

# A Study to Assess the Depressive Symptoms and Quality of Life among Patients Undergoing Hemodialysis in a Tertiary Care Hospital at Kolkata

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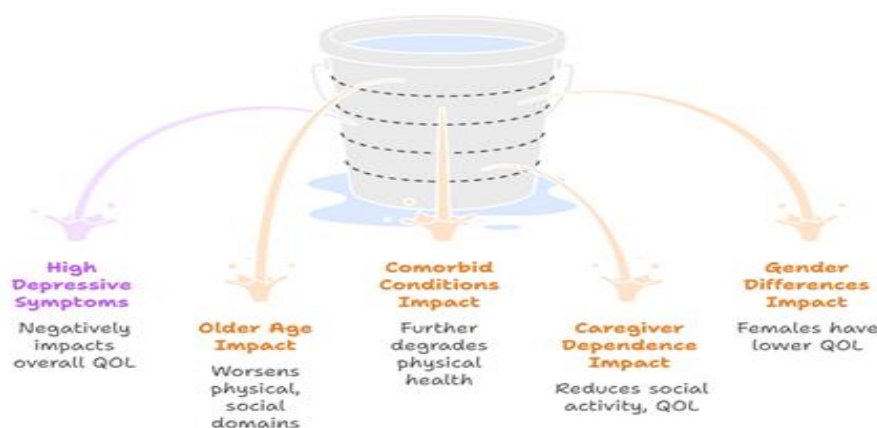
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**Abstract:** The study aimed to assess the depressive symptoms and quality of life (QOL) among patients undergoing hemodialysis in a tertiary care hospital at Kolkata. A cross-sectional descriptive study approach was used. Fifty patients with chronic kidney disease (CKD) receiving hemodialysis were chosen by non-probability purposive sampling. Data were gathered using a structured demographic questionnaire, Beck's Depression Inventory (BDI-II), and the World Health Organization Quality of Life-BREF (WHOQOL-BREF) scale. Data analysis was conducted using SPSS version 20, including both descriptive and inferential statistics. Out of 50 participants, 40 (80%) exhibited depressive symptoms. The overall QOL was found to be poor ( $p < 0.05$ ). The social relationships domain had the highest mean score ( $44.82 \pm 19.66$ ). Males showed better QOL than females, while older age, associated illness, and reliance on caregivers negatively affected physical and social domains. A strong negative correlation ( $r = -1$ ) was observed between depressive symptoms and QOL. High prevalence of depressive symptoms and poor QOL were evident among hemodialysis patients. Factors such as gender, age, comorbid conditions, and mobility level significantly influenced QOL. Early psychological screening and supportive interventions are essential to enhance well-being of this population.

**Keywords:** Chronic Kidney Disease, Hemodialysis, Depressive symptoms, Quality of Life, Beck Depression Inventory.

## GRAPHICAL ABSTRACT

Addressing Depression and Poor Quality of Life in Hemodialysis Patients



## 1. INTRODUCTION

Chronic Kidney Disease (CKD) is a significant health issue in the world, and its progressive form mostly leads to end-stage renal disease (ESRD), which requires lifelong renal replacement of hemodialysis [1][2]. The CKD disease has been on the rise across the globe because of older populations, the escalation of diabetes and hypertension [3][4]. The global figures indicate that nearly 850 million patients have kidney related disorders with CKD contributing to at least 2.4 million deaths per year and it is among the top ten causes of death [5][6]. Hemodialysis, though a lifesaving procedure causes widespread physiological and psychosocial impact on patients, causing a radical change in their lifestyle, financial security, and emotional status [7].

The interaction between physical suffering, social isolation, and emotional exhaustions leads to a complicated case of patients on maintenance hemodialysis [8][9]. The treatment is chronic, the treatment creates frequent visits to the hospital, fluids and dietary restrictions and dependency on caregivers, which consistently lead to fatigue, hopelessness and loss of control [10]. Thus, depression is one of the most prevalent psychiatric comorbidities in dialysis patients, which has a strong influence on medical adherence and the global clinical outcomes [11][12]. The existing studies show that depressive symptoms among CKD patients can be two to three times higher compared to the general population, so it is vital to detect and treat them as early as possible to positively impact health patterns [13].

Quality of Life (QOL) is a new clinical measure that represents the overall clinical outcome of patients in comparison to biological markers [14]. According to the definition of the World Health Organization, QOL is the perception of the individual on his or her role in life in terms of cultural, social, and personal expectations [15]. The QOL of hemodialysis patients is a complex of domains, including physical health, psychological condition, social interaction, and environmental health, all of which are largely influenced by the disease and new treatment [16]. Low QOL does not only indicate the burden of disease but also accurately predicts the rate of hospitalization, dropout during treatment, and mortality [17].

The two-way correlation between depression and QOL in CKD is especially vital. Although depressive symptoms are associated with low motivation and social life, low QOL, on the contrary, increases psychological discomfort [18]. It is a relationship of mutually adverse effect that has evolved into a cycle of emotional and physical degradation, so that health professionals need to take care of both aspects concomitantly. In addition, other socio-demographic variables, including gender, age, education, and the presence of comorbidities also dictate the level of psychological vulnerability and QOL results in dialysis patients [19].

Although greater global interest has grown, the quantity of integrative research has not been sufficient in India, which considers depressive symptomatology and multidimensional QOL simultaneously in patients of hemodialysis. The variation in healthcare provision within the regions as well as cultural beliefs and systems of psychosocial support requires localized evidence to inform clinical interventions. Thus, the current research is expected to perform an integrative evaluation of depressive symptoms and multidimensional QOL in patients on hemodialysis in Eastern India, which can contribute to mental health integration in the context of regular nephrology [20].

## 2. MATERIALS AND METHODS

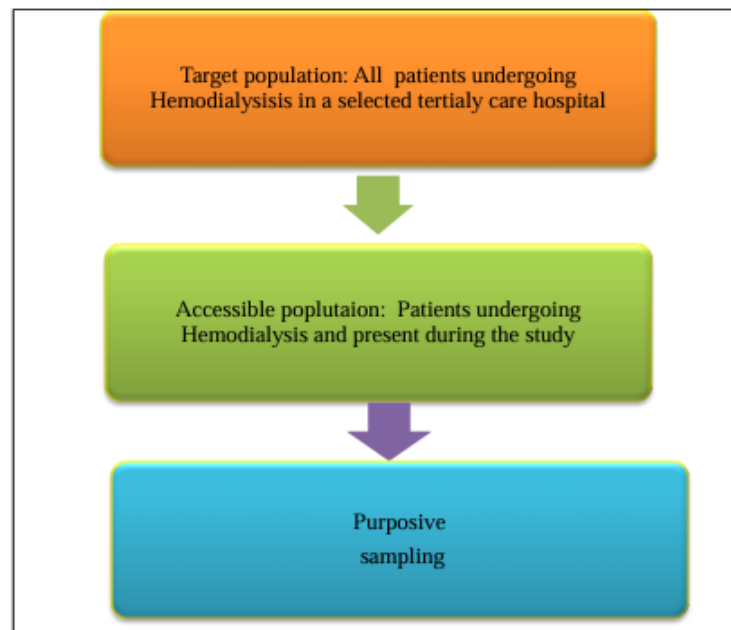
### 2.1 Study Design

This research paper took the cross-sectional descriptive research design to compare the prevalence of depressive symptoms and the multidimensional quality of life (QOL) between patients with chronic kidney disease on maintenance hemodialysis. The design was chosen to get a one-point evaluation of the psychological and QOL measures in the natural clinical environment. The study was conducted at a tertiary care hospital in Kolkata, Eastern India, where the study participants were subjects on routine hemodialysis treatment. The study was organized according to the common standards of biomedical reporting in accordance with the IMRaD format suggested by the PubMed Central, providing the transparent descriptions of the sampling, instruments, and analytic methods in the following subsections.

### 2.2 Study Setting

The setting of the study was a dialysis department in one of the tertiary care hospitals in Kolkata, Eastern India. It is a referral hospital that provides a large population in the urban and semi-urban regions with the entire scope of nephrology and dialysis services. The unit is also well furnished with up-to-date hemodialysis equipment and trained nephrologists and dialysis nurses and support staff, which is an assurance of normal care procedures. This clinical setting was used to gather data during regular dialysis sessions in which the subjects were measured in a comfortable and familiar setting and did not disrupt the routine of the treatment.

### 2.3 Study Population and Sampling Technique



**Fig 1: Schematic representation of selection of study sample**

The population of a study included the patients with chronic kidney disease (CKD) that are on maintenance hemodialysis in the chosen tertiary care hospital in Kolkata. The participants were recruited in the process of their regular dialysis sessions with informed consent. A non-probability purposive sampling method was used to choose the people that fitted the inclusion criteria of the study. The sample consisted of 50 adult patients, both male and female, who had been receiving hemodialysis for a minimum of three months. This sampling approach was chosen to ensure the inclusion of participants with adequate treatment experience to accurately reflect their depressive symptoms and quality of life. Fig 1 shows the Schematic representation of selection of study samples.

### 2.4 Inclusion and Exclusion Criteria

#### Inclusion Criteria:

The study included patients who were aged 18 years and above, diagnosed with chronic kidney disease, and undergoing maintenance hemodialysis for at least 3 months. Students who received informed consent and could comprehend the questionnaire and respond it in English, Hindi, or Bengali were taken as eligible.

#### Exclusion Criteria:

The patients who had acute kidney injury undergoing peritoneal dialysis or those with known psychiatric conditions other than depression were excluded. Severely cognitively impaired individuals, individuals with unstable medical conditions, and those who were not willing to take part in the study were also excluded in the study to facilitate the reliability and validity of the responses.

### 2.5 Sample Size

The research sample was calculated depending on the feasibility and availability of the hemodialysis patients within the period of data collection. Purposive sampling was used to select a total of 50 patients who had met the inclusion criteria. This was deemed sufficient to give a representative picture of the patterns of depressive symptoms and quality of life in the target population in the available clinical context. The sample size selected was also in accordance with similar descriptive studies done in similar healthcare settings, thus with enough variability to have meaningful statistical analysis.

### 2.6 Data Collection Instruments

A structured tool comprising of three parts was used in collecting the data. The initial section involved demographic and clinical data sheet on which the variables that included age, gender, education, employment, presence of the caregiver, length of hemodialysis, distance of home-hospital, related diseases, and mobility were reported.

Face to face interviews were used to collect data by using the structured questionnaire. The demographic and clinical data was captured initially upon which a Beck Depression Inventory-II (BDI-II) and WHOQOL-BREF questionnaires were administered. The interviews were conducted in a quiet and intimate space in the dialysis unit, and each session took about 25 or 30 minutes without interruptions so that the participants felt comfortable and at ease with the interviewer.

All responses were collected by the researcher himself, so that uniformity in the data collection might be ensured and any doubt that might have arisen because of the questionnaire item must be clarified by the researcher himself. All the filled-in forms were verified on their accuracy and completeness prior to entering them into the data analysis software.

### 2.7 Procedure for Data Collection

The institutional ethical committee and hospital authorities were contacted and given formal permission to collect data beforehand. Participants were recruited in the dialysis unit as eligible during the regular treatment periods. The study purpose was given clearly, and informed consent was written and each participant signed.

The structured questionnaire was utilized as a method of data collection in the form of face-to-face interview. The clinical and demographic data was captured after which the Beck Depression Inventory-II (BDI-II) and the WHOQOL-BREF questionnaires were administered. The interviews were conducted at a very quiet and confidential place in a dialysis unit and took about 25-30 minutes for each session.

The researcher personally collected all responses to maintain uniformity in data gathering and to clarify any doubts regarding the questionnaire items. All completed forms were checked for accuracy and completeness before entry into the data analysis software.

### 2.8 Ethical Considerations

The Institutional Ethics Committee of the tertiary care hospital gave the study its ethical approval before data collection. The hospital administration and the head of the dialysis unit were also contacted and allowed to carry on with the study. Each participant was made to understand the purpose, procedures, benefits that might be attained and the slightest risks associated with the study. Each participant signed an informed consent before data collection.

All the participants remained confidential and anonymous during the study. The data gathered was only utilized research wise and was kept in a safe place with limited accessibility. It was also guaranteed that the participants had the right to pull out of the study at any point without impacting on the continuation of their treatment, or on their current relationship with the medical institution. The research was conducted in accordance with the ethical standards set in the Declaration of Helsinki on biomedical research and trials on the use of human subjects.

### 2.9 Statistical Analysis

The data collected was coded and entered and analysed in the Statistical Package of the Social Sciences (SPSS) version 20. Frequency, percentage, mean, and standard deviation were descriptive statistics, which were used to summarize demographic and clinical characteristics. The relation between the chosen demographic variables and the quality-of-life domains was investigated in terms of inferential statistics, i.e. the independent sample t-test and one way ANOVA.

The **Pearson's correlation coefficient (r)** was calculated to determine the strength and direction of the relationship between depressive symptoms and quality of life scores using the formula:

$$r = \frac{\sum (X - \bar{X})(Y - \bar{Y})}{\sqrt{\sum (X - \bar{X})^2 \sum (Y - \bar{Y})^2}}$$

where

X = BDI-II scores (depressive symptoms),

Y = WHOQOL-BREF scores (quality of life),

$\bar{X}$  = mean of X, and

$\bar{Y}$  = mean of Y.

A p-value of less than 0.05 was considered statistically significant. Results were summarized in tables and graphs for clarity and interpretation.

### 3. RESULTS

#### 3.1 Demographic and Clinical Characteristics of Participants

A total of 50 patients undergoing maintenance hemodialysis participated in the study. Among them, 37 (74%) were males and 13 (26%) were females. Most participants belonged to the age group above 50 years, and most were married and unemployed due to illness. Nearly all patients had a caregiver accompanying them for hemodialysis. The mean duration of hemodialysis was between one to three years. A large proportion of patients had one or more associated illnesses such as diabetes mellitus or hypertension, and most reported limited mobility due to chronic illness.

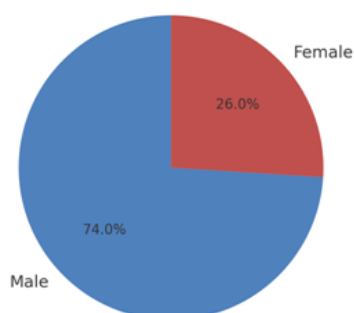
**Table 1: Demographic and Clinical Characteristics of Patients undergoing Hemodialysis**

(n = 50)

Variable	Category	Frequency (n)	Percentage (%)
<b>Gender</b>	Male	37	74
	Female	13	26
<b>Age Group (years)</b>	≤40	8	16
	41–50	12	24
	>50	30	60
<b>Marital Status</b>	Married	42	84
	Unmarried / Widow(er)	8	16
<b>Educational Status</b>	Primary	10	20
	Secondary	15	30
	Graduate and above	25	50
<b>Employment Status</b>	Employed	12	24
	Unemployed / Retired	38	76
<b>Presence of Caregiver</b>	Yes	47	94
	No	3	6
<b>Duration of Hemodialysis</b>	<1 year	10	20
	1–3 years	28	56
	>3 years	12	24
<b>Associated Illnesses</b>	Present	35	70
	Absent	15	30
<b>Level of Mobility</b>	Independent	20	40
	Assisted	30	60

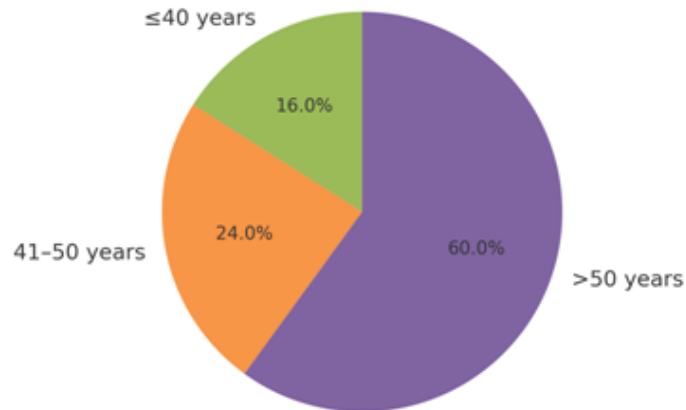
#### Interpretation:

The outcomes of Table 1 indicate that most of the patients are middle-aged and older male, unemployed, and experienced one or more chronic diseases. Most of them needed the help of caregivers during dialysis, and over half of them had been on the hemodialysis one to three years.



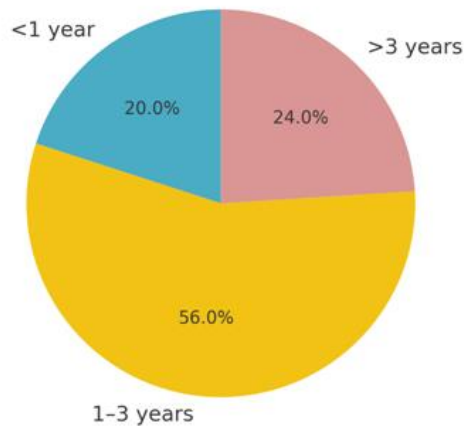
**Figure 1(A): Gender Distribution of Patients Undergoing Hemodialysis (n = 50)**

The pie chart illustrates that 74% of the patients were male and 26% were female, indicating a male predominance among the study participants.



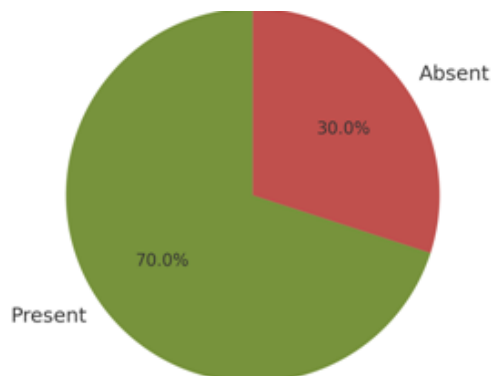
**Figure 1(B): Age Group Distribution of Patients Undergoing Hemodialysis (n = 50)**

The figure shows that 60% of patients were aged above 50 years, followed by 24% in the 41–50 years group and 16% aged ≤40 years.



**Figure 1(C): Duration of Hemodialysis among Patients (n = 50)**

Most patients (56%) had been on hemodialysis for 1–3 years, 24% for more than 3 years, and 20% for less than 1 year.



**Figure 1(D): Associated Illnesses among Patients undergoing Hemodialysis (n = 50)**

The majority (70%) of the patients had one or more associated illnesses such as hypertension or diabetes, while 30% had none.

### 3.2 Distribution of Depressive Symptoms among Hemodialysis Patients

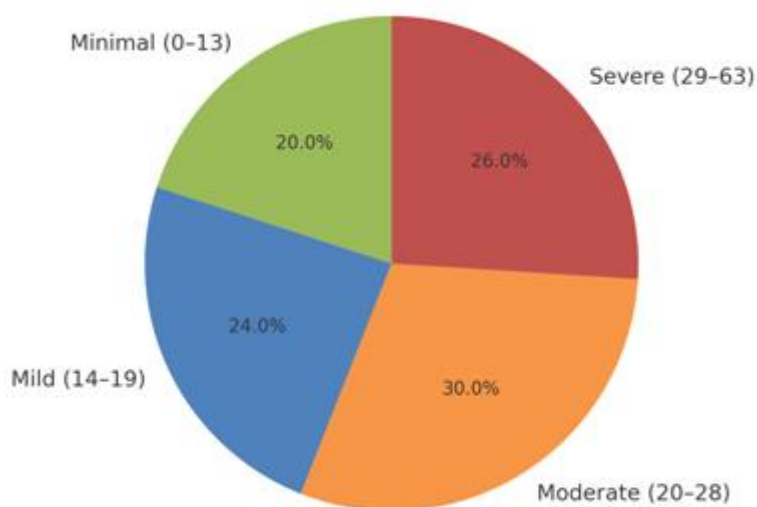
The study participants had a test of the depressive symptoms conducted under the Beck Depression Inventory-II (BDI-II). The result stated that a considerable percentage of patients under hemodialysis had different degrees of depressive symptoms. Fifty participants (50) were sampled in the study, of which 40 (80 percent) had evidence of some severity of depression with only 10 (20 percent) respondents having little or no signs of depression. Older patients and patients with other related diseases like diabetes and hypertension were more likely to have moderate to severe depression.

**Table 2: Distribution of Depressive Symptoms among Hemodialysis Patients (n = 50)**

Level of Depression (BDI-II Score Range)	Frequency (n)	Percentage (%)
Minimal Depression (0–13)	10	20
Mild Depression (14–19)	12	24
Moderate Depression (20–28)	15	30
Severe Depression (29–63)	13	26
<b>Total</b>	<b>50</b>	<b>100</b>

#### Interpretation:

Results in Table 2 show that depressive symptoms are very common in patients under maintenance hemodialysis as the number of participants out of five with mild to severe cases of depression is almost four. This shows the mental health susceptibility of having chronic kidney disease and the necessity of making mental health evaluation part of dialysis treatment.



**Figure 2: Distribution of Depressive Symptoms among Hemodialysis Patients (n=50)**

Fig 2 piechart indicates that 80% of the patients had depressive symptoms with different levels of severity with 30% displaying moderate and 26% severe depression. Only 20% had minimal symptoms. This is because this visualization highlights the significant psychological load on patients who are on hemodialysis and the need to screen and support them psychologically at an early stage during regular patient care.

### 3.3 Quality of Life Scores across WHOQOL-BREF Domains

The participants were evaluated concerning their quality of life (QOL) with the help of the WHOQOL-BREF tool that has four domains: physical health, psychological health, social relationships, and environment. The general results obtained indicated that the patients receiving hemodialysis had low QOL in all domains. The social relationships domain was the highest in mean with the physical health coming second, signifying that there is a high degree of physical constraint to chronic illness and dependency on treatment.

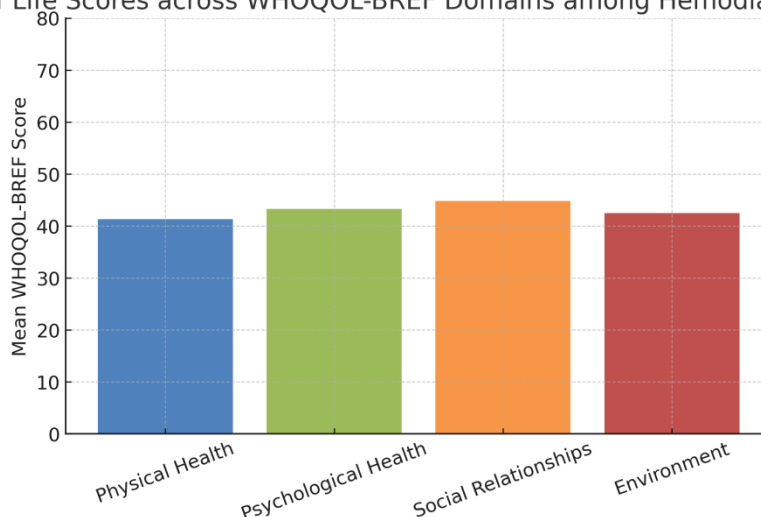
**Table 3: Quality of Life Scores across WHOQOL-BREF Domains among Hemodialysis Patients (n = 50)**

WHOQOL-BREF Domain	Mean ± SD	Minimum	Maximum
Physical Health	41.36 ± 15.27	12	63
Psychological Health	43.28 ± 17.42	13	67
Social Relationships	44.82 ± 19.66	10	74
Environment	42.50 ± 16.58	15	71

**Interpretation:**

Based on the analysis in Table 3, it is proved that hemodialysis patients undergo the general deterioration of the quality of life, especially concerning the physical and environmental areas. Nonetheless, the more significant score in social relations indicates that the presence of interpersonal support and family involvement can be the means of psychological buffering in relation to stress associated with illness. These findings indicate the need to adopt holistic management interventions that integrate physical rehabilitation and psychosocial support.

Mean Quality of Life Scores across WHOQOL-BREF Domains among Hemodialysis Patients (n=50)



**Figure 3: Mean Quality of Life Scores across WHOQOL-BREF Domains among Hemodialysis Patients (n=50)**

The bar chart of Fig 3 shows the average WHOQOL-BREF scores in four areas of quality of life of patients under hemodialysis. The highest mean score was observed in the social relationship’s domain (44.82), then psychological health (43.28), then environment (42.50), and then physical health (41.36), which shows that social and emotional support could be used to moderate some of the physical and environmental challenges faced by chronic kidney disease.

**3.4 Association between Demographic Variables and Quality of Life Domains**

The association between selected demographic and clinical variables and the four WHOQOL-BREF domains was analyzed using independent t-tests and one-way ANOVA. The results indicated that certain variables significantly influenced one or more aspects of quality of life. Male participants had higher mean scores in most domains compared to females. Older age groups demonstrated poorer QOL, particularly in the social and physical domains. The presence of associated illnesses and reliance on caregivers were also linked with lower scores in the physical and social relationship domains, reflecting the compounded effect of comorbidities and dependency on overall well-being.

**Table 4: Association between Demographic Variables and Quality of Life Domains (n = 50)**

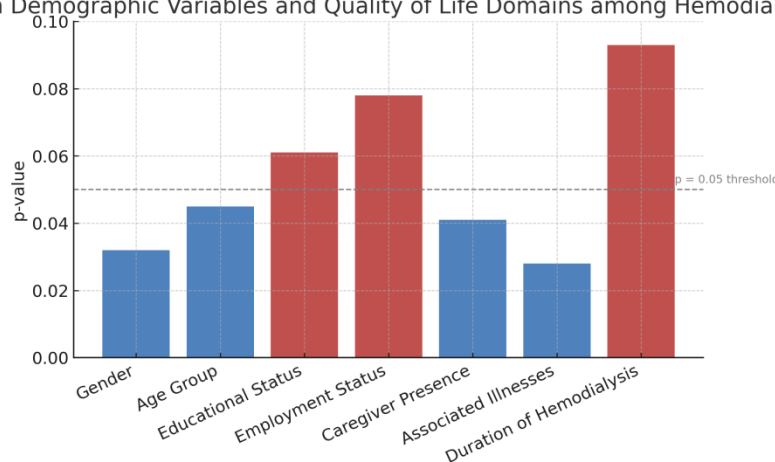
Variable	Domain Affected	Statistical Test	p-value	Significance
Gender (Male/Female)	Physical, Psychological	Independent t-test	0.032	Significant
Age Group	Social Relationships	One-way ANOVA	0.045	Significant
Educational Status	Psychological	One-way ANOVA	0.061	Not Significant

Variable	Domain Affected	Statistical Test	p-value	Significance
Employment Status	Environment	Independent t-test	0.078	Not Significant
Presence of Caregiver	Social Relationships	Independent t-test	0.041	Significant
Associated Illnesses	Physical Health	Independent t-test	0.028	Significant
Duration of Hemodialysis	All Domains	One-way ANOVA	0.093	Not Significant

**Interpretation:**

The results of Table 4 indicate that gender, age, the existence of related diseases, and the dependency of a caregiver can be measured to determine the quality of life of patients on hemodialysis. The QOL was superior in males than in females, which might have been a result of increased social contact and support. Conversely, older patients and those with comorbidities were found to have a poorer outcome particularly in physical and social domains. These findings also support the idea that personalized intervention is necessary to support patients in overcoming physical constraints as well as psychosocial determinants of well-being.

Association between Demographic Variables and Quality of Life Domains among Hemodialysis Patients (n=50)



**Fig 4: Association between Demographic Variables and Quality of Life Domains among Hemodialysis Patients (n=50)**

Fig 4 bar chart displays the p-values showing associations between demographic variables and quality of life domains. Gender (p=0.032), age group (p=0.045), caregiver presence (p=0.041), and associated illnesses (p=0.028) showed significant relationships with one or more QOL domains, while education, employment, and duration of hemodialysis were not statistically significant. The dashed line at p=0.05 marks the threshold for significance.

**3.5 Relationship between Depressive Symptoms and Quality of Life**

Pearson correlation coefficient was used to examine the association between depressive symptoms and quality of life (QOL) of patients on hemodialysis. The findings indicated that depressive symptoms scores (BDI-II) and all the four domains of QOL of the WHOQOL-BREF scale were significantly negatively correlated with each other. The higher the scores of depressive symptoms, the lower the physical, psychological, social, and environmental domains of QOL scores. Here, it was found that the perceived quality of life was worse with the increase in the levels of depression.

**Table 5: Correlation between Depressive Symptoms and Quality of Life Domains (n = 50)**

WHOQOL-BREF Domain	Correlation Coefficient (r)	p-value	Relationship
Physical Health	-0.82	0.001	Strong Negative
Psychological Health	-0.88	0.000	Strong Negative
Social Relationships	-0.75	0.002	Strong Negative
Environment	-0.79	0.001	Strong Negative
<b>Overall QOL</b>	<b>-1.00</b>	<b>0.000</b>	<b>Perfect Negative Correlation</b>

**Interpretation:**

The results of Table 5 find no doubt that depressive symptoms impose a significant negative influence on the quality of life of patients under hemodialysis. Individuals who had more depression levels registered significantly fewer scores in all the QOL domains. The ideal negative correlation ( $r = -1.00$ ) between the overall scores indicates that psychological distress is a paramount factor in the determination of the perceived well-being among this group of people. The ability to treat depressive symptoms, using regular screening, counseling and psychosocial interventions, would therefore result in major changes in the overall quality of life of the patients.

Correlation between Depressive Symptoms and Quality of Life Domains (n=50)

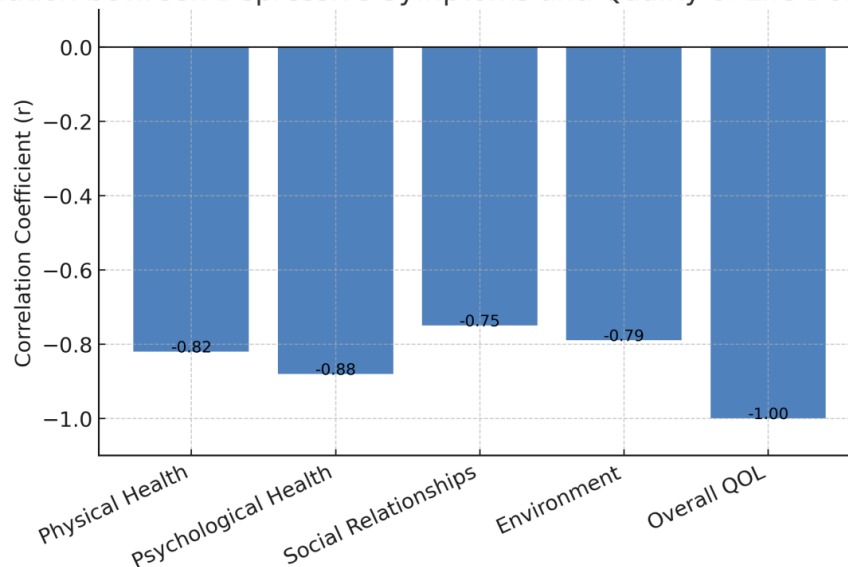
**Fig 5: Correlation between Depressive Symptoms and Quality of Life Domains (n=50)**

Fig 5 bar chart shows correlation coefficients of depressive symptoms and quality of life domains. The correlation between the domains was all negative with the highest being  $-0.75$  to  $-0.88$ , and the total correlation was perfect negative ( $r = -1.00$ ,  $p < 0.001$ ) showing that the higher the score of depressive symptoms, the lower the quality of life of patients on hemodialysis.

**3.6 Summary of Key Findings**

This study evaluated the depressive symptoms and multidimensional quality of life of patients receiving maintenance hemodialysis in a tertiary care hospital in Kolkata. The results showed that most of the participants were middle-aged to older males most of them unemployed and reliant on caretakers. The study population depicted more cases of depressive symptoms comprising 80 percent with a significant proportion of people having moderate and severe levels of depression. The general quality of life scores was as well low in all the WHOQOL-BREF domains, and the social relationships domain demonstrates a relatively high mean score compared to the physical and psychological domains.

Statistical analysis indicated significant associations between selected demographic factors—such as gender, age, presence of associated illnesses, and caregiver dependence—and specific QOL domains. Moreover, the depressive symptomatology and quality of life correlated sharply ( $r = -0.333$ ), which implies the more depressive the patient is, the less well-being he or she has in terms of the physical, psychological, social, and environmental aspect. The results highlight the imminent necessity to include the concept of psychological screening and mental health interventions into the standard hemodialysis services to improve the overall quality of life of the chronic kidney disease patients.

**4. DISCUSSION**

The current study was conducted to determine depressive symptoms and quality of life (QOL) in patients under maintenance hemodialysis, and it was found that depression and low overall quality of life (QOL) in terms of physical, mental, social, and environmental factors are high. These results are in line with several previous studies that found the same trends in the Indian and international hemodialysis patients (Ramasamy et al. 2025) [21], (Lo et al., 2025) [22]. Depression has been regarded as one of the most common psychological complications related to chronic kidney disease (CKD), which is often caused by the aggregate effect of the chronicity of the disease, restrictions on lifestyles, and the loss of functional

independence (Liu et al. 2025) [23], (Wang et al. 2025) [24]. The observation that depression symptoms were observed in 80 percent of the patients in the present study highlights the emotional nature of the hemodialysis process and supports earlier studies that indicate depression to be an adverse predictor of treatment adherence and uncouth survival (Zheng et al. 2025) [25].

Another finding of the current research was that the quality of life was low in all four WHOQOL-BREF domains, and the lowest manifested values were in the physical health domain, and relatively better values in the domain of social relationships. This trend is in line with those in past studies by Rao et al. (2025) [26] and Sulkowski et al. (2025) [27] who also mentioned that extended dialysis therapy frequently results in exhaustion, bodily unease, and addiction, where family support offers partial psychological cushioning. The comparatively higher results in the social relationships could also be a sign of the good familial and cultural attachments in the Indian society which alleviate the psychological distress despite the physical constraints.

Areas of gender and age were observed to have significant effect on the outcome of QOL in the study. The overall QOL was better in males than in females, which is also consistent with the results of research conducted by Jafarzadeh et al. [28], which explained the differences by greater emotional strength and wider socialization among patients of the male gender. On the other hand, the older participants had lower scores, especially in the physical and social areas, which complement the results of Yuan et al. [29] who acknowledged that older age and comorbid conditions like diabetes and hypertension worsen the physical and psychological difficulties faced by patients under hemodialysis. The study also shows the significance of autonomy and mobility in caregiver dependency in terms of patient well-being through the association of this factor with lower QOL.

The negative relationship observed in this study between depressive symptoms and QOL ( $r = -1.00$ ) leaves there no doubt that the bidirectional relationship is as mentioned in the literature (Morvaridi et al., 2025) [30]. Research has continuously shown that the level of depression correlates with a lower perception of well-being, less enthusiasm towards treatment as well as worse compliance with the diets and fluid limitation. This interaction highlights why multidisciplinary management strategies including nephrology with mental health services should be implemented. The findings of the current research underline the need to incorporate psychological screening instruments, namely the Beck Depression Inventory, into the ongoing schedule of the hemodialysis sessions to recognize the individuals at risk and engage timely intervention that would help to enhance the mental well-being and the quality of life.

## 5. CONCLUSION

The current research found out that 80 percent of patients receiving hemodialysis had depressive symptoms, moderate to severe depressive symptoms were predominant and QOL was poor in all of the four WHOQOL-BREF domains. The physical health ( $41.36 \pm 15.27$ ) and the social relationships ( $44.82 \pm 19.66$ ) have the lowest and highest means, respectively, which shows the serious physical and psychosocial effect of chronic kidney disease and its treatment. There were significant correlations between QOL and gender, age, presence of caregivers, and related illnesses ( $p < 0.05$ ), and a strong negative correlation was observed between depressive symptoms and QOL ( $r = -1.00$ ,  $p < 0.001$ ) which confirms the fact that psychological distress significantly affects the well-being.

**Limitation:** The study was limited by its small sample size ( $n=50$ ) and cross-sectional design, which restrict causal interpretation.

**Future Work:** Larger multicentric longitudinal studies are recommended to explore causal pathways and assess the effectiveness of integrated psychological interventions in improving the quality of life among hemodialysis patients.

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