PSIHOCLINIC CONSIDERATIONS AS A DETERMINANT OF QUALITY OF LIFE IN THE EMERGENCE OF ANXIETY AND DEPRESSION

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Abstract
Beyond doubt, the quality of life circumscribes each and everyone's condition and evolution, not only as year institutional model, sanctioned by the social organization's history, but especially as a dynamic, living and dramatically transformative interactional model, in the perspective of producing, modeling and self-achievement of the human being.
The quality of life is Determined as well as by the outside - the socio-cultural environment, the satisfaction level of the material Needs (nutrition and living space, budget, comfort, cultural Possibilities and civilized existence) as by the inner (the interpersonal relationship's quality).
The general objective of our study took into Consideration the highlighting of the anxious and depressive disorders emerged in the psychological profile of the human being as a result of the low quality of life.
The hypothesis of the study this scientific approach started that has the target of overtaking the connection between anxiety, depression and the quality of life.
The results of the study, based on the processed date from the two samples of subjects, confirmed the existence of two correlations statistically remarkable which is: the quality of life and the quality of depression vs live vs anxiety. The lower the quality of life is, the depression and anxiety has the high.
Thereby the emotional (affective) path - Love and the Harmony Between sexes and generations, knowledge, the interpersonal valorization and stimulation for the common welfare, as indicators of the intergenerational and intersexes Relationships and of course the quality of life - is as important as the material prosperity path. However the affective and transformative path is the priority.
Keywords: psychology, the quality of life, anxiety, depression

1. Quality of life - concept

Quality of life circumscribes life undoubtedly each state and evolution, not only as institutional model, enshrined in the history of social organization, but especially as interactional dynamic model, living, open and dramatically transformative in the perspective of producing, modeling and self-realization of the human being (Birch, 2000).

Quality of life is determined both by the outside - cultural social setting, level of satisfaction of material needs (food and living space, budget, comfort, and cultural opportunities for civilized living consumption) - and the inside (quality of interpersonal relations). The latter can be estimated through several indicators so-called "subjective" but whose impact is essential in any family prediction (Enăchescu 2003):

- socio-emotional climate;
- "Sexual well-being";
- authenticity and completeness of communication between partners and their children;
- maintaining a dynamic balance between fusion and psychological autonomy;
- intergenerational influence borders;
- coherence and consensus conjugal and parental role models for children in the education offered;
- degree of comfort and psychological security, resulting in a sense of belonging family, as antidote to loneliness and abandonment imbalances;
- psychic and somatic health of family members;
- storage capacity and transmission of the spiritual-values positive patterns, psychosocial.

Psychologists have identified a number of symptoms in Romanian population of a genuine psychological crisis:

 Eminent danger of deinstitutionalization and denuclearization as a result of significant growth of the phenomenon of instability, divorcing rate correlated with fewer remarriages and low marriage rate. The immediate consequence is the weakening and, most often, socio-pathologicalization of the relations between spouses and - especially - the relationship between parents and spouses (Gavrieliuc, 2002). Moreover, beyond the appearance of the family institution stated by marriage, witnessing transformations in the structure of female and male roles, the substitutions and inversions forced against "sex prerogatives", distortions or amputations of exercise family roles at evasion or abandonment role, so that the gap is widening between status and role (Mitrofan, Ciupercă, 2000);

 Non-authenticity of family relationships is the second specific tendency of many contemporary couples from the institutional framework, which still continues to hold the largest share. This phenomenon is highlighted in marginal proliferation of

pathogenic (semi-marriage and pseudo-marriage) that betrays the first signs of family psycho-socio-pathology (Mitrofan, Ciupercă, 2000).

The human being carries within itself the vocation of happiness, his becoming pursuing self-assertion, self-actualization and self-realization. Emotional path - love and harmony between the sexes and generations, knowledge, interpersonal valuing and fostering the welfare of the community as intergenerational relations and intersex indicators of quality of life and therefore is as important as the way of material prosperity (Macsinga, 2003). But the emotional path is transformative and priority. It expresses the authentic freedom of man and the most important source of his being, his destiny individually and collectively.

2. Psychological disorders that may occur in the life of every person

2.1. Anxiety

Danish word *Angest* was equated with *angst* in German, in English with *dread, fear* or *anxiety*, while French translations *angoisse* imposed; he experienced widespread in wars existentialist philosophy, especially because Heidegger and Sartre's theorizing. The significance of Kierkegaard's anxiety is the shiver of fear to something undefined and indeterminable, unlike the feeling of fear, the object is actually individually (Enăchescu, 2003).

A state of increased anxiety has many *causes*, including medical or psychiatric disorders, various drugs and various substances of abuse (including caffeine). However, the most common cause is the inability of the individual to cope with stress agents. Stress can be defined as any physical or mental stress undergone by the individual. Feeling accented anxious may be caused by medical disorders (such as thyroid disease) and psychiatric (such as panic disorder or depression). The young adult population, psychiatric disorders are a common cause of anxiety (Vintilă, 1999).

Similar to pain, anxiety may be a signal for the individual. This signal warns that the organism is overloaded.

Measures to reduce anxiety - are to reduce stress agents and to increase confrontation with them. Some ways to reduce stress enumerate giving up a class, reduced working hours or denial of social obligations (Green, Șchiopu, 1999).

Ways to increase the capacity of confrontation with stress include exercise, adequate sleep period, a healthy diet, a better organization of time and increasing periods of relaxation. Relaxation strategies include activities such as muscle relaxation, meditation sessions or listening to music. These strategies are effective when they are applied constantly, thereby avoiding the occurrence of a pronounced anxiety. (It's hard to relax when there is a strong anxious feeling!) (Munteanu, 2004).

The vast majority of anxiety disorders respond to treatment. Treatment may include, besides the strategies of the above, specific medication and or psychotherapy.

2.2. Depression

Depression is a soul state, an "experience" with sad tonalities, whose ampleness, intensity and duration are variable. The boundary between normality and pathology is often uncertain. Depression can be induced by existential difficulties or by the demands and constraints of society.

The concept of depression - incidentally used by the Baillarger in the XIX - century, the term designates all episodes of sadness, lowering psychological tone and accompanied by behavioral, capacity and subjective experience changes (Enăchescu, 2003).

The feeling of sadness is not depression, but depression involves inevitable sadness with an intensity that can influence daily life, work, self-esteem, judgment and basic functions such as sleep and appetite (Birch, 2000).

Sadness as a feeling of grief can be the emotional echo of an unpleasant event; it becomes pathological if it is exaggerated in intensity and duration to it and especially if it occurs without apparent cause.

Depression is not always obvious; she has masks, avatars and dark catacombs. Depression can be masked by joviality, action, under an Olympian calm, and even "laughing soaked with unseen tears." The severity of depression is given by the non-recognition of it, by the environment or by depressed himself. That is "glued" to apathy, indifference, resignation and expresses no mood that often goes unnoticed by others. Depression is streamlined, trivialized by the interpretations soothing fatigue, laziness, caprice, originality ... the family seemed to be touched by blindness, sometimes despite an impressive ensemble of clues that will later be acknowledged (Enăchescu, 2003).

Practical Work Part

Chapter I - Research Methodology

1. **General objective**

Highlighting psychological disturbances on the profile of the person on the occurrence of anxiety disorders and depression, which results in low quality of life.

2. **Specific objective**

- capturing the link between anxiety, depression and quality of life;

3. **The study hypothesis**

Hyp. - There is a significant link statistically between anxiety, depression and quality of life.

Research Design

Regarding specific type of investigation which is addressed herein, it can be considered that of applied research, which is based on real data and aim that practical conclusions will be drawn. The present study was designed as a non-experimental

design, the independent variables not being handled, representing a number of variables - the etiquette investigated. Thus, in this paper there are the following variables: the anxiety level, the depression level, age and quality of life. Also, depending on the objectives, we can consider quantitative research correlational type and comparative emphasis on establishing an association/relationship between two or more aspects of a situation, such as the interdependence between concern for quality of life and anxiety or depression, revealing it thus the covariance link between two variables.

In an attempt to eliminate *foreign variables* that could have intervened in this study were adopted the following control modes (Varga 2004):

- simple research methods from the point of view of the application;
- short training, clear and identical for all subjects;
- all subjects have a lower quality of life of at least 6 months.

4. **The Presentation of the sample**

To accomplish this work we randomly selected two independent samples as follows:

- a sample of 40 people with a lower quality of life;
- a sample of 40 healthy people, it is the witness lot.

All people are working; they are from urban areas and belong to the same age group: 25-40 years.

5. **Presenting the research method and the used samples**

The method used to achieve this research is based on a questionnaire survey.

The materials used for the purpose of testing the previously mentioned hypothesis are:

A. Inventory for anxiety State - Trait Anxiety Inventory

It was applied to highlight the level of anxiety. The form STAI X1 of the inventory outlines the appearance of anxiety condition and form STAI X2 of the inventory outlines the appearance anxiety trait. For the present study was important capturing personality trait anxiety in type 2 diabetes patient.

STAI X2 - form comprises 20 items which consist of closed-answer questions. These require a self-assessment of their individual feelings, predominant reactions which refer to the individual's habitual tendency to manifest anxiety. Anxiety targets the notion of anxious personality characterized by emotional instability, waiting, anxious waiting, tendency to exaggerate, giving increased importance to trivial events.

The 20 items of inventory requests a self-assessment of their individual feelings manifested regularly in his behavior on a scale of 4 (almost never, sometimes, often, and almost always).

The total quota is obtained by summing the encircled figures by topic for each form individually. The minimum quota that can be obtained can be 10, and the maximum 80.

B. Beck Depression Questionnaire

I applied the Beck depression questionnaire, long form consisting of 21 items. Each item consists of 4 statements that correspond to 4 degrees of intensity of a depression symptom (sadness, pessimism, sense of failure, dissatisfaction, guilt, feeling the penalty, disliking myself, self-accusation, self-determination, changing self-image, difficulties at work, sleeping disorders, fatigue, anorexia, weight loss, somatic concerns, and loss of libido). The score obtained is directly proportional to the intensity of depressive symptoms. Minimum quota obtainable is 0 and the maximum quota 68.

C. Multidimensional Health Questionnaire

The questionnaire includes a total of 100 items, with reference to people's health. The subject has the task of giving each item a score, depending on the validity of claims to it, using the following scale:

A - not my thing at all;
B - defines me very little;
C - it characterizes me to some extent;
D - it's relatively well characterized;
E - it characterizes me very much.

The questionnaire consists of 20 subscales related to health, each containing 5 items.

D. Questionnaire for assessing quality of life.

It was developed by Robert A. Cummins in 1997. The questionnaire was taken from the Internet and made available for research purposes only. The questionnaire contains 21 items grouped by 3 depending by the measured aspect for each subscale consisted.

Subscales number is 7. For each item, the subject can choose between five possible answers, each version of them corresponding subject, a box to be ticked according to their own preference. Each answer has a certain number of points between 0 and 5. The final quota for each subscale in part, is obtained by summing the figures for individual boxes. The minimum rate may be 0 and the maximum rate 15. The 7 subscales refer to quality of life, and these are: material wellbeing, health, productivity, intimacy, safety, place in the community, emotional well-being.

Loyalty index is alpha-chrombach .724

6. **Procedure**

To avoid any misunderstanding error duties imposed by both the subjects and the investigator's perspective, it sought a clearer procedure for carrying out the research. Therefore, subjects were given training on questionnaires and that there is no time limit. Also it was specified to subjects that their responses are confidential and that the final results will be presented to an audience. Participants were informed that

there are no good or bad answers, true or false and that everything depends on himself and every case (Sava, 2004).

In order to process data obtained by subjects to use the SPSS.17 statistical processing program, in which the quotas were introduced gross to be examined and to obtain the necessary outputs. Statistical processing methods used to verify the proposed hypotheses are:

- correlation;
- independent t test to compare the differences between the two environments.

Chapter II - Results Analysis and Processing

2.1. Results and discussions

The figure below shows the composition of the population that represents the both samples, by age categories.

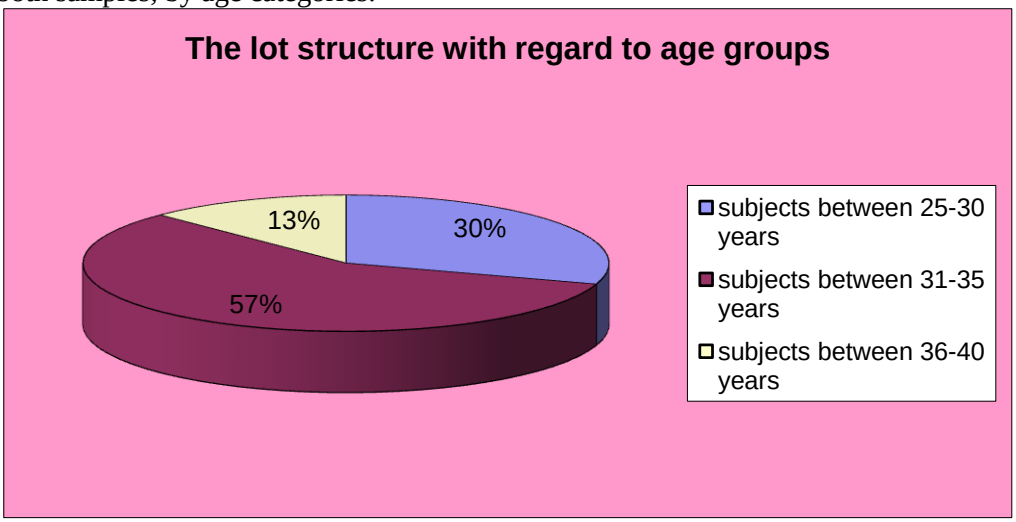

Figure no.1. Lot structure with regard to age groups

2.2. Statistical approach for *specific hypothesis* - *there is a link between anxiety, depression and quality of life*

To check the validity of this hypothesis was applied Beck Depression Questionnaire that we followed the emergence of depression described in the chapter on methodology. In order of those specified, followed notification to the significant differences in people with lower quality of life and healthy individuals, regarding depression.

To observe the influence that the quality of life has in terms of depression, the SPSS program was used, more precisely; t test was used for independent samples. The statistical analysis consisted of comparing the two samples: the sample of people with

a low quality of life and the sample of healthy individuals. In Table 3 shows the results of the two samples by calculating t.

Table 3. Presentation of the results obtained by the two samples on t test questionnaire for depression

Depression							
People Sample	**N**	**Minimum**	**Maximal**	**Mediate**	**Standard deviation**	**t**	**p**
Low quality of life	40	0.4	1.1	0.5	0.15		
Healthy	40	0.0	1.0	0.3	0.21	**5.87**	**p = .000 (p <.01)**

The null hypothesis (HO) differences regarding the depression in people with low levels of quality of life compared with healthy individuals is due to chance. By processing of statistical data obtained from the questionnaire on depression t = 5.87, p <.01 *(see Table 3).* Average quality of life in people with low is 0.5, standard deviation is 0.15, and the average healthy people media is 0.3 and the standard deviation 0.21. The result is statistically significant, so the null hypothesis is invalidated and statistical hypothesis is accepted. We can say that people with a low quality of life presents a higher level of depression than healthy people.

Table 4. Presentation of results from correlations between quality of life and anxiety, depression

Disorder	**Depression**	**Anxiety**
Quality of life hold	r = .271 *	r = .397 **

* Significant for p <.05
** Significant for p <.01

A significant relationship between *quality of life and depression,* r = .271, p <.01 *(see table 4)* that as the nature awareness of quality of life becomes more negative, the more depression increases.

Another significant relationship between *quality of life and anxiety*, r = .397, p <.05 *(see table 4),* the lower quality of life the more anxiety is increased.

Specific research hypothesis proposed to check whether *there is a link between quality of life and depression, anxiety.*

After processing the data from the two samples of subjects, we obtained a number of two significant correlations, namely: quality of life and depression, quality of life and anxiety respectively. The quality of life is lower, the greater the anxiety and depression.

Conclusion

The quality of life circumscribes undoubtedly the status and evolution of each one, not only institutional model, as enshrined in the history of social organization, but especially as interactional dynamic model, living, open and dramatically transformative in the perspective of production, modeling and self-realization of the human being.

The human being carries within it the vocation of happiness, pursuing his becoming self-assertion, self-actualization and self-realization. The emotional path - love and harmony between the sexes and generations, knowledge, interpersonal valuing and fostering the welfare of the community as indicators of intergenerational relations and quality of life, intersex and implicitly - is as important as the way that material prosperity. But the emotional and transformative way is priority. It expresses the authentic freedom of man and the most important source of his being, his individual and collectively destiny.

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