاب من دائرة صحة بابل/ المدير العام /مركز التدريب والتنمية البشرية/وحدة ادارة البحوث ذي العدد ٢٩١ في ٢٠٢٢/٣/١ للتفضل بالاطلاع والعمل بموجبه

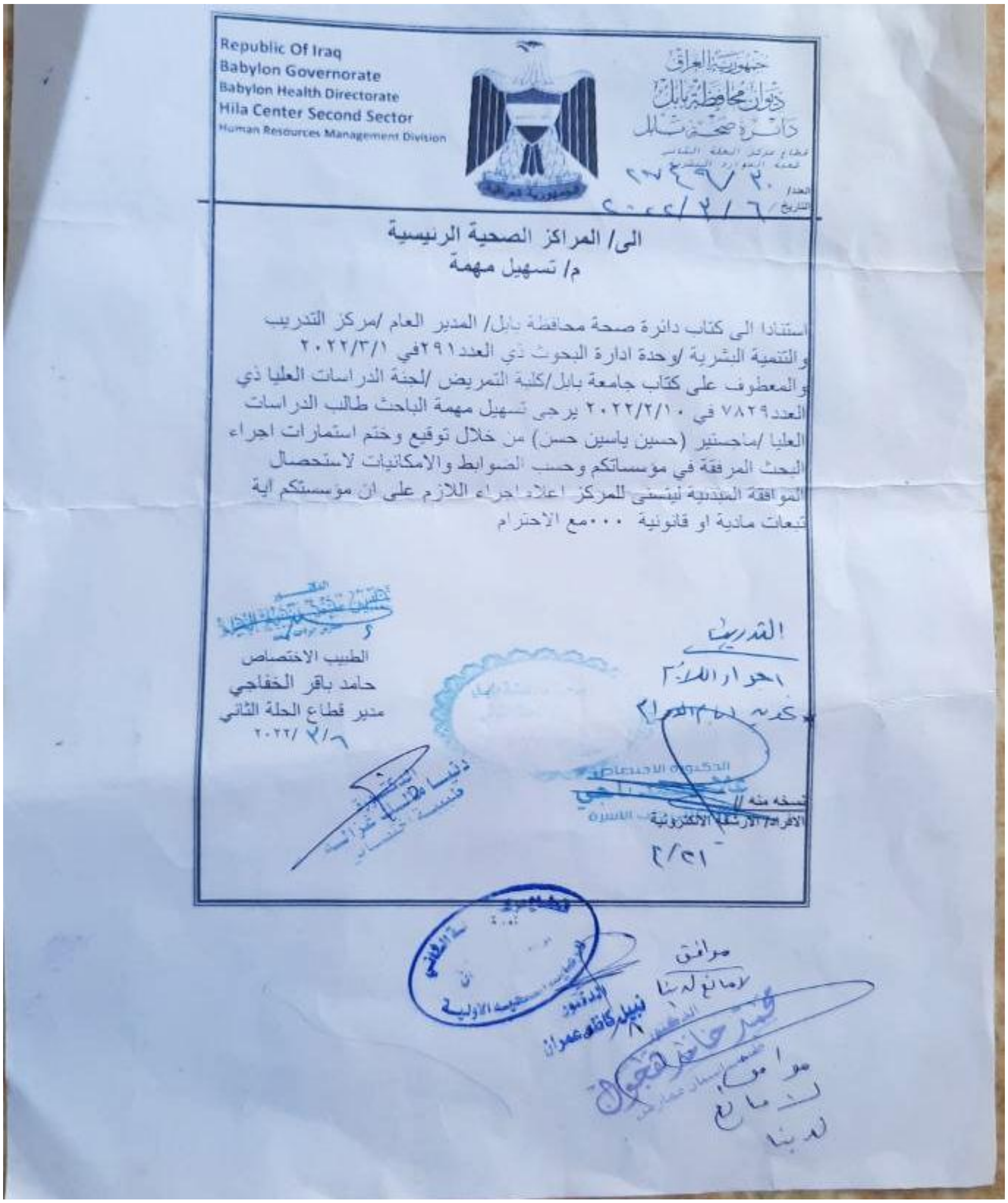
مع الاحترام.

المرفقات
الكتاب اعلاه

الطبيب الاختصاص
علي زغير حميد
مدير قطاع مركز الحلة الأول
٢٠٢٢/٣/ ٦

نسخة منه الى :-
الافراد/٢٣

Appendix B



Republic Of Iraq
Babylon Governorate
Babylon Health Directorate
Hila Center Second Sector
Human Resources Management Division

جمهورية العراق
ديوان محافظة بابل
دائرة صحة بابل

العدد/ ٢٠٧٩٧٤٧٢
التاريخ/ ٦/٢/٢٠٢٢

الى/ المراكز الصحية الرئيسية
م/ تسهيل مهمة

استنادا الى كتاب دائرة صحة محافظة بابل/ المدير العام /مركز التدريب والتنمية البشرية /وحدة ادارة البحوث ذي العدد٢٩١في ٢٠٢٢/٣/١ والمعطوف على كتاب جامعة بابل/كلية التمريض /لجنة الدراسات العليا ذي العدد٧٨٢٩ في ٢٠٢٢/٢/١٠ يرجى تسهيل مهمة الباحث طالب الدراسات العليا /ماجستير (حسين ياسين حسن) من خلال توقيع وختم استمارات اجراء البحث المرفقة في مؤسساتكم وحسب الضوابط والامكانيات لاستحصال الموافقة المبدئية ليتسنى للمركز اعلاه اجراء اللازم على ان مؤسستكم اية تبعات مادية او قانونية ٠٠٠مع الاحترام

الطبيب الاختصاص
حامد باقر الخفاجي
مدير قطاع الحلة الثاني
٦/٢/٢٠٢٢

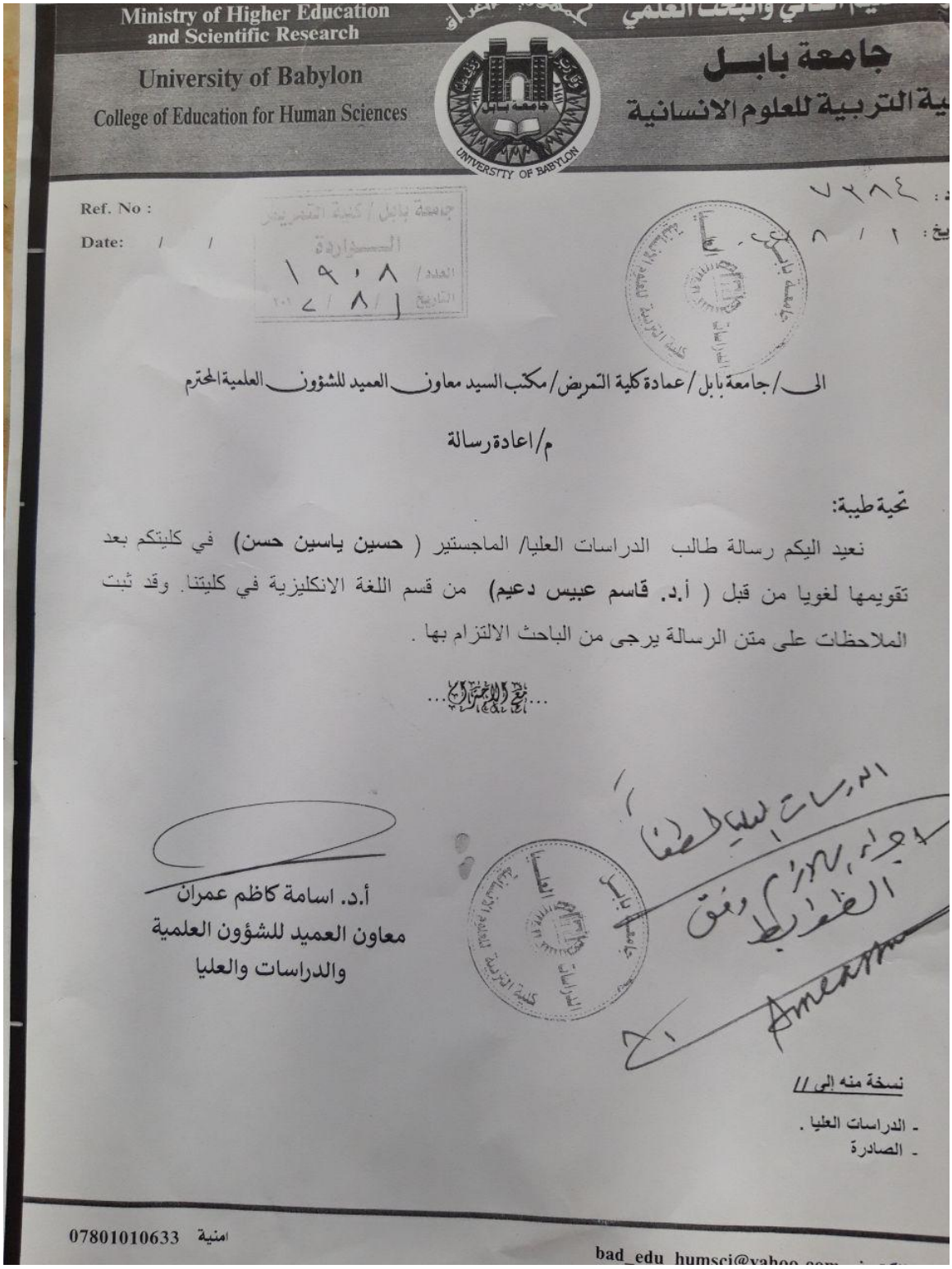
نسخه منه
الارشفة الالكترونية

Appendix C

Panal of Experts

ت	اسم الخبير	اللقب العلمي	مكان العمل	سنوات الخبرة	الاختصاص الدقيق
1	د. امين عجيل ياسر	استاذ	جامعة بابل/ عميد كلية التمريض	37 سنة	تمريض صحة الاسرة والمجتمع
2	د. سلمى كاظم جهاد	استاذ	جامعة بابل/ كلية التمريض	39سنة	تمريض صحة الاسرة والمجتمع
3	د. عبد المهدي عبد الرضا حسن	استاذ	جامعة بابل/ كلية التمريض	42 سنة	تمريض الصحة النفسية والعقلية
4	د .علي كريم خضير	استاذ	جامعة كربلاء / عميد كلية التمريض	30 سنة	تمريض الصحة النفسية والعقلية
5	د .عرفات حسين الدجيلي	استاذ	جامعة الكوفة /كلية الطب	17 سنة	طب الصحة النفسية والعقلية
6	د.صافي داخل نوام	استاذ مساعد	جامعة كربلاء / كلية التمريض	15 سنة	تمريض الصحة النفسية والعقلية
7	د .قحطان قاسم محمد رضا الخزرجي	استاذ مساعد	جامعة بغداد /كلية التمريض	12 سنة	تمريض الصحة النفسية والعقلية
8	د .حيدر حمزة علي الحدراوي	استاذ مساعد	جامعة الكوفة/ كلية التمريض	12 سنة	تمريض الصحة النفسية والعقلية
9	د. حسام مطشر	استاذ مساعد	جامعة الكوفة/ كلية التمريض	12 سنة	تمريض الصحة النفسية والعقلية
10	د .حسن علي حسين عبدالرزاق الزيدي	استاذ مساعد	جامعة بغداد /كلية التمريض	12 سنة	تمريض الصحة النفسية والعقلية
11	د.اشوان عبد الزهرة هاشم	استاذ مساعد	جامعة الكوفة /كلية الطب	8 سنة	طب الصحة النفسية والعقلية

Appendix D



Ministry of Higher Education and Scientific Research

University of Babylon

College of Education for Human Sciences

جامعة بابل

كلية التربية للعلوم الانسانية

Ref. No :

Date: / /

جامعة بابل / كلية التمريض
الصادرة
العدد / ١٩٠٨
التاريخ / ٨ / ٧ / ٢٠٢١

الى / جامعة بابل / عمادة كلية التمريض / مكتب السيد معاون العميد للشؤون العلمية المحترم

م/ اعادة رسالة

تحية طيبة:

نعيد اليكم رسالة طالب الدراسات العليا/ الماجستير (**حسين ياسين حسن**) في كليتكم بعد تقويمها لغويا من قبل (**أ.د. قاسم عبيس دعيم**) من قسم اللغة الانكليزية في كليتنا. وقد ثبت الملاحظات على متن الرسالة يرجى من الباحث الالتزام بها .

مع الاحترام

أ.د. اسامة كاظم عمران
معاون العميد للشؤون العلمية
والدراسات والعليا

نسخة منه إلى //

- الدراسات العليا .
- الصادرة

امنية 07801010633

bad_edu_humsci@yahoo.com

Appendix E

(1)

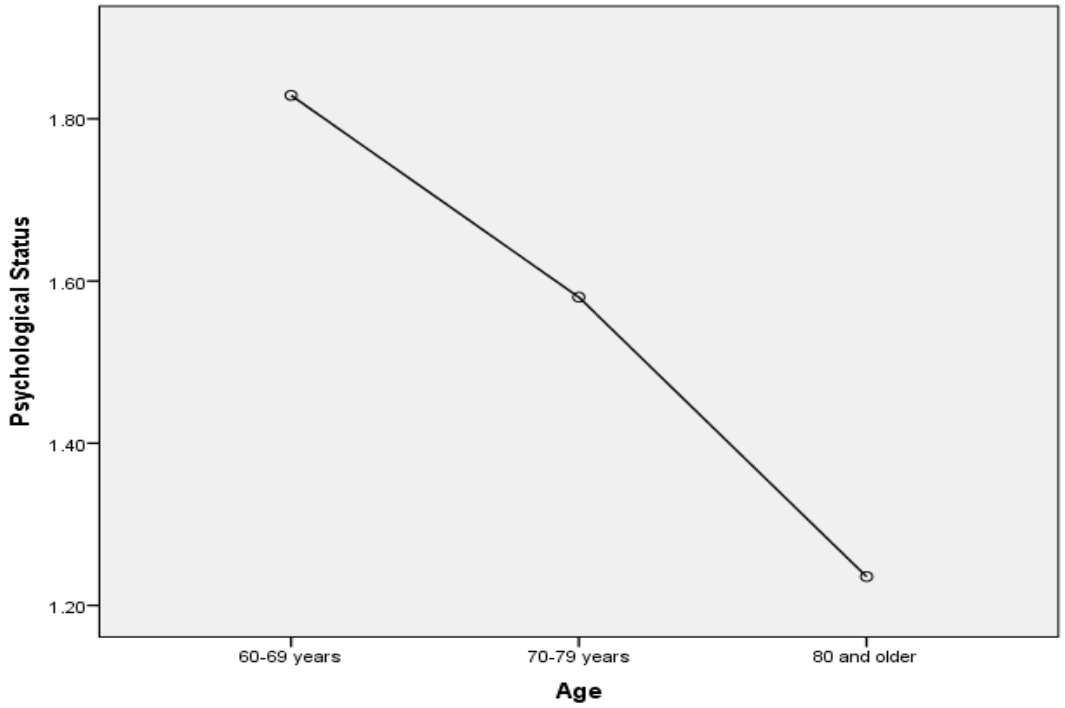
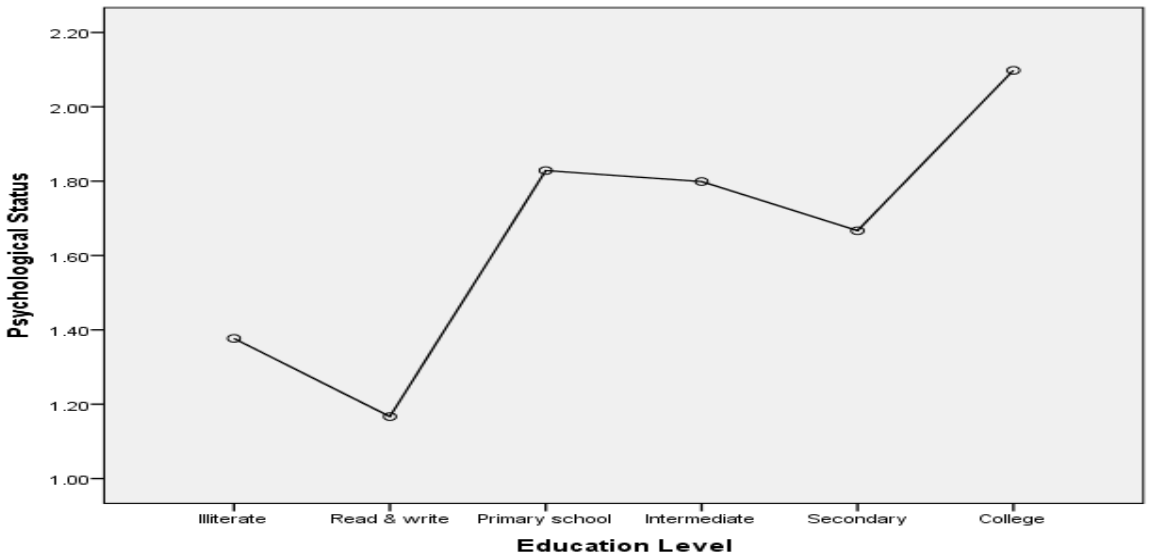


Figure 4-5.Distribution of Psychological Status according to Age Groups

(2)

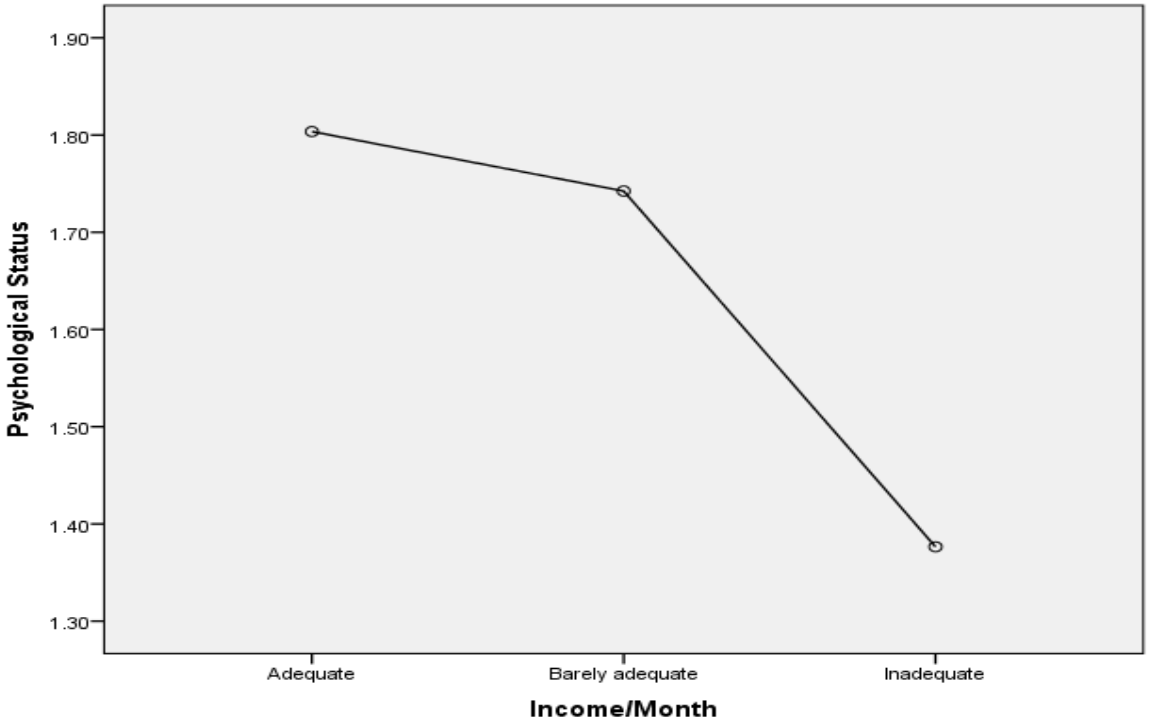
Figure 4-6.Distribution of Psychological Status according to Education Level



Appendix E

(3)

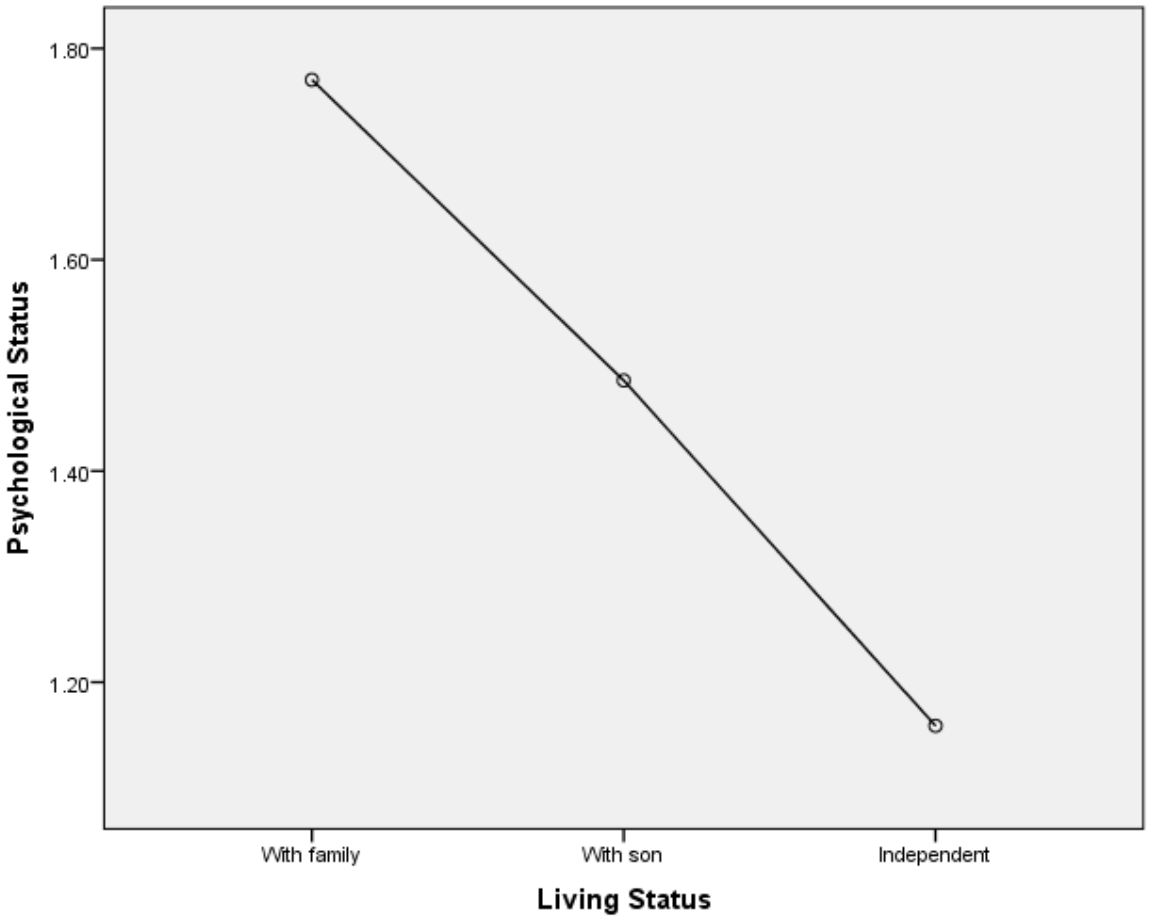
Figure 4-7.Distribution of Psychological Status according to Monthly Income



Appendix E

(4)

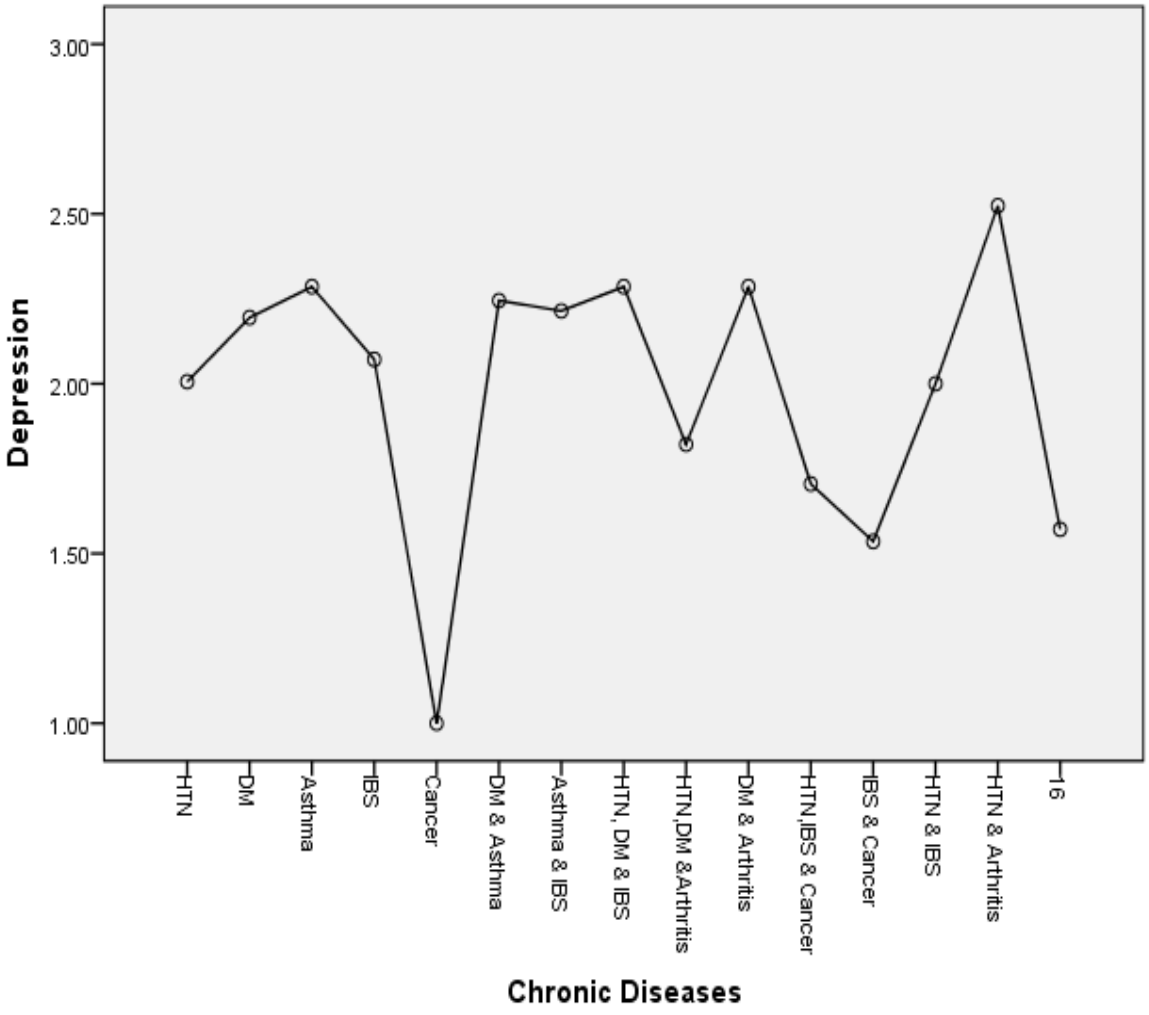
Figure 4-8.Distribution of Psychological Status according to Living Status



Appendix E

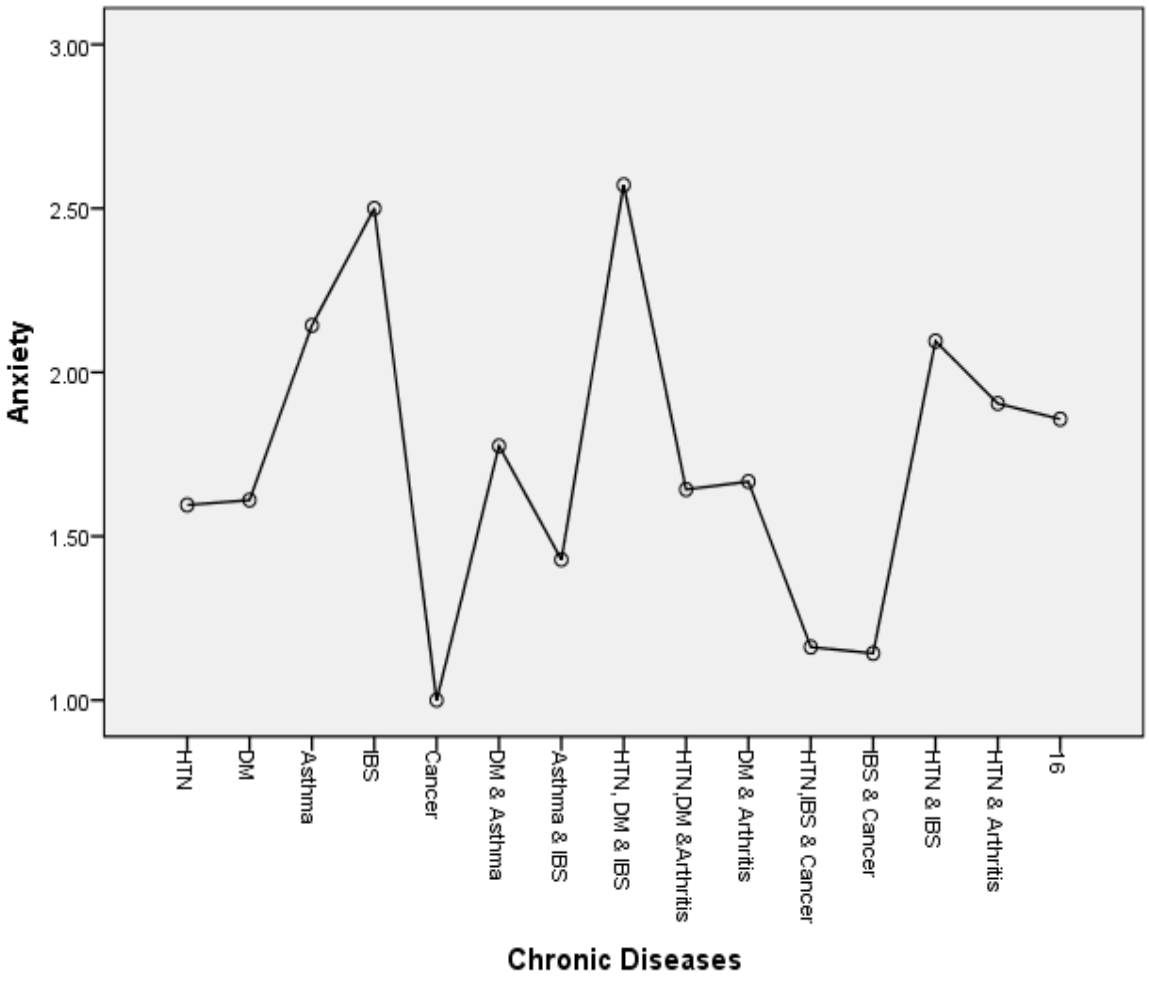
(5).

Distribution of Depression according to Chronic Diseases



Appendix E

Figure 4-10.Distribution of Anxiety according to Chronic Diseases



الخلاصة

الشيخوخة تحدث في مواقع ومجتمعات مختلفة، الشيخوخة هي العملية الطبيعية التي تحدث الشيخوخة تحدث في مناطق و بلدان مختلفة من العالم . الشيخوخة هي عملية طبيعية تحدث بشكل تدريجي ومستمر منذ بداية البلوغ المبكر. ترتبط الاضطرابات الطبية المزمنة المتعددة بفقدان جودة الحياة وضعف الأداء وانخفاض الحركة. يميل الأشخاص المصابون بمرض عقلي أو أمراض القلب والأوعية الدموية ، وكذلك أولئك الذين يعانون من العديد من الاضطرابات الصحية المزمنة ، إلى تدهور الحالة الصحية وصعوبة أكبر بكثير في القيام بأنشطة الحياة اليومية. يرتبط المرض المزمن بزيادة مخاطر الإصابة بالأمراض العقلية وكذلك دخول المستشفى والوفاة. الغرض من هذه الدراسة هو تقييم الحالة النفسية لكبار السن ، وتحديد الفروق في الحالة النفسية فيما يتعلق بالبيانات الاجتماعية والديموغرافية ، ومعرفة الارتباط بين الحالة النفسية وأنواع الأمراض المزمنة. هذه الدراسة هي دراسة تحليلية وصفية باستخدام أسلوب التقييم لتقدير الحالة النفسية والاجتماعية لدى كبار السن المصابين بأمراض مزمنة. كانت فترة الدراسة من 9 فبراير 2022 إلى 6 يوليو 2022 أجريت في مركز مدينة الحلة ، وتم اختيار عينة هادفة (غير احتمالية) من 100 مسن يعانون من أمراض مزمنة من المراكز الصحية. يتم توزيع هذه العينة (مراكز الأورام والمراكز الصحية والمستشفيات) في مركز مدينة الحلة. يتكون الاستبيان من (21) فقرة. وكشفت النتائج أن معظم العينة متوسط العمر فيها 69 عاما ، والأعمار 60-69 سنة سجلت أعلى نسبة. فيما يتعلق بالجنس ، خمسون بالمائة للذكور والإناث. كانت هناك حالة نفسية حادة لكبار السن المصابين بأمراض مزمنة. بالإضافة إلى ذلك ، أظهرت النتائج إلى أن هناك علاقة بين الأمراض المزمنة والحالة النفسية لكبار السن. توصي الدراسة الى تقديم برامج خاصة في المراكز الصحية لدعم الحالة النفسية لكبار السن المصابين بالأمراض المزمنة. الوكالات الخاصة المسؤولة عن رعاية المسنين كمتابعة تطبيقية لنشاط المسنين في الحياة اليومية.

وزارة التعليم العالي والبحث العلمي
جامعة بابل/ كلية التمريض

الحالة النفسية لكبار السن المصابين بأمراض مزمنة

رسالة مقدمة من قبل

حسين ياسين حسن

الى مجلس كلية التمريض/ جامعة بابل
جزء من متطلبات نيل درجة ماجستير في علوم التمريض

بإشراف

أ. د. سجاء هاشم محمد

2022ميلادي 1444 هجري