**NEAR EAST UNIVERSTY**

**GRADUATE SCHOOL OF SOCIAL SCIENCES PSYCHOLOGY DEPARTMENT**

**APPLIED (CLINICAL) PSYCHOLOGY MASTER PROGRAM**

**MASTER'S THESIS**

# THE RELATION OF POST TRAUMATIC GROWTH, DEPRESSION AND LIFE SATISFACTION FOR OLD AGED PEOPLE

**İPEK KIZILOLUK**

**NICOSIA**

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# THE RELATION OF POST TRAUMATIC GROWTH, DEPRESSION AND LIFE SATISFACTION FOR OLD AGED PEOPLE

**PREPARED BY**

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**NICOSIA**

**2016**

# ÖZET

## Farklı Ortamlarda Yaşayan Yaşlı Bireylerde Geçirilmiş Travma Durumuna Göre Travma Sonrası Gelişim, Depresyon ve Yaşam Doyumu Arasındaki İlişkinin İncelenmesi

**Hazırlayan: İpek KIZILOLUK**

**Ocak, 2016**

Bu araştırmanın amacı, farklı ortamlarda yaşayan yaşlı bireylerde, geçirilmiş travma durumlarına göre travma sonrası gelişim, depresyon ve yaşam doyumu arasındaki ilişkinin incelenmesidir. Araştırmada 65 yaş üstü herhangi bir beyin hastalığı olmayan yaşlı bireyler hedef alınarak, travma yaşayan ve yaşamayan olmak üzere, 64'ü eş ya çocuk ile yaşayan, 38'i huzurevinde yaşayan 17'si yalnız, 3 kişi ise diğer olmak üzere toplam 120 kişi ile gerçekleştirilmiştir. Katılımcılara ilk olarak, Gönüllü olur Formu verilerek araştırmanın amacı anlatılmış ve onay alınmıştır. Sonrasında Mini Mental Test, Sosyo-Demografik Bilgi Formu, Travma Sonrası Gelişim Ölçeği (TSGÖ), Geriatrik Depresyon Ölçeği (GDÖ) ve Yaşam Doyum Ölçeği (YDÖ) kullanılarak veriler toplanmıştır. Verilen toplanması sonrasında elde edilen verilerin istatiksel Analizleri gerçekleştirilmiştir. Veriler SPSS programında T-test, Anova ve Korelasyon uygulanarak sonuçlar elde edilmiştir.

Yapılan araştırma sonucunda sosyodemografik bilgiler ve ölçekler farkı ortamlarda yaşayan yaşlılar travma yaşayan ve yaşamayan örneklem grubu arasında karşılaştırılarak yapılan daha önceki benzer araştırma sonuçlarıyla benzerlik göstermiştir. GDÖ, YDÖ ve TSGÖ birbirleri ile karşılaştırılmış, karşılaştırılma sonucunda travma sonrası gelişim ile depresyon arasında negatif bir ilişki bulunmuştur. Yaşam doyumu ile depresyon arasında da negatif bir ilişki bulunmuştur. Travma sonrası gelişim ile yaşam doyumu arasında pozitif yönde bir ilişki bulunmuştur.

**Anahtar Sözcükler**: **Yaşlılık, Travma, Travma Sonrası Gelişim, Depresyon, Yaşam Doyumu**

## ABSTRACT


### RELATON OF POST TRAUMATIC GROWTH, DEPRESSION AND LIFE SATISFACTION FOR OLD AGE PEOPLE

**Prepared by: İpek Kızıloluk**

**January, 2016**

Aim of this study is to investigate the relation between post traumatic growth after an experienced trauma, depression and life satisfaction for old aged people who are living in different atmospheres. This study is targeted as participants who do not have any brain injuries and older than 65 years old and having a trauma experience or not; this study is done by totally 120 participants; in which 64 of the participants are people who are living with their spouse or children, 38 of the participants are living in nursing homes, 17 of the participants are living alone and 3 of the participants are not specified. First of all; voluntary form is given to participants, purpose of the study is described and approve of participants is taken. After the approval, standardized mini mental test, socio-demographic information form, Post Traumatic Growth Inventory (PTGI), Geriatric Depression Scale and Life Satisfaction Scale is used to take data. After taking the data, the data are statistically analyzed. T-test, Anova and correlation is used to take results from the data in SPSS program.

Results of this study showed similarities between other previous studies which look for comparing of traumatized old aged people with not traumatized sample group with socio-demographic information and scales. Post traumatic growth inventory, geriatric depression scale and life satisfaction scale is compared and after comparison; a negative relation between post traumatic growth and depression is found. Also a negative relation between life satisfaction and depression is found. Post traumatic growth and life satisfaction showed a positive relation.


**Keywords: Old ages, Trauma, Post Traumatic Growth, Depression, Life Satisfaction**.

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İpek KIZILOLUK

January, 2016

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# ABBREVIATIONS

**PTGI-** Post Traumatic Growth Inventory

**GDI-** Geriatrik Depresyon Inventory

**LSI-** Life Satisfaction Inventory

**SMMT-** Standardize Mini Mental Test

**DSM-** Diagnostic and Statistical Manual of Mental Disorders

**APA-** American Psychological Association

## INTRODUCTION

Old ages are one of the stages of developmental stages of human life which have dimensions of social, biological and psychological; is described as last circuit of the life cycle which is based on 65 ages old and older. When it is looked to Jung's life stages, old ages are like childhood. Person sinks to unconsciousness and waits for disappearing without thinking about at all Gençtan, 2004). Depression is psychological disorder, which can be seen frequently in old ages that causes hitch in actions of daily life and depression also causes severe disabilities old aged people give up and don't do business and occupation because they think they have no power.

Additionally, depression was frequently diagnosed in recent years, which has brought about a rise in the number of researches on this issue. There for within the scope of this study the literature about old age, depression and life satisfaction has been examined.

In thıs chapter firstly specifications of old age and psychiatric illness seen in old age; depression, life satısfaction, trauma and post traumatic growth have been researched. Researched were compared with experience trauma and not experience trauma for old age people who are living different atmospheres. There after experience trauma which take active roles in depression and life satısfaction have been included. Finally, purposes of the study researching question have been given.

## 1.OLD AGE

### 1.1 Description Old Age

Old age is one of the stages of developmental stages of human life which have social, biological and psychological dimensions; is described as last circuit of the life cycle which refers to 65 ages old and older. When it is looked to Jung's life stages, old ages are resamble childhood. Person sinks to unconsciousness and waits for disappearing without thinking about at all Gençtan, 2004). According to Erikson human development consists of 8 stages and last stage of maturity is evaluate as ego integrity versus despair (Erikson, 1982).

Old age can be described as maturity and it can be described as an insufficiency of physical and psychological skills that combines with illnesses that may caused by negative morphological,

physiological and pathological changes (Aydın, 1999). Old aging is a stage, in which people have losses in physiological appearance, role and status, and become dependent to others because of disabilities and physiological illnesses (Tamam, 2001).

In recent years, as parallel to technological improvements and increases in life quality; human life started to gets longer. Life expectancy in 1955 is 48 years from birth to death, it became 59 years in 1975, increased to 65 in 1995 and it is expected to be 73 years in 2025 (Who, 1998). Percentage of mature people in society; which is accepted as 65 years old and older, is increased to 15% in developed countries (Tamam, 2001). Population ratio of 65 years old and older is 6.9% (3,4). In our country %63 of the matures live in their places, %36 lives near their children and %1 lives in nursing homes (Atalay et al., 2003).

Worldwide addiction in old ages was 10,5% in 1955, it increased to 12,3% in 1995 and it is expected to be %17,2 in 2025 (Who,1998). According to Turkish Statistical Institute, ratio of 65 year of old people to whole population is 5,7% in 2000, and it has been found as 7,0% in 2009. In 2009, addiction percentage was %10,46 in our country. According to Turkish Statistical Institute, life expectancy from birth is announced as 71,5 years for men and 76,1 years for women. According to 2008 Address Based Population Registration System Population Projections; it is expected that life expectancy from birth will be 73,1 years for men and 78,9 years for women in 2025 (Tsı, 2009).

In old ages, having physical health problems risks may rise, by this disturbance it is easy to see social and economical weaknesses and psychological problems (Şahin and Yalçın; Gülseren et al., 2003). Depression, which is one of the most common disorders is a syndrome which lasts with insignificance, insufficiency, feeling petty and slowness in speech, actions and physiological functions. Nursing homes seem as trusted places for old aged people in their last period of life; by moving from extended family to nuclear family structure related with economical and social causes (Aşkın, 1999). Especially depression is an important factor which effects life satisfaction either combined with other illnesses or alone. If depression is not treated it may cause negative results ever death or problems in general health status, but if it is treated properly life satisfaction may increase (Şahin et al, 2003).

Studies showed that; rises in depression points, rises in chronological illnesses and if elder person cannot do daily life activities, life satisfaction points will decrease (Gülseren, 2000). Also studies show that; old aged person who lives in nursing home has more psychological symptoms than old aged person who lives with family (Altınyollar et al., 2001).

## 1.2 PSCYHIATRIC ILLNESSES SEEN IN OLD AGE PEOPLE

### 1.2.1Depression in Old Ages

Depression is a psychological disorder, which can be seen frequently in old ages if causes hitch in actions of daily life and also causes severe disabilities. Factors of increase of age, disability in physical skills, decline in cognitive functions, weakening in social relations and daily activities, worsening in economical status, living alone, weakness in social support may increase the risk of depression in old ages (Çivi and Tanrıkulu, 2000; Steffens et al., 2000).

If psychosocial changes are considered, social activity of individual, power, intimate relations, prestige, social life and support will decrease; individual will lose their active role and becomes in a more passive role. Person starts to lose the loved ones one by one. Their children may be moved to other houses, they may have lost their spouse or loved ones, known values may be lost, may not oriented to fast changes in life with known knowledge, life type may have beeen changed, realized the shortness of life, or lost the economical freedom. If person does not take enough social support; may feel powerless in care of isolation by the effects of these cases (Şahin, 2003). Fast increase in population, industrialization and urbanization, corruption in traditional family structure due to internal and external migration, economic problems, working women effect the social structure leads to decrease and nucleation of family structure. This causes social and family status and this changes for old aged people (Toprak, 2002). Generally old aged people live with their family and children in our culture but in recent years, a change in nuclear family structure, isolated elder people from family and lead to loneliness (Altay, 2009). In recent studies it is seen that depression in old ages ranges between 24% and %72 (Hacıhasanoğlu and Türkleş, 2008; Maral et al., 2001). From the different sections old aged people of society; 15% to 25% of old people who lives in home, 25% of old people who live in care center for a long time and %30 of old people who live in nursing home, have depression (Elopoulos, 2005; Mavandadi et al., 2007).

#### 1.2.1.1 Epidemiology of Geriatric Depression

Geriatric depression is world widely increasing public health problem (Üstün, 2004). Epidemiologic studies about geriatric depression shows that depression symptoms for old people is between 8,0-35,0 % , major depression symptoms are between 0,8-2,9 %. From the 31 million of 65 years old and older people in USA; 5 million old people effected from depression (Birrer and Vemur, 2004). It is cited that old people who live in society has 15% to 25%, 25% of old people who lived in care centers for a long period and 20% to 30% of old people who live in nursing house, have depression (Eliopoulos, 2005; Kurlowich and Greenberg, 2007). It is found that 25% of old people who have heart problems, cancer or arthritis also have depression, but it is found that for the people who are staying in hospital this percentage increases to 45% (Raynold, 1999).

According to these results, co morbid illnesses increase the risk of depression in maturity. Depression frequency may change for gender. It is found that being a woman is one of the main risk factors of having depression. Biological structure, psychological properties, personality structure, problem coping strategies, social and cultural status of woman; makes woman more recipient to have depression (Birrer and Vemuri, 2004). Various studies show the same results which were made with old people (Ünal and Özcan, 2000). In a study it is found that women have 46% and men have 20% depression (Zunzunegui et al., 1998). It is also found that women have more depressive mood according to men and there is no difference in age for women, but an increase in age will increase the depressive symptoms for men (Güz and Çolak, 2002; Steffens et al., 2002). Living alone and being widow is risk factors for depression and for people who lost their couples will have sadness, loneliness, feeling of abandoned and these cases cause increase in depression level (Aksüllü, 2001). In a study made with people who live in houses, it has been found that married people have 15,6% and widow and single ones have 46,5% depression. According to this study, people who are living in home, being single or widow is a risk factor for depression and will increase this risk 4,72 times more from married people (Maral et al., 2001).

Education level and income status is also a factor that affects the depression frequency. According to USA Health and Retirement Study and English Longitudinal Study of Ageing, in a study made in 2002 from the data of 65 years old people; it has been found that in USA depression symptoms frequency (14,9) is lower than England(17,6%). From the results it is claimed that USA has lower depression symptom frequency because they have higher education and income levels. These results were same with previous studies that high socio-economical

status and education has relation with low depressive symptoms (Koster et al., 2006; Zivin et al., 2010).

In a study made with old people who have depression it is found that education level is lower than the control group who does not depression (Güz et al., 2007). A study about geriatric depression also shows that lowness of income is also a factor that increase the depression symptom levels (Mohd Sidik et al., 2003). Socioeconomic status has effects on depression and old people who perceive their economic level as low and middle will have relation with depression. Education level and income status also plays an important role in protection of depression and coping strategies about depression. A study made cottage with old people depressive point percentage is significantly higher for people who do not have social assurance than people who have social assurance. It is believed that social assurance has positive part in health spending and decreasing future anxiet. In our country and other countries; it is cited that old people who are living in nursing houses have higher depression frequency than normal population. (Aksüllü et al., 2004; Abrahams et al., 1992).

#### 1.2.1.2 Etiology of Depression

Depression is not a normal part of aging process for people 65 years old and older who are living in society. Depression is related with some cases like health, several organ functions, social status, losing spouse or loved ones (Beekman et al., 2002; Zivin et al., 2010). With maturity several changes will occur in people's life. Corruption in psychical health, collapse of resistance to outer factors, moving from productivity to unemployed after retirement occurs. After this, person may be isolated and has economical difficulties. Children will move to other houses, losing spouse, and peers or loved ones and these losses may harden the adaptation ability which is already in a difficult situation. With the effects of urbanization and moving from patriarchal family structure to nuclear family structure, role and statue in family will change and individual starts to have other loses about shelter problems. Living in big urban areas and accommodation and protection problems may increase the probability of placement in nursing houses for old people (Palabıyıkoğlu et al., 1984).

Several changes occur in aging process. This aging process can be divided into three groups as; biological, psychological and social.

#### 1.2.1.2.1 Biological Changes

In aging process some physiological changes occur in person's brain structure that negatively affects cognitive functions as memory, attention, and perception, and psycho motor activities; like decrease in cerebral blood stream, decrease and thickness in myelin sheath, increase in glia cells and decrease in the amount of neuron and synapses (Victor, 1997). Also the weight and volume of the brain decreases in aging process. When compared with healthy control groups it is found that 60 years old and older people who have depression have decrease growth in frontal lobe which is an important part of the brain. In another study it is seen that in major depression difference of the volume of frontal lobe with left or right hemisphere is lower than the control groups (Laila et al., 2000; Kumar et al., 2000). Several neurotransmitters start to lose their densities which seem important for the etiology of depression. Decreasing of the density of serotonin, noradrenalin, dopamine and gamma-amino butyric acid seems as a cause for predisposition to geriatric depression (Tamam, 2000).

With the aging, corruption can be seen in the sensory areas like vision, hearing and disabilities may occur. There will be problems like not understanding the questions or not being able to answering and with these problems cognitive inabilities, depression and anxiety disorders may be seen (Yevasage, 1993).

#### 1.2.1.2.2 Psychological Changes

As a gaining of old age, decrease in the biological and social motives, which are the main power of psychic structure, may create depression in old age peoples life. Decreasing in creative talents, perception, and speed of thinking and carelessness can be observed. (Toprak et al.,2002). After these changes, depression and anxiety can be observed in elder people whom retire from productivity and suffer from lack of attention to environment and weakness of short term memory, squeamish, egocentric, sometimes skeptical, need someone for daily life and emancipate from environment. (Göktaş, Özkan 2006; Tamam, 2001).

#### 1.2.1.2.3 Social Changes

Due to aging individuals experiencing decreasing values in power, reputation, functionality, economical independence and harsh living conditions have changes their position from active to passive. Elder people transforms from a point of helping people whom they care of their selves to a more consuming and needy point. Losing of people; who beloved, their partners, friends and children is considered as social changes. Also one of the most social changes is

retirement. With retirement individual income decreases, loses his/her social statue and can be a needy person. (Kaya ,1999).

As a societies age average increases their priorities and needs changes. In an old population health and social problems come into prominence. In highly industrialized societies decreasing numbers of family members and seeing more nuclear families, being less productive and active increases the fatigue emotions, and this situation causes depression and other psychiatric disorders. In societies which are dependent on traditions the role of the old age people is different so the frequency of depression can be different (Kennedy et al., 1989; Ramachandıran et al.,1982).

### 1.2.2 DEMENTIAS and ALZHIMER DISORDER

Losing cognitive skills and feeling insufficient in daily life activities in old ages can be described as dementia. Several dementia causes and varieties can be seen. For a clinician it is important to identify if the present cognitive dysfunction is reversible or not. Causes of reversible dementias are listed below; (Thai et al., 1988)

- Depression and anxiety disorders
- Thyroid illness,
- Nutrition disorders
- Pellagra
- Side effects of drugs
- Drug toxicity, Delirium; especially glucose and electrolyte balance disorder
- Central nervous system infections, brain tumor
- Organ insufficiency

If the problems above are diagnoses and treat cognitive dysfunction is cured. But there is no certain reverse in dementias listed below. In these patients, symptom related treats, control of psychiatric symptoms and approaches related to upgrade the quality of life and care is needed (Rabins et al., 1982).

Frequently seen dementias;

- Alzheimer Dementia
- Vascular dementia
- Front temporal dementia
- Lewy body dementia

- Parkinson dementia
- Dementia related to space occupying lesion
- Other (Ca metabolism disorders, syphilis, Jacop-Creuzfield disorder)

Memory is the first damaged brain function in Alzheimer disorder that means this disorder starts with forgetfulness. Individual don't record the seen or heard information, don't send these information to memory stores and cannot remember the information when needed. As it understand here, Alzheimer spreads to entorhinal cortex and hypo campus and in 10 to 15 years spread to other parts of brain. Patient start to ask same questions again and again who before remembers the names and subjects. Patients remember the past very well but cannot remember the previous days. Some patients talk about different topics and feel the gaps even they not remember anything. This situation is called as confabulation and can be misleading for the clinician. With the spreading of disorder may cause dysfunctions of brain skills like speaking, naming the objects, reasoning about events, organization of future and doings, comparing what is real and what is not (Coffey, 2000; Coopeland, 2002).

It is important to questioning the areas below in evaluation of the patient.

1. Forgetfulness
2. Memory loss that affects the daily life activities
3. Losing the skills obtained before
4. Communication
5. Orientation disorders
6. Difficulties in reasoning
7. Difficulties in abstract thinking
8. Rich psychiatric symptoms

### 1.2.3 ANXIETY DISORDERS

It is rare to start primary anxiety disorders in old age except of agoraphobia. Generally, patients who get aged in clinical environment, long time anxiety disorders can be seen, sometimes severity may increase. If it occurs first time in old ages co morbidity should be think; like depression, dementia or new physical illness (Flint,2004). There are no different standards in phobias for young people or old ages. Agoraphobia can be seen as fear of falling, physical inabilities, which were tired to hide, can cause socially back off in old ages. There are no

different diagnosis criteria for generalized anxiety disorder but it is seen that old aged people tend to show more bodily symptoms of anxiety (Flint, 2004; Carmin et al., 1999).

For panic disorder the range is below than 0.5% for old people. Also it is rare to start primarily in old ages but if it starts the diagnosis criteria is not different from young people. It is generally seen together with other illnesses especially heart and lung diseases.

Also in obsessive compulsive disorder diagnosis criteria of young people is accepted. 5% of the old people who come to clinics take obsessive compulsive disorder diagnosis and their disorder continues for a long time. Most common obsessions in old ages are; transmission, suspicion, harm to others. In diagnosis clinician should be careful because old people with obsessive compulsive disorder should mix their suspicion obsession with control compulsion and come to clinics with forgetfulness complaint, in differential diagnosis clinician should be careful. Depression is also common co morbid (Flint, 2004; Leroux et al., 2005).

Post traumatic stress disorder is not related with age, it is related with experience so it can be in every age. There is no information about the frequency in old ages but it is seen that 20% of people who survive from world war II, took their symptoms to 70 years old and older.

### 1.2.4 SLEEPING DISORDER IN GERIATRIC

Sleeping disorders are the frequently seen problems in old aged population. Insomnia can be primary and secondary caused. It is cited that 40% of 65 years old and older individuals have problems related to sleeping, 12% to 25% of them have continuous insomnia (Ford, Kamerow, 1989; Melinger, Balter, 1985). Sleeping disorders seen in old age are;

#### 1.2.4.1 Night Respiratory Disorder

Sleep apnea is a disorder that causes hypoxemia caused by 10 second or more hesitation in respiratory in sleep, frequent sleeping, day sleeping and dysfunctions. This situation affects the 4% of the adult population in different levels. Division in sleep may cause accidents, memorial losses and confusions. Snore can be seen more than 50% of adult men's sleep and 30% of women's and cause divisions in sleep (Ford, 1999; Prinz et al., 1990).

#### 1.2.4.2 Rem Sleep Behavior Disorder (Parasomnia)

Extreme motor activities in sleep are characterized as injuries in patients' and spouses' life. Patient may talk, scream, get out of bed, fall or move by the effects of dreams. In general

population there are findings that this problem is seen as 0.4- 0.5%. It is seen more in old aged peoples and men. Etiology and paraphysiology is not understand yet (Schenk, 1986).

#### 1.2.4.3 Movement Disorders

Restless leg syndrome may be seen as 5% in late ages. It is more frequent in women. There are studies that shows there are relation with iron deficiency.

## 1.3 LIFE SATISFACTION

Life satisfaction is the state or result after comparing what the person want and what they have. Life satisfaction shows the results after person wishes-expectations and reality of life. Life satisfaction also expresses well being of person by different aspects as happiness, mood etc. (Özer, 2003). The concept of life satisfaction first put forward by Neugarten (1961). Satisfaction is meeting expectations, needs, claims and wishes. On the other hand, it is described as organism meets the basic biological needs like hunger, thirst, sex and psychological needs like curiosity, love, intimacy, success and having a balance between them (Neugarten,1961).

Life satisfaction is the general attitude to states or results between wishes (what people want) and reality (what they have), well-being by happiness, mood, having more positive emotions than negative ones and satisfaction from life (Neugarten et al., 1961).

Important thing in old age is not feeling useless. It seen as an important obstacle to have life satisfaction if old age people are feeling worthless lost functioning, and feeling powerless. Person who work and produce little time after the retirement may feel in self in emptiness and may feel dysfunctional (Seviğ et al., 1992). It is important to not feel useless in old ages. Person may join activities which give happiness or enjoyment to overcome this feeling of useless because joining to free time activities is an important factor to deal with problems caused by old age changes (Allison and Smith, 1990).

Well being is one of the important determinants of health, and it creates a part of the subjective well being and life satisfaction. Factors that affect life satisfaction are; age, sex, work conditions, education level, religion, ethnicity, income, marriage and family life and free time activities (Karataş, 1988).

### 1.3.1 Life Satisfaction of Old Aged People

There are 5 criterions for life satisfaction of old aged people described by Neugarten. By these criterions old aged people whose life satisfaction is high supposed to have;

1-Get pleasure by daily activities,

2- Have a meaning of life, have purposes in life and accept the responsibility of past life,

3-Have the faith that arranged the predicted purposes,

4- Have a positive 'self' image and accept self as valuable even in which age,

5- Have a optimistic attitude to life.

Old aged people give up and don't do business and occupation because they think they have no power (Nahcivan et al., 1999). Never thinking being useless is the important factor in old aging. The best thing to get rid of this feeling of useless is deal with activities which gives happiness. Feeling worthless, useless and powerless is the important obstacle to have life satisfaction for old aged people. People who work and create may feel useless after retirement. They start to think that they enter a stage, in which they should start to commemorate their past life experiences. This situation normally affects the life satisfaction in a negative way (Kubilay, 1994).

**1.4 TRAUMA**

Trauma is the sudden, unpredicted situations that may cause spotted stress levels which can be seen from other people in individuals' life which cannot be seen in normal life time like having a threatening for life or body integrity for own self or family, witnessing a serious injury or death of other people or sudden damage to house or to the society that the individual is living in (DSM-IV-TR, 2005).

Trauma leads people to a situation that people don't know what to do, because of extreme fear and horror, by the influencing effect of trauma. Effects of those unexpected situations can be described as trauma. Sudden events are also factors that affect dealing techniques. In a life there may be lots of situations that may cause distress or sorrow but not all those situations cause trauma. If the situation causes a deep pain, sorrow, fear, horror or despair, or if the person has a concern of death or a relatives' death, it can be named as psychological trauma. Trauma types that cause psychological traumas are; psychological traumas that may cause by social traumas (wars, rape, accidents, attacks, disasters), human made traumas (war, torture, rape), accidents (work, traffic), sudden deaths or having a diagnosis of a serious illness (Herbert, 2007).

After a psychological trauma, post traumatic stress disorder and other psychiatric disorders may be seen. Depression and anxiety are some of them. Developing a post traumatic stress disorder is effected by factors that change the severity of the stressor and by the predisposition of the

person. Personal factors may not have effects on a severe trauma but may have effects on a nominal trauma. Minority of social support, introverts, and psychiatric problems lived before, special meaning of the situation for the person, guilty emotions, living emotions, feeling desperate, sudden stressors, traumatic events lived in childhood, and predisposition of people may increase the effects of this stress disorder (Breslau, 1996).

Severity of trauma, pre-experienced trauma and predisposition of trauma may increase the psychological problem; it may also trigger other psychological problems to come up. It is specified that people who experienced trauma in their early lives, if the trauma re-experienced, the trauma may affect people more than people who did not experienced trauma in their early life (Zelst et al., 2003; Mollica et al., 2007).

### 1.4.1 POST TRAUMA RELATED DISORDERS

#### 1.4.1.1 Post Traumatic Stress

Post Traumatic Stress Disorder is disorder which is consist of a group of symptoms which are lasts longer than predicted, that may cause huge stress in individual after experiencing an unusual physical or emotional trauma, this fear, horror or despair is the main cause of the stress; re-experiencing the situation again and again, slowdown in responses, loss of interest for external world, increased physical activity, having different levels of autonomic, dysphoric and cognitive symptoms (APA, 1994).

It is possible to specify the symptoms that help to diagnosis are extreme arousal, re thinking about the thoughts and feelings that cause despair, extreme anxiety about remembering the trauma by related symbols most important item of developing this disorder can be experiencing a traumatic event as well nature of the trauma, severity of the trauma and experiencing type, by this way possible personal predisposition to trauma may affect person after the trauma (Bowman L.M., 1999).

Post traumatic stress symptoms are not limited to persons who experience the trauma. Witnessing a trauma, listening to the details of a trauma or just hearing news about the situation may create anxiety for others (Erikson et al., 2001).

#### 1.4.1.2 Post Traumatic Stress Symptoms

As mentioned before; post traumatic stress symptoms can be seen as three basic groups as having bad times about not showing the emotions by avoiding all of the memories about trauma, divergence from the actions that give pleasure before the trauma, and as not having pleasure (Emmelkamp, Bouman and Scholing, 1995).

All the Post Traumatic Stress Symptoms according to DSM-IV is listed below (DSM-IV-TR, 2005).

Diagnostic criteria of Post Traumatic Stress Disorder according to DSM-IV (APA, 1994):

A. The person has been exposed to a traumatic event in which both of the following were present:

1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

2. The person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions.

2. Recurrent distressing dreams of the event.

3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience; illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). In this situation importance is at feeling that the trauma is experiencing again and again.

4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5. Physiological reactivity on exposure to internal or external cues that is described in 4th sentence that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma

3. Inability to recall an important aspect of the trauma

4. Markedly diminished interest or participation in significant activities.

5. Feeling of detachment or estrangement from others or social life.

6. Restricted range of affect.

7. Sense of a foreshortened future. In this sentence it can be seen that there are beliefs about life style cannot be same as before the trauma, cannot have positive course during the work and private life.

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1. Difficulty falling or staying asleep

2. Irritability or outbursts of anger

3. Difficulty concentrating on any thoughts of subjects

4. Hyper vigilance

5. Exaggerated startle response (as seen as a react)

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

#### 1.4.1.3 Cognitive and Information Processing Model

After a severe stress, individual information processing system may be broken and this makes individual impossible to assimilate their life. Experiences which are not integrated may easily alerted and may fix to life (intrusion). Painful experiences may not be suppressed or exclude. In experiences which were recorded with anxiety and fear; stimulants which stimulate one of the emotions or thoughts may actuate all of these. This general hyper arousal and disorganized record behind it evaluated as the resource of hyper arousal in post traumatic stress disorder, memory disorders and impulsivity.

#### 1.4.1.4 Behavioral Theory

Trauma creates a chaos in individuals' life that experiences it. This unprepared and unconditioned situation leads to changes after that. Individual start to think that experienced this trauma before by the life experiences before the trauma. They start to give the same reactions to past situations but these behaviors are not suitable to new situation and the reactions start to be complicated. This chaos increases the anxiety. To get a post traumatic stress disorder diagnosis, other objective/empirical ways is not related to the trauma. Because of that to put a Post traumatic stress disorder diagnosis, psychological and biological factors and etiology, it is important to use a wide perspective and flexible attitude to individual.

#### 1.4.1.5 Adjustment Disorder

In post traumatic stress disorder, the stress level is in a treating level but in adjustment disorders. İt is in a acceptable level. Also in adjustment disorders symptoms of re-experiencing the traumatic situation is not seen.

#### 1.4.1.6 Obsessive Compulsive Disorder

There are unwanted, repeated thoughts but they are not related with traumatic situations. Post traumatic stress disorder can be seen with obsessive compulsive disorder and symptoms can be fixed with each other.

#### 1.4.1.7 Depressive Disorders

In general depressive disorder is the most confused disorder with post traumatic disorder and can be seen together. In post traumatic disorder, the risk of experiencing a depressive attack is found as 69% by Roszell and colleagues (1991) and 68% by Keane and colleagues (1990).

## 1.5 POST TRAUMATIC GROWTH

Traumatic events may cause negative effects like stress, anxiety, depression or post traumatic stress symptoms for people who experienced trauma but as well; major life events or traumatic events have positive effects on coping processes. Studies made with the concept of post traumatic growth have an importance in recent years (Tedeschi and Calhoun, 2004).

According to Tedeshi, Park and Calhoun; post traumatic growth concept means positive changes in cognitive and emotional ways of individuals' life, and having positive effects on behavior (Tedeschi, Park, Calhoun, 1998). In other words, Post traumatic growth symbolize the

growth of psychological functionality, awareness for life and growth of past awareness level after traumatic event (Tedeschi et al., 1998).

Tedeschi, Park and Calhoun (1998), examine the post traumatic growth concept in a three dimension as change in self-perception, change in interpersonal relations and change in life philosophy (Tedeschi et al., 1998).

The first dimension of post traumatic growth change in self-perception, also divides in three elements in itself. The first element can be expressed as renaming self as 'survivor' instead of 'trauma victim' makes individual to have a special statue and power (Tedeschi et al., 1998). Second element is 'self confidence'. Individual who overcome a stressful life event like a trauma, feel self powerful to overcome problems that may arise in future and high self-reliance (Aldwin, Leveson and Spiro, 1994). Last change in individual's self-perception is realizing that how a life is delicate, fragile and valuable after a traumatic situation. This emotion makes person to regulate priorities in life and realizing the value of life and cause positive changes in interpersonal relations (Tedeschi et al., 1998).

Second dimension of post traumatic growth is related to interpersonal relations. Several changes may be seen after a trauma in interpersonal relations. This changes in interpersonal relations, is divided into two as opening self and expressing the emotions and transmission of pity/compassion emotions to others. After a trauma individual may represent him/herself easily and express the emotions in an impressive way. After a while individual improves to express the emotions and feelings about the trauma more clearly. A study made with individuals who overcome prostate cancer shows that after the illness they started to open themselves easily to their couples and solve their problems more easily and overcome these problems more easily (Thornton and Perez, 2006).Also as mentioned before the feeling of 'fragility of life' feeling allows people who experienced trauma to help people who are in a bad situation showing compassion and sacrifice to others, improving empathy ability, interpersonal sensitivity and increasing of positive relations (Tedeschi et al., 1998).

Third dimension of post traumatic growth is changing the priorities in life and changes in philosophy of life. The changes in life philosophy is consist of sub-dimensions like, value of life and priorities, theme about existence and looking for meaning, spiritual growth and wisdom (Tedeschi and Calhoun, 1996). After a traumatic experience people start to understand the value of life and can make some changes in priorities. Person may understand to give more time to close relations after a stress or life event. Generally; person start to know value of life and little

happiness in life; start to think that death is inevitable and start to think about life purposes in that dimension, and make priorities to self purposes (Tedeschi et al., 1998). Spiritual growth may cause in religious changes after a trauma that badly results. Also an openness of change in religion is related to post traumatic growth (Tedeschi et al., 1998).

**Post Traumatic Stress Disorder and Post Traumatic Growth**

In our county, studies about post traumatic growth concept have a short history of investigation. It has been studied if couples who lost their children have any post traumatic growth and it has been found that having another child and age has a significant role in this growth (Yıldırım, 2003, as cited in: Durak, 2007).

It has been found in a researches; participants who work as a voluntary in a civil organization after the 1999 Marmara earthquake, their stress level and post traumatic growth is researched, and as a conclusion being a volunteer, having optimistic oriented approach and having a fatalistic approach, has a significantly predictive effect on post traumatic growth (Tanrıdağı, 2005). After a study made with rheumatoid arthritis patients; piety, perceived social support, coping strategies, source loss and arthritis self-sufficiency socio-demographic and illness-related variables have relation with psychological problems (anxiety- depression) and post traumatic growth. In the results of the study it has been found that post traumatic growth and depression have negative relation but post traumatic growth and helpless coping, problem oriented coping and detected social support has positive relation (Dirik, 2006).

In a study post traumatic growth is examined longitudinal with individuals who win against cancer; and post traumatic growth scale is applied to individuals two times, once 3 months after the diagnosis and once after 8 years. With the regression analyses it has been found that having emotional social support after 3 months of diagnosis predicts to experiencing positive results 8 years after the diagnosis (Schroevers, et al., 2010).

## 1.7 RESULT OBJECTIVE

Main goal of this study is investigation of trauma related life satisfaction, depression and post traumatic development of elder people who live in Adana, in different locations. There are two main hypotheses, which are; (a) if there is high level of development after trauma, depression decrease, life satisfaction rise. (b) If development is low level of after trauma, depression gets higher, life satisfaction will decrease. An elder person who lives in nursing home has high level

of life satisfaction or what are the effects of trauma on life satisfaction. These will investigate in the research in a detailed way.

# METHODS

## 2.1 PARTICIPANTS

Three scales which have validity and reliability of Turkish forms are going to give for 120 people who are living in Adana with family or in nursing home, participants are 65 years old or older and the participants were separated into groups according to their trauma situations and the participants will choose with snowball sampling. Purpose of using standardize mini mental test in this study is, it has importance on validity of the scales used in study. The participants are 57% women and %43 men.

## 2.2 PROCEDURE

In the study, voluntary form was given to participants, the study is described and participants were asked for confirmation. For data collecting, first of all standardize mini mental test were given to identify if there is any brain disturbance. For personal information demographic information form, for depression level geriatric depression scale, for life satisfaction life satisfaction scale and for development after trauma post- traumatic development scale were given. Duration of the questionnaire is approximately fifty minutes.

There are two groups which are; participants who are older than 65 and living with their families and, participants who are older than 65 and living in nurse home. Also these two groups are divided into two as participants who experienced trauma and participants who did not experienced trauma. In the study there are participants who have dementia diagnosis, participants with cognitive problems, mental retardations, participants with Parkinson, degenerative disease, and neurological illness multiple sclerosis were not included. Data were analyzed by SPSS.

## 2.3 INSTRUMENT FOR COLLECTİNG DATA

In the study, voluntary form was given to participants, the study is described and participants were asked for confirmation. For data collecting, first of all standardize mini mental test were given to identify if there is any brain disturbance. For personal information demographic information form, for depression level geriatric depression scale, for life satisfaction life satisfaction scale and for development after trauma post- traumatic development scale were given. Duration of the questionnaire is approximately fifty minutes.

### 2.3.1 FORM OF VOLUNTARINESS

In the voluntary form, the study and the purpose of the study is described to participant. After that desired information were reported to participants and also voluntariness and privacy is informed for the participants.

### 2.3.2. STANDARDİZE MINI MENTAL TEST (SMMT)

Standardize Mini Mental Test is improved by Folstein and colleagues (153). Aim of the test is to give information about the cognitive disturbance. In Turkish validity and reliability of this test for trained people is made by Güngen and colleagues (154) and for untrained people by Ertan and colleagues (155). It has 30 questions and the cut point is 23-24. At the top left part name, surname, age, sex, occupation questions, at the top right part date, active used hand, education level and time and total point is written.

In SMMT there are orientation, recording memory, attention and calculation, recall and language parts.

In orientation part, the current year, city, district, building and the floor is asked. This part has 10 questions and it has 10 points. In recording part, 3 words (table, flag, and dress) are asked for the participant for repeat. Participant has 20 seconds and each true word worth for 1 point. In this section there are 3 points. Words will be repeated for maximum 5 times for learning in the condition of wrong or missing answers. In attention and calculation section, participant is asked for calculate from 100 to 0 by subtracting 7 each time (100, 93, 86, 79, 72, 65). Each true subtraction will get 1 point (total 5 point). For the untutored participants, it is asked to tell the days of a week in a reverse way (Sunday, Saturday, Friday, Thursday, Wednesday, Tuesday and Monday). Each true answer will get 1 point from 5 total points. In recall part, participant is asked for remembering the 3 words used in recording section. Each true answer will get one point from 3 total points. Language section is divided into 6 subjects. Shown two objects (watch, pen) are asked for participant to name them. In 20 seconds, the two correct answers will get two points. ‘’ If and but don’t want’’ is asked for the participant to repeat. If it is repeated correctly in 10 seconds participant will get 1 point. After that; participant is asked for doing what said. ‘’ please take the paper on the table with your left/right (non-dominant) hand, fold it into two with both hands and leave the paper on the floor.’’ And 30 seconds will give for the participant. Each correct operation will get 1 point from 3 total points.

On a paper ‘’ close your eyes’’ is written with big fonts and easily readable way. Participant is asked for reading and doing for what the paper says. For the untutored participants, look at my face and do what I do is said. If it is done truly participant will get 1 point. A pen and a paper is given for participant and is asked for writing a significant sentence. A true sentence (which has subject, object and verb) will get 1 point if it is written in 30 seconds. Untutored participants are asked for telling something about their house. A true sentence in 30 seconds will get 1 point.

Paper, pencil, rubber is given and the participants is asked for copy the image of two nested pentagon. Untutored participants are asked for copy two nested square. In a minute if the corner number is correct one point is given.

### 2.3.3 DEMOGRAFIC INFORMATION FORM

After the standardize Mini Mental Test, demographic information, which is important for the study is collected from the participants. It is a form that formed by researcher for the participants who are living with their families and participants who are living in nursing home. The form that is designed for obtaining the personal information about elder people is determined to look health and social status and relation between other people. At the top of the form subject of the study, number of survey and date is located. For the name and surname of the participant nickname is used. Date of birth is recorded. Sex is checked as female or male. Marital status is asked by ‘married’, ‘single’, ‘widow’ or ‘separated’. Having a child status is asked by yes or no question. Participants also answered the question ‘who you are living with?’ with family, alone, nursing home or other. Education status is answered by ‘literate’, ‘primary school’, ‘middle school’, ‘high school’, ‘university’. It is also asked if the participant has any social security or monthly income. This form also helped for looking any experienced trauma.

### 2.3.4 GERIATRIC DEPRESSION INVENTORY

Geriatric Depression Scale is designed by Yesavage and colleagues (156) to look for geriatric depression. It is consistent of 30 questions and has a shortened version as 15 questions. 5 question in the scale is fictionalized as positive (1, 5, 7, 11, 13) and others are negative. In the evaluation of the scale every positive question is equalized with ‘no’ and every negative question equalized with ‘yes’ gets a 1 point. Getting 6 point or more is accepted as significant for depression symptoms. Turkish reliability and validity is made by Ertan and colleagues (144) (test- re-test consistency r= 0,77; internal consistency a=0,92). At the top of the form name, surname, age, sex and survey date is recorded.

### 2.3.5. LIFE SATISFACTION INVENTORY

Life Satisfaction Scale developed by Neugarten to determine the life satisfaction of individuals and adapted to Turkish by Köker in 1991. In this scale there are 5 sentence which are 1- having fun from daily life activities, 2- living a meaningful life, having purposes about life and accepting the responsibility of past life 3- having a faith about reaching to predicted purposes 4- having a positive 'self' image and seeing self as a valuable being even having weakness due to senile 5- having a optimistic attitude about life (Neugarten et al., 1961). For each sentence there are 7 options Likert type which goes from 'it is not suitable' to 'it is very suitable'.

According to Neugarten Life Satisfaction Scale, 7 point and below means low life satisfaction, 8 to 12 points means middle life satisfaction and 13 and more points mean high life satisfaction.

### 2.3.6 POST TRAUMATIC GROWTH INVENTORY

Post traumatic Growth Inventory is used for measuring positive transformations of individuals who experienced trauma after experiencing the trauma. This inventory is designed by Tedeschi and Calhoun in 1996; it has 21 sentences with six Likert type option which goes from 'I did not experience this difference.' To 'I experienced this difference a lot.' This scale has a range between 0- 105. Having a high point from the scale, shows that the individual has highly growth after the traumatic experience (Tedeschi and Calhoun, 1996).

In the original scale made by Tedeschi and Calhoun in 1996, internal consistency is between $\alpha$=.67 and $\alpha$=.85. In the test- re-test study correlation coefficient is 0.71. This scale has positive correlation with optimism, religious participation, extraversion, openness to experience, compatibility and conscience subscales. In the factor analyses there are 5 sub-dimensions; positive interpersonal relations, change in self-perception, understanding the value of life, realizing the new opportunities, and growth in faith system (Tedeschi and Calhoun, 1996). This scale is adapted to Turkish by Dürü in 2006. For the reliability of Post traumatic growth scale Cronbach Alpha method is used. Internal consistency coefficient is $\alpha$=.93. Correlation of Post Traumatic Growth Scale has respectively .23, .26, .21 with Post Traumatic Dissociative Life Scale, Impact of Event Scale and Post Traumatic Symptom Checklist sub-scale. Construct validity of this scale is looked by factor analysis. In the various solutions, optimal 5 factor solutions, 15 of 21, changed in original scale. This 5 factor solution explains 67.84% of variance (Dürü, 2006). Turkish form of Post Traumatic Growth Scale's internal consistency is found as $\alpha$= .93 (N=349) by Dürü (Dürü, 2006).

## RESULTS

In this study, the ralatiom between depression, life satısfaction and post traumatic growth was researched, by comapring results with those of socio-demografic information. İn accordance with that purpose, T-Test, Chi-Square, Anova and correlation were conducted by reporting the results of the statistical analyses.

### 3.1 STATİSTİCAL ANALYSIS OF SOCİODEMOGRAFIC DATA COMPARED BETWEEN PARTICIPANT

In thıs analyses comparing the answer the guestions in Demografic İnfotmation Form was aimed. The analysıs carried out by evaluating the data of experiencing trauma, experiencing loss, experiencing chronic illness, experiencing seriosus illness, family type, gender, job, marital status, living place, which were asked in the form of the participant.

**Table 1. The comparison of experiences trauma and not experiences trauma between living with who**

| | Experiences trauma N(%) | Nor experiences trauma N(%) | Total n(%) | $X^2$ (P) |
|---|---|---|---|---|
| Elderly leaving with family | 47(39.0) | 17(13.0) | 64(52.0) | 7.876[a] 0,049** |
| Alone | 10(8.2) | 7(5.7) | 17(13.9) | |
| Nursing Home | 34(28.0) | 10(3.3) | 44(31.1) | |
| Another | 3(2.5) | 0(0.0) | 3(2.5) | |
| Total | 94 122.0 | 28 122.0 | 122 100.0 | |

*p≤0.05 ** p<0.001

When experience traumatized and not experienced traumatized compared with chi-square analysis, elderly leaving with family was found have significantly higher experiences trauma.

**Table 2. The comparison of experiences trauma end not experiences trauma between gender**

| | Experiences trauma n(%) | Not experiences trauma n(%) | Total n(%) | $X^2$ (P) |
|---|---|---|---|---|
| Female | 55(46.0) | 14(11.5) | 69(57.0) | |
| Male | 39(32.0) | 14(11.5) | 53(43.4) | ,636[a] |
| Total | 94(77.0) | 28(23.0) | 122(100.0) | ,516 |

*****p≤0.05 ****** p<0.001

When the gender of experiences trauma and not experiences trauma compared with chi square analysis, no significant difference was found.

**Table 3. The comparision of experiences serious illness and not experiences serious illness between living with who**

| | Experience Serious illness n(%) | Not experience serious illness n(%) | Total n(%) | $X^2$ (P) |
|---|---|---|---|---|
| Live With Family | 28(23.0) | 36(30.0) | 64(53.0) | 7,690[a] |
| Alone | 9(7.0) | 8(6.0) | 17(13.0) | 0,042****** |
| Nursing Home | 24(20.0) | 14(11.0) | 38(31.0) | |
| Another | 0(0.0) | 3(2.5) | 3(2.5) | |
| Total | 61(50.0) | 61(50.0) | 122(100.0) | |

*****p≤0.05 ****** p<0.001

When the partipicant of experiences trauma and not experiences trauma compared with chi square analysis, living with family group was found to have significantly higher experience serious illness.

**Table 4. The comparison of experiences loss and not experiences loss between gender**

| | Experiences loss n(%) | Not experiences loss n(%) | Total n(%) | $X^2$ (P) |
|---|---|---|---|---|
| Female | 48(40.0) | 21(17.0) | 69(57.0) | 8,438[a] |
| Male | 23(19.0) | 30(20.0) | 53(39.0) | 0,005**** |
| Total | 71(58.0) | 51(42.0) | 122(100.0) | |

***** $p \leq 0.05$ ****** $p < 0.001$

When the gender of experiences loss and not experiences loss compared with chi square analysis, female group was found to have significantly higher experience loss.

**Table 5. The comparison of living with who between education status**

| | Live with family n(%) | Alone n(%) | Nursing home n(%) | Another n(%) | Total n(%) | $X^2$ (P) |
|---|---|---|---|---|---|---|
| Literate | 7(6.0) | 2(2.0) | 6(5.0) | 0(0.0) | 15(13.0) | 34,868[2] |
| Primary school | 28(23) | 3(2.0) | 16(13.0) | 1(1.0) | 48(39.0) | 0,002** |
| Middle School | 11(9.0) | 5(4.0) | 2(2.0) | 0(0.0) | 18(15.0) | |
| High school | 7(6.0) | 4(3.0) | 2(2.0) | 2(2.0) | 15(13.0) | |
| University | 11(9.0) | 1(1.0) | 4(3.0) | 0(0.0) | 16(13.0) | |
| Have Received Training | 0(0.0) | 2(2.0) | 8(7.0) | 0(0.0) | 10(9.0) | |
| Total | 64(52.0) | 17(14.0) | 38(31.0) | 3(2.0) | 122(100.0) | |

***** $p \leq 0.05$ ****** $p < 0.001$

When the educational status of participant compared with chi square analysis, living with family group was found to have significantly higher educational status.

**Table 6. The comparison of experiences trauma and not experiences trauma between job**

| | Experiences trauma n(%) | Not experiences trauma n(%) | Total | $X^2$ (P) |
|---|---|---|---|---|
| Unemployed | 6(5.0) | 3(2.0) | 9(7.0) | 6,374[a] ,173 |
| Housewife | 45(37.0) | 13(11.0) | 58(48.0) | |
| Retired | 36(30.0) | 7(6.0) | 43(36.0) | |
| Farmer | 2(2.0) | 0(0.0) | 2(2.0) | |
| Self-employment | 5(4.0) | 5(4.0) | 10(8.0) | |
| Total | 94(77.0) | 28(23.0) | 122(100.0) | |

*****p≤0.05 ****** p<0.001

When the job and trauma experiences compared with chi-square analysis, house wife and retired group was found to have significantly higher experiences trauma.

**Table 7. The comparison of experiences divorced and not experiences divorced between gender**

| | Experience Divorced n(%) | Not experience Divorced n(%) | Total n(%) | $X^2$ (P |
|---|---|---|---|---|
| Female | 7(6.0) | 62(51.0) | 69(57.0) | 4,143[a] ,102 |
| Male | 11(9.0) | 41(34.0) | 53(43.0) | |
| Total | (18.0) | 103(85.0) | 122(100.0) | |

*****p≤0.05 ****** p<0.001

When the partipicant of experiences divorced and not experiences divorced compared with chi square analysis, there wasn't found to have no significantly experience divorce.

**Table 8. The comparison of have a chıldren and not having chıldren between living with who**

| | Have a chıldren n(%) | Haven't got a chıldren n(%) | Total n(%) | $X^2$ (P) |
|---|---|---|---|---|
| With family | 59(49.0) | 5(4.0) | 64(53.0) | 24,392[a] |
| Alone | 11(9.0) | 6(5.0) | 17(14.0) | 0,000** |
| Nursing home | 33(27.0) | 5(4.0) | 38(31.0) | |
| Another | 0(0.0) | 3(2.0) | 0(0.0) | |
| Total | 103(84.0) | 19(16.0) | 122(100.0) | |

*****p≤0.05 ****** p<0.001

When the partipicant of have a chıldren and not have a chıldren compared with chi square analysis, living with family group was found to have significantly higher have a chıldren.

**Table 9. The comparison of family type between living with who**

| | Extended family n(%) | Nuclear family n(%) | Total n(%) | $X^2$ (P) |
|---|---|---|---|---|
| With family | 35(29.0) | 29(24.0) | 64(53.0) | 10,523[a] |
| Alone | 8(7.0) | 9(7.0) | 17(14.0) | 0,008** |
| Nursing home | 29(24.0) | 9(7.0) | 38(31.0) | |
| Another | 0(0.0) | 3(3.0) | 0(3.0) | |
| Total | 72(59.0) | 50(41.0) | 122(100.0) | |

*****p≤0.05 ****** p<0.001

When the family type is compared with living with who, compared chi-square analyse living with family group was found to have significantly higher extended family.

**Table 10. The comparison of gender between living with who**

| | Living with family N(%) | Alone N(% | Nursing homen(%) | Another (%) | $X^2$ (P) |
|---|---|---|---|---|---|
| Female | 32(50.0) | 9(53.0) | 26(68.0) | 2(67.0) | 5,612 |
| Male | 32(50.0) | 8(47.0) | 12(32.0) | 1(33.0) | 0,48** |
| Total | 64(100.0) | 7(100.0) | 38(100.0) | 3(100.0) | |

*p≤0.05 ** p<0.001

When the partipicant of gender compared with chi square analysis, living with family group was found to have significantly higher than the others

## 3.2 The Compared Statistical Analyses Of The Scales Which Were Given To The Participant Demografic-information

Post Traumatic Growth Qoustionaire, Geriatric Depression Inventory, Life Satıcfactıon Inventory which were given to the subjects have been compared. Following subscales were compared among the participant.

**Table 11. The comparison of participant's mean score of GDI according to experience loss and not experience loss.**

| | N(%) | m±sd | T(p) |
|---|---|---|---|
| Experiences loss | 71 | 3,52±,283 | 11,483 |
| Not experiences loss | 51 | 1,43±,093 | 0,027** |

*p≤0.05 ** p<0.001

İn the present study the mean score of geriatric depression inventory according to experience loss compared by independent sample t test it was found that there was statistically significant differences between the mean score of experiences loss and depression.

**Table 12. The comparison of participant's mean score of PTGI according to experience life events and not experience life events.**

| | N(%) | m±sd | T(p) |
|---|---|---|---|
| Experiences trauma | 94 | 2,54 ±2,50 | -11,398 |
| Not experiences trauma | 28 | 1,54± ,291 | 0,036** |

*****p≤0.05 ****** p<0.001

İn the present study the mean score of geriatric depression inventory compared according to experiences life events by independent sample t test, it was found that there was no statistically significant differences between the mean score experience trauma and depression.

**Table. 13 The comparison of participant's mean score of GDI according to experience divorce and not experience divorce**.

| | N(%) | m±sd | T(p) |
|---|---|---|---|
| Experiences divorce | 18 | 16,28±1,85 | -10.446 |
| Not experiences divorce | 103 | 12,64 ±1,67 | 0,002***** |

*****p≤0.05 ****** p<0.001

İn the present study the mean score of geriatric depression inventory compared according to experiences divorce by independent sample t test. İt was found that there was statistically significant differences between the mean score of depression subscale and groups.

The participant whose divorced had higher depression mean score than the not experience divorce group.

**Table. 14 The comparison of participant's mean score of GDI according to experience illness and not experience illness**

| | N(%) | m±sd | T(p) |
|---|---|---|---|
| Experiences serious illness | 60 | 8,53±2,77 | -7,625<br>0,037** |
| Not experiences serious illness | 61 | 4,55±,126 | |

*p≤0.05 ** p<0.001

İn the present study the mean score of geriatric depression inventory compared according to experiences serious illness by independent sample t test. İt was found that there was statistically significant differences between the mean score of depression subscale and groups.

The participant whose not experience serious illness had higher depression mean score than the not experience serious illness group.

**Table.15 The comparison of participant's mean score of PTGI according to extended family and nuclear family.**

| | N(%) | m±sd | T(P) |
|---|---|---|---|
| Extended family | 71 | 12,91±1,60 | 12,115 |
| Nuclear family | 49 | 9,72±0,57 | 0,047** |

*p≤0.05 ** p<0.001

İn the present study, the mean score of post traumatic growth inventory compared according to family type groups by independent sample t-test. İt was found tha tthere was statically significant differences between the mean score of post traumatic growth scale and family type.

The participant whose in The extended family group had higher post traumatic growth mean score than the nuclear family.

**Table.16 The comparison of participant's mean score of LSI according to experience loss and not experience loss**

| | N(%) | m±sd | T(P) |
|---|---|---|---|
| Experience Loss | 71 | 1,83±2,63 | 7,007 |
| Not Experience Loss | 51 | 2,40±4,80 | 0,024** |

*****p≤0.05 ****** p<0.001

İn thepresent study, the mean score of life satisfaction inventory compared according to experience loss groups by independent sample t-test. İt was found that there was statically significant differences the mean score of life satisfaction inventory according to experience loss. The participant whose in not experiences loss group had higher life satisfaction mean score than the experince loss.

**Table. 17 The comparison of participant's mean score of PTGI according to experience trauma and not experience trauma**

| | N(%) | m±sd | T(p) |
|---|---|---|---|
| Experiences trauma | 94 | 13,30±1,90 | 7,104 |
| Not experiences trauma | 28 | 11,13±0,21 | 0,000** |

*****p≤0.05 ****** p<0.001

İn the present study, the mean score of post traumatic growth inventory compared according to family type groups by independent sample t-test. İt was found that there was statically significant differences between the mean score of post traumatic growth scale and experiences trauma. The participant whose in experiences trauma group had higher post traumatic growth mean score than the not experinces trauma.

**Table. 18 The comparison of participant's mean score of PTGI according to experience loss and not experience loss**

| | N(%) | m±sd | T(p) |
|---|---|---|---|
| Experiences loss | 71 | 12,07±1,40 | 5,329 |
| Not experiences loss | 51 | 13,40±1,91 | 0,022** |

*p≤0.05 ** p<0.001

İn the present study, the mean score of post traumatic growth compared according to experiences loss groups by independent sample t-test. İt was found that there was statically significant differences between the mean score of post traumatic growth scale and experiences loss group.

The participant whose in not experiences loss group had higher post traumatic growth mean score than the experiences loss.

**Table. 19 The comparison of participant's mean score of PTGI according to gender**

| | N(%) | m±sd | T(p) |
|---|---|---|---|
| Female | 68 | 18,68±6,07 | 7,148 |
| Male | 53 | 13,98±2,62 | 0,008** |

*p≤0.05 ** p<0.001

İn the present study, the participant's mean score of post traumatic growth inventory compared according to gender groups y independent sample T-test. İt was found that there was statically significant differences between the mean score of post traumatic growth scale and gender.

The participant whose in female group had higher post traumatic growth mean score than the male group.

**Table. 20 The comparison of participant's mean score of LSI according to gender.**

| | N(%) | m±sd | T(p) |
|---|---|---|---|
| Female | 69 | 6,44±2,53 | 5,952 |
| Male | 53 | 8,53±4,40 | 0,004** |

*p≤0.05 ** p<0.001

İn the present study, the mean score of life satisfaction inventory compared according to gender groups was by independent sample t-test. İt was found that there was statically significant differences between the meanscore of life satisfaction scale and gender.

The participant whose in male group had higher life satisfaction mean score than the female.

**Table. 21 The comparison of participant's mean score of LSI according to family type**

| | N(%) | m±sd | T(p) |
|---|---|---|---|
| Extended family | 71 | 14,90±3,41 | 9,654 |
| Nuclear family | 49 | 13,1±2,7 | 0,000** |

*p≤0.05 ** p<0.001

İn the present study, the mean score of life satisfaction inventory compared according to family type groups by independent sample T-test. İt was found that there was statically significant differences betweenthemeanscore of life satisfaction scale and family type.

The participant whose in The extended family group had higher life satisfaction mean score than the nuclear family.

**Table.22 The comparison of mean of post traumatic growth between having chıldren groups**

| | N(%) | m±sd | T(p) |
|---|---|---|---|
| Having chıldren | 102 | 3,62±1,5 | 8,159 |
| Not having chıldren | 19 | 2,83±1,3 | 0,041** |

*p≤0.05 ** p<0.001

İn the present study, the mean score of post traumatic growth scale and having chıldren groups compared by independent sample T-test. İt was found that there was statically significant differences between the mean score of life satisfaction scale and havingchıldren.

The participant whose in having chıldren group had higher life satisfaction mean score than the not having chıldren.

**Table. 23 The comparison of participants mean score of GDI according to gender**

| | N(%) | m±sd | T(p) |
|---|---|---|---|
| Female | 69 | 22,60±4,60 | -13,054 |
| Male | 53 | 5,84±1,65 | 0,02** |

*p≤0.05 ** p<0.001

İn the present study, the mean score of depression scale and gender groups compared by independent sample t-test. İt was found tha there was statically significant differences between the mean score of depression scale and gender.

The participant whose in female group had higher depression mean score than the male groups.

**Table. 24 The comparison of participants mean score of GDI according to education level**

| | m±sd | F(p) |
|---|---|---|
| Litarete | 3,50±0,09 | 5,223 |
| Primary School | 4,52±,0,55 | 0,000***** |
| Middle school | 7,60±,1,68 | |
| High school | 10,60±,2,37 | |
| Universty | 11,65±,3,81 | |
| Have received training | 4,40±,147 | |
| Total | 42,27±8,64 | |

*****p≤0.05 ****** p<0.001

İn the present study the mean participant mean score of GDI compared according to educational level, by using one way anova. İt was found that, there was statistically significant differences between the mean score of experiences loss and GDI.

There is statistical differences at the advancebetween high school and have received training to(p=0,000). Universty totaly point is higher than have received training.

**Table. 25 The comparison of participant's mean score of GDI according to marital status**

| | m±sd | F(p) |
|---|---|---|
| Married | 9,60±3,47 | 6,591 |
| Widowed | 8,50±2,43 | 0,047****** |
| Single | 8,54±3,30 | |
| Divorced | 12,54±3,51 | |
| Total | 59,32±16,05 | |

*****p≤0.05 ****** p<0.001

İn the present study the paticipant's mean score of GDI compared according to marital status by using one- way anova. Finally it was found that, there was statistically significant differences between the mean score of marital status and depression(0,047**)**. The mean scores of divorced and widowed participant higher than married.

**Table. 26 The comparison of participant's mean score of GDI according to living with who**

| | m±sd | F(p) |
|---|---|---|
| Live with family | 11,84±1,57 | 3,350 |
| Alone | 11,24±1,10 | 0,024** |
| Nursing home | 12,52±1,91 | |
| Another | 11,01±,153 | |
| Total | 46,61±159,63 | |

*****p≤0.05 ****** p<0.001

İn the present study the participant's mean score of GDI compared according to living with who using by one- way anova. Finally it was found that there was statistically significant differences between the mean score of living with who and depression.

The mean scores of nursing home participant's point is higher than living with family(p=0,024).

**Table. 27 The comparison of participant's mean of GDI according to job**

| | m±sd | F(p) |
|---|---|---|
| Unemployement | 9,54±,096 | 6,659 |
| Housewife | 12,50±2,3 | 0,000** |
| Retired | 10,61±1,13 | |
| Farmer | 11,11±2,1 | |
| Self-Employement | 8,11±,021 | |
| Total | 43,76±6,49 | |

*****p≤0.05 ****** p<0.001

İn the present study the participant's mean score of GDI compared according to job by by one-way anova. İt was found that there was statistically significant differences between the mean score of farmer and house wife (p=0,000). The mean scores of housewife participant's higher than the farmer.

**Table. 28 The comparison of participant's mean scores of GDI according to the campus type**

| | m±sd | F(p) |
|---|---|---|
| Village | 11,50±1,1 | 3,199 |
| Town | 10,70±,113 | 0,026** |
| City | 12,53±1,3 | |
| Big city | 12,49±1,2 | |
| Total | 47,22±50,93 | |

*****p≤0.05 ****** p<0.001

İn the present study the participan's mean score of GDI compared according to the campus type by using one- way anova. There was statistically significant differences, the mean score of city group total point is higher than the village.

**Table. 29 The comparison of participant's mean score of PTSG according to education status**

| | m±sd | F(P) |
|---|---|---|
| Litarete | 12,90±1,80 | 7,757 |
| Primary school | 12,60±1,71 | 0,023** |
| Middle School | 12,10±1,10 | |
| High School | 10,3±,180 | |
| Universty | 9,60±,143 | |
| Have a Received Training | 12,91±1,90 | |
| Total | 121,3±11,86 | |

*****p≤0.05 ****** p<0.001

İn the present study the mean score of post traumatic growth total point and educational status group compared by one- way anova. There was statistically significant differences the mean score Universty total point is higher than the have a received training.

**Table. 30 The comparison of participan's mean scores of PTSG according to the living with who**

| | m±sd | F(p) |
|---|---|---|
| Live with family | 14,61±2,43 | |
| Alone | 9,80±1,13 | 11,120 |
| Nursing home | 13,1±1,80 | 0,44** |
| Another | 4,23±,577 | |
| Total | 41,74±5,93 | |

*p≤0.05 ** p<0.001

İn the present study the mean score of participant's PTGI compared living with who by using one- way anova. There was statistically significant differences, the mean score of living with family total point is higher than alone.

**Table. 31 The comparison of participant's mean score of LSI between the education status**

| | m±sd | F(p) |
|---|---|---|
| Litarete | 7,50±,143 | 7,264 |
| Primary | 9,70±1,22 | 0,043** |
| Middle school | 10,40±1,30 | |
| High school | 13,60±1,80 | |
| Universty | 13,81±1,91 | |
| Have Received Training | 7,23±,125 | |
| Total | 62.04±68,53 | |

*p≤0.05 ** p<0.001

İn the present study the participant's mean score of LSI compared according to educational status is compared using by one- way anova. There was statistically significant differences, The mean scores of Universty totaly point higher than Have a received Training.

**Table. 32 The comparison of participant's mean scores of LSI according to marital status**

| | m±sd | F(p) |
|---|---|---|
| Married | 12,60±3,46 | 8,591 |
| Widowed | 6,50±1,42 | 0,037** |
| Single | 8,54±2,31 | |
| Divorced | 5,54±,151 | |
| Total | 59,32±16,05 | |

*****p≤0.05 ****** p<0.001

İn the present study the participant's mean score of LSI compared according to marital status using by one- way anova. There was statistically significant differences the mean score of married totaly point is higher than widowed.

**Table. 33 The comparison of participant's mean score of PTSG according to the campus type**

| | m±sd | F(p) |
|---|---|---|
| Village | 3,8±1,20 | 5,829 |
| Town | 3,04±0,49 | 0,041** |
| City | 3,34±1,22 | |
| Big city | 5,50±1,72 | |
| Total | 3,50±1,40 | |

*****p≤0.05 ****** p<0.001

İn the present study the participant's mean score of LSI compared according to campus type is using by one- way anova. There was statistically significant differences, The mean scores of Big city totaly point is higher than Town.

**Table. 34 The comparison of participants' mean score of LSI according to the living with who**

| | m±sd | F(p) |
|---|---|---|
| Live with family | 18,07±7,06 | 4,412<br>0,045** |
| Alone | 8,6±3,2 | |
| Nursing home | 7,05±4,04 | |
| Another | 16,7±,7,1 | |
| Total | 68,49±21,94 | |

*p≤0.05 ** p<0.001

İn the present study the participant's mean score of LSI compared according to living with who is using by one- way anova. There was statistically significant differences, The mean scores of Live with family participant's totaly point is higher than alon.

### 3.3 Results Of Correlations Analyses

**Table 35 Correlation of Depression and Life Satısfactıon**

| | Depression |
|---|---|
| Life satisfaction | R=-0,57<br>P=,039** |

*p≤0.05 ** p<0.001

When the relation between the mean score of depression subscales with life satisfaction is investigated with pearson correlation analysis middle negative correlation is found between life satisfaction and depression.

**Table 35 Correlation of Depression and Posttraumatic growth**

| | Post trumatic growth |
|---|---|
| Depression | R=-0,26<br>P=,047** |

*****p≤0.05 ****** p<0.001

When the relation between the mean score of depression subscales with post traumatic growth is investigated with pearson correlation analysis low negative correlation is found between post traumatic growth and depression.

**Table 36 Correlation of Posttraumatic growth and Life Satisfaction**

| | Post traumatic growth |
|---|---|
| Life satisfaction | R=0,21<br>P=0,36** |

*****p≤0.05 ****** p<0.001

When the relation between the mean score of post traumatic growth subscales with life satisfaction is investigated with pearson analysis low level positive correlation is found between life satisfaction and post traumatic growth.

## DISCUSSION

In this study; which includes post traumatic growth, depression and life satisfaction of 65 years old or elder people who live in different environments, it has been found that people who live with family has significantly lower averages of geriatric depression scale points than people who are living alone and people who are living in nursing homes. Average geriatric depression scale points of elder people who participated in this study is found as Geriatric depression points of elder people is significantly different from each other; in which people who live with their families are 53%, people who are alone are 14% and people who are living in nursing homes are 31%.

People who are living in nursing homes have higher depression rates than normal society; and factors of these higher rates seems as loneliness, not having enough social support, having economical difficulties for living alone and having illnesses which needs maintenance. The difference between the depression frequencies in studies can be caused by properties of the elder groups, purpose of the study and differences between used methods. People who are living in nursing homes and people who are living alone have higher depression rates than people who are living with their families; this situation can cause by different factors, some of them are; medical problems in old ages, illnesses which need maintenance, functional problems, having low life satisfaction, low social support and communication, low education status and income, retirement, losing loved ones. In this study which looks for how do people experienced past life events in which degrees, how do they pass this situation, the process, it has been found that if traumas like divorce from spouse, losing spouse or parent, having a diagnosis of severe health problem and other traumas, have a positive growth, life satisfaction will be higher and depression will be lower. But if the people show negative post traumatic symptoms after a trauma, people will show negative post traumatic growth and will have low life satisfaction and high depression. Depression frequency is found significantly higher for women (57, 0%) than men (43,0%). In several studies it has been found that being a woman is a main risk factor of having depression. In a study of geriatric depression, women have significantly higher depression points than men (Hacıhasanoğlu and Yıldırım, 2009; Ünal, 2000). Women have longer life span than men; because of that women population is more than men population. Women who lost their spouse and who become alone, have to maintain difficult life struggles alone by them. Medical events, socioeconomic and environmental conditions effects more than other stress factors. In a study made with elder people it shows that there is no difference between frequencies of depressive symptoms between genders. Frequency of depression is

found higher for elder people groups than lower age groups. As the person get older losses will increase and more illnesses may appear so depression will seen more severe loss of functions and suicide risks may appear (Karadağ et al., 2008). In a study made with old people it has been found that age is a risk factor for depression (Osborn et al., 2003; Beekman, 2004). On the other hand, in other studies no relation between age and depression is found (Hacıhasanoğlu and Yıldırım, 2009; Üstün et al., 2005).

Marital status is also found as a risk factor for having depression. Lowest depression frequency is found in married old people and highest depression frequency is found for people who lost their spouse. Depression can be seen more for people who are living in nursing homes and who are living alone than people who are living with their families; people who are living alone and people who are living in a nursing home seem as these people may lose their spouse or they may separate from their spouse and this may increase the risk of having depression. In a study of prevalence and risk factors of geriatric depression, being widow or separate found as a risk factor to have more depressive symptoms than married people (Karadağ et al., 2008). Marriage seem as a protector factor against having depression; sharing emotions like happiness, pain or grief with the spouse, braving against negative life events with the spouse, holding thigh to each other and to life will protect people from having depression. On the other hand, in other studies that looks for geriatric depression in nursing homes and risk factors of depression; no relation with marital status and depression is found (Hacıhasanoğlu et al., 2009; Sütoluk et al., 2004).

In a study; a significant relation is found between education levels and incomes with depression for old aged people. Relation between education level and depression is showed in several studies (Karadağ et al., 2008; Koster et al., 2004). Having a low income level is seen a factor of having depression for women. It is believed that education level and income is an important factor to eliminate preventing causes and negative factors of depression, to protect old people from depression and to find new ways to find possible solutions about depression. In some studies; no relation between education level and depression prevalence is found (Üstün et al., 2005; Hacıhasanoğlu et al., 2009). Although no relation between the occupation group and depression is found in this study; after retirement, reduction in productivity and retirement in income will cause increase in depression. In a study about geriatric depression; lowness of income level is seen as a risk factor that will increase the frequency of having depression (Karadağ et al., 2008; Mohd Sidik S et al., 2003). It is believed that having a good education level and high income will decrease the anxiety about health and social problems in old aged people and increase the life satisfaction, so in this situation depression is decreased. In a study

about depression prevalence and risk factors; old aged people who have social support will have lower depression rates than old aged people who do not have social support.

Prevalence of depression symptoms, situations which will cause negative emotions in past life events, having a diagnosis of a severe illness, divorce, leaving a job, losing parent, children or spouse, geriatric depression symptoms and life satisfaction is found related with depression. Losing a loved one and related grief will increase the tendency of depression. Especially in a situation of losing the spouse the depressive symptoms will usually seen. Especially in a time of two years after the loss of spouse depressive symptom properties will seen, after these two years people, who are living in a grief; it is believed that 14% of these people will have major depression. In a grief which shows depressive symptoms; life satisfaction of old age people will be affected and disabilities may seen (Tamam, 2001; Kaya, 1999).

In old aged people who do not see their health in a good situation, having chronic illnesses or having psychological or social problems should not be forgotten. In the study it is found; 75, 7% of old aged people have chronic illnesses. It is found that depression prevalence for old aged people who have chronic illnesses is higher. Having a bad physical health conditions is seen as an important risk factor of having tendency to depression (Amuk et al., 2003). Physical illnesses may decrease the life satisfaction and also may cause depression with biological effects. Also it is known that the medicals for treatments may cause depressive symptoms (Tamam, 2001). Depressive tables caused by chronic illnesses, may affect the life satisfaction and increase the negative effects of the illness (Toprak et al., 2002). In several studies (20-22, 65) a significant relation between having chronic depression and depression is found. On the other hand, in a study made with old aged people no relation between chronic illnesses and depression is found (Bahar et al., 2005).

In a study made with old age people; sleep duration of elder people is longer for people who do not have depression symptoms than elder people who have depression symptoms. Also it is specified that frequency of elder people who have depression symptoms is higher in the group of elder people who have sleeping problems (Karadağ et al., 2008). In a study made with old age people; it is specified that depression is often seen together with changes in sleep and also getting up at night and wake up at early hours in mornings is increasing in depression for old age people (Neubauer, 1999).

Staying away from enough timed and quality sleep may affect bodily and psychological health of elder people, vice versa; increase in sleeping problems may be seen. Elder people who have

to stay away from their home atmosphere or having difficulties for adapting for new places may cause sleeplessness and because of this depression may be seen. There is no relation between depression and living with family or living alone before coming to nursing home (Altay, 2009).

Old ages, is a period that lots of loss is seen. Old aged people who exclude from their families will have more losses because of being moved away from their families and social atmosphere. Social values, family structures, cultural values, life perceptions and post traumatic growth after a traumatic event will show differences because of education status, marital status and living atmosphere; and these factors will affect depression and life satisfaction of old aged people. Women will be more affected by depression than men in old ages like they were affected in young ages. With aging losses increase, new illnesses appears so depression can be seen more in elder age groups. Marriage is an important process in has important properties like managing to connect spouses to each other and life and being a support and morale resource for families. Naturally, old aged people who lost their spouses or get divorced; depression frequency seen more than old aged people who are married. Also; seeing more depression in old aged people who do not have any child will affirm this thought. Depression rates are higher for old aged people who are not literate and do not have any continuous income. Also it can be say that having a good education and high income will play in an important role for protection from depression and finding proper coping strategies for coping with factors that causes depression. Bodily, psychologically and socially some problems should be think about in elder people who do not find good their health perceptions. Thus, old age people who have bad health perceptions, chronic or severe illnesses or sleep problems, depression rates are higher. Sleep problems will reciprocally affect with bodily, psychologically and socially difficulties for elder people. In our country, corruption of traditional family structure for several reasons, existence of economical problems and women attending to work life affect social structure in time and lead families to being small and nuclear. This situation leads old aged people to isolation from family and loneliness in time.

Depression rates increase when old aged people, who are living alone, losses the contact with their relatives and have decreased communication with relatives. Old aging is a risky period in which there are lots of losses. Old aged people who are living in institutes will have more losses because of living away from their families and social atmosphere. Also several factors will affect the relation between old aged people in institutes; these factors can be summarized like being from different socio-cultural atmospheres, having different education status and incomes, having several medical problems and functional disorders, having different activities in spare

times and having different expectations from life. Old aged people readily have the risk of facing depression, when the corruption in the relations in nursing homes is added to this risk, this leads to increase in the rates of depression. Old aged people who appreciate their free time with active occupations have less depression. Old aged people who are occupied with a work, who are productive; have really high life satisfaction rates. According to Myers old aged people who are older than 60 years, working or producing; look 72% positive to life and looks for future in a hope and confident way (Uysal, 1993). Iwatsuba and colleagues study life satisfaction retired men and women in Paris. In the first phase of the study 627 cases, 464 cases in the next phase are studied and Life Satisfaction Inventory is used. It is found that life satisfaction is linked with physical proficiency level, not being occupied, family factors, physical and psychological condition (Iwatsuba, 1996).

In a study made in Seyranbağları nursing home a relation between life satisfaction and occupation is seen (Karataş, 1988). It is determined that age is a important factor on life satisfaction for men and having positive self image and finding self as valuable even having some insufficiency for women (Özer, 2001). In a study made with old aged people who are living in nursing homes and with their families; it is found that there is a relation between marital status, education status, occupation, evaluation of free time and health status of old aged people with life satisfaction (Özer, 2001). In other studies, it is found that life satisfaction can be affected by the socio-demographic factors like age, gender, occupation, work, education, religion, marriage and family.

Family is the most important social institute that contributes for people to be ready for old ages and know about the struggles about it. Mutual trust, love and respect that gained from families are important factors for old aged people. These factors prepare old aged people to gain life satisfaction in their life (Öztunç et al., 1992; Uysal, 1993). Also, life satisfaction can be affected by income status, life events, activities and personalities (Kubilay, 1994; Ho, 1995). In this study it is also found that having severe illness diagnosis, divorcing, loosing and other experienced traumatic events may affect life satisfaction. Post traumatic growth is affected by age and education status for old aged people (Belizzi et al.; Vickie et al.). Post traumatic growth is more effective for women and higher points got from inventory. Interpersonal processes and cognitive capacity have important and effective role in this process (Tedeschi, Calhoun; 2004). For old aged people; life satisfaction is dependent to factors like personality, learning coping strategies, changes in life conditions and control focuses (Kubilay, 1994).

Old ages can be described as ‘losing period’ with period-specific problematic factors like decline in physical area, leaving productive role, changes in social status, weakening in interpersonal support and losing health (Trekya, 1992; Bahar, 2005; Aksüllü, Doğan, 2004). Life satisfaction is accepted as one of the most important factors of conformity to old ages that affect psychological health of people (Kudo et al., 2007).

It is found that participants who joined the study and who are living in nursing homes have low life satisfaction levels and participants who are living alone. In a study that looks for the self care power of the old aged people and life satisfaction, average point of life satisfaction inventory is found low(Çimen, 1996). In another study that examined life satisfaction of old aged people who are living in nursing homes or in family; average point of life satisfaction inventory is found for old aged people who are living in nursing homes life satisfaction point is higher than for old aged people who are living with families (Özer, 2001). Also again in a study made to examine healthy life style behaviors and life satisfactions of old age people it is found that the point of life satisfaction inventory is (Lhan’ın, 2003). According to studies above, life satisfaction is low in nursing home and widowed people in this study. When the education status and life satisfaction is examined it is found that when the education status is increase life satisfaction points increase too. There is a negative relation between life satisfaction and depression of the old aged participants who joined in this study. When the life satisfaction increased, depression decreased. Income status gives power to old aged people, and old aged people feel more independent, independent people orient life individually and life satisfaction will increase. Generally having a chronic illness decrease the life satisfaction of old aged people. It is found that having a chronic illness has negative effects on life satisfaction and psychological status (Yılmaz et al., 1996). There fore this study is parallel to previous literature. Having a diagnosis of severe illness decrease the life satisfaction of old aged people and increase the depression levels. According to child number and life satisfaction relation frequencies; old aged people who have one child have higher life satisfaction points. In a study that look for the meaning of life in old ages; old people who have social support from children are happy and have higher life satisfaction points (Özmete, 2008).

In a study made in nursing home of Adana with 88 old aged people, it is found that communication of old aged people with their children and relatives is insufficient (Ergün et al., 2003). In this study, people who have children have more life satisfaction than people who do not have any children. Similarly, status of having a child is effective situation which effects depression status.

Living alone made people to think that they are useless. To beat method for people who feel useless; these people should join activities that give enjoyment to individual to get rid of this uselessness feeling. Free time activities are important factor that help old aged people to cope with problems in their life and changes in life and these free time activities are determinative factor for life quality. It is found that depending on the increase of life satisfaction, depression is decreased. According to gender and life satisfaction relation in these study it is found that; averages of women's points are lower than men's points. Men old aged people feel self more healthy and active and have higher life satisfaction than women (Özmete, 2008). According to atmosphere of living place and life satisfaction it is found that; old aged people who are living alone and who are living in nursing homes have similarities and these rates are low. In the literature it is found that living in own house increases the life satisfaction. In a study that look for the life satisfaction of old aged people who are living in nursing homes or with families; it is found that average points of life satisfaction inventory is low than for old aged people who are living in nursing homes and who are living with their families (Özer, 2001).

Life satisfaction of old aged people is not just related with how they are living but also related with how they adapt to external factors. Level of performing the life-long expectations, success, failures, experienced traumas, having diagnosis of severe illnesses, retirement etc. life events affects individuals' psychological health positively or negatively. Social relations, life styles, adapting to life styles, level of acceptance of current situation will affect the life satisfaction of individual (Kudo et al, 2007; Klavuz, 2002).

As a result; in this study of post traumatic growth, depression and life satisfaction of old aged people who are living in different atmospheres; it is found that living alone or living in nursing homes are important risk factors for experienced trauma depression and life satisfaction.

Old aging is an unavoidable period of time which has chronologic, social, biological and psychological dimension despite of having huge studies. Old aged people show differences from young people by biological and behavioral properties (Yazgan, 2006). Life events about old aging can be exampled as loss of spouse, loss of occupation and/or occupational role, loneliness, social isolation, diagnosis of severe illness, economic and physiological losses and living in nursing homes. Traumatic events and results of traumatic events in old ages should be examined differently from other population groups because of cognitive problems like decrease in meaning, perception and memory disorders (Özgüler et al., 2004; Yaluğ et al., 2007).

Period of old aging seem as a period in which decreases of supports which help handling with traumatic events. Estrangement feeling which can be seen in old ages, isolation from society, unwillingness may cause breaking offs from society. This period can be evaluate as a period in which going to past and reviewing memories is seen to protect self respect. But this situation may cause anxiety and depression by re-experiencing post traumatic stress symptoms; if old aged people experienced any trauma in their past life or exposed such trauma (Özmen, 2003). Similarly, in this study it is remarkable that there are traumatic lives events like; loss of spouse or child, loss of work, divorce, diagnose of severe illness. Co-morbid to post traumatic stress disorder; old aged people who experienced trauma most common psychiatric disorders are major depression, other anxiety disorders, psychosomatic complaints, thought disorders and alcohol addiction (Özgüler et at., 2004). There are studies which shows that most of old aged people who have post traumatic stress disorder diagnosis have major depression symptoms in three years and war veterans who have diagnose of post traumatic stress disorder have 50% rates of co-morbid diagnosis of general anxiety disorder (Averill& Beck, 2000; Krause et al., 2004). For young patients; as well as the factors which cause predisposition to post traumatic stress disorder, symptoms about traumatic events experienced in past life may appear or blaze up in old ages by the stressors of old age period (Chung et al., 2005; Charles et al., 2005).

Because of this situation; sensitive people should be known in advance for services of protective psychological health care. Effects of pre experienced trauma, symptoms of post traumatic stress disorder in old ages and risk factors and causes should be explained. As a result, there is a need for new studies with wider sample to see if there are any differences about post traumatic stress disorder in old ages and neurobiological, clinical or treatment process.

## CONCLUSION

Health professions who are working in nursing homes should be thoughtful because old age people who are living in nursing homes or who are living alone may have rates of depression risks. There should be educations about geriatric health. Living a division, having a diagnosis of severe illness, having a chronic illness are situations that bog down people's life. There should be priority for old age people who have low education status and low incomes and lived severe traumas. Having losses in this period may cause changes in social, psychological and physiological changes and this may increase the risk factors of depression; these situations also affect life satisfaction and prevent post traumatic growth.

Old aged people should have professional help to get a positive perspective after a trauma and by this help old aged people's psychology will get well. Knowing properties of geriatric depression will cause healthier approach to those patients, and prevents negative effects of depression on present physiological illness. It is important to take a help for old aged people for their life satisfaction and effects of depression. It will help to see the actual risks of old age people and having deeper studies about deficiencies. Social support can be protective in every period of old ages.

Based on these results; to protect health of old aged people, to have a healthier and happier life, so to have satisfaction from life there is a list of suggestions below:

- It must be ensured that old aged people have cooperation and solidarity with their atmosphere.
- There should be opportunities for old age people to attend to actively to society.
- It must be ensured that old aged people feel useful.
- It should be provided for old age people to see positive sides of their life.
- There should be regular health controls to protect bodily health of old aged people and prevent negative effects of old ages.
- Health professions who are giving service to old age people should have private education about old ages and problems about old aging.
- There should be day and night care homes to meet shelter needs of old aged people.
- There should be educations about old aging for society from mass media to have a positive perspective about old aged people in society.

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## APPENDIX

### GÖNÜLLÜ OLUR FORMU

Bu araştırma, Yakın Doğu Üniversitesi Sosyal Bilimler Enstitüsü Klinik Psikoloji Yüksek Lisans Programı Çerçevesinde düzenlenen bir çalışmadır. Bu çalışma Adana Huzur Evi'nde, ailesi ile yaşayan yaşlılar içinden rastgele seçilen 120 kişi ile yapılacaktır.

Bu çalışmanın amacı; Farklı ortamlarda yaşayan yaşlı bireylerin geçirilmiş travma durumlarına göre, travma sonrası gelişim, depresyon ve yaşam doyumu arasındaki ilişkinin incelenmesidir. Çalışma da bir demografik form ve dört tane ölçek kullanılacaktır. Demografik Bilgi Formu sizin yaş, cinsiyet, gibi özellikleriniz hakkındaki bilgileri içermektedir. Ölçekler ise travma sonrası gelişim, depresyoni yaşam doyumu ile ilgili soruları içermektedir.

Gönüllülerin bu çalışmadaki sorumlulukları vakit ayırarak ölçeklerin boşluk bırakılmadan doldurulmasına yardımcı olmaktır. Bu çalışma gönüllülük esasına dayanmaktadır. Gönüllülerin araştırmaya katılımı gönüllü olup araştırma herhangi bir risk taşımamaktadır. Gönüllülerin istedikleri zaman herhangi bir cezaya maruz kalmadan araştırmaya katılımı reddedebilir veya araştırmadan çekilebilirler. Araştırmada öngörülen süre 50 dakikadır.

Bu araştırmanın hiçbir aşamasında isminiz kullanılmayacaktır. Araştırmada toplanan bilgiler bireysel olarak değil, tüm katılımcıların ortalama puanları alınarak hesaplanacak ve değerlendirilicekir. Araştırma tamamen bilimsel amaçlarla düzenlenmiştir. Size ait bilgiler kesinlikle gizli tutulacaktır. Soruların doğru bir cevabı yoktur. Anketleri eksiksiz cevaplamak bu araştırma sonuçlarının toplum açısından yararlı bilgi olarak kullanılmasını sağlayacaktır. Çalışma ile ilgili herhangi bir bilgi almak isterseniz ipek.tdr@gmail.com veya 05355972328 numaralı teefondan iletişime geçebilirsiniz.

'Bilgilendirilmiş Gönüllü Olur Formundaki tüm açıklamaları okudum. Bana yukarıda konusu ve amacı belirtilen araştırma ile ilgili yazılı ve sözlü açıklama aşağıda adı belirtilen psikolog tarafından yapıldı. Arsştırmya gönüllü katıldığım ve istedğim zaman gerekçeli veya gerekçesiz olarak araştırmadan ayrılabileceğimi biliyorum. Sonuç olarak araştırmaya hiçbir baskı ve rıza olmaksızın kendi rızamla katılmayı kabul ediyorum.'

PSİKOLOG

İPEK KIZILOLUK

Gönülünün Adı/Soyadı/Tarih/İmza

## EKLER

**EK-1**

**SOSYODEMOGRAFİK FORM**

**1**-Cinsiyet

Kadın( ) Erkek( )

2-Yaşınız

3-Eğitim düzeyiniz

Okur-yazar ( ) İlkokul( ) Ortaokul( ) lise( ) üniversite( )

4-En uzun süre yaşadığınız yerleşim yeri

Köy( ) Kasaba( ) Şehir( ) Büyükşehir( )

5-Medeni Durum

Evli( ) Eşi ölmüş( ) Bekar ( ) Boşanmış ( )

6-Meslek

İşsiz( )Ev hanımı( ) Emekli ( )Çiftçi( ) Serbest meslek( )

7-Aile tipi

Geniş aile( ) Çekirdek aile( )

8- Kiminle yaşıyorsunuz?

Eş veya çocuk( ) Yalnız( )

9-Sosyal Güvence

Var( ) yok( )

10-Çocuk

Var( ) Yok( )

11- Daha once geçmiş yaşantınızda travma yaratabilecek bir yaşam olayı yaşadınız mı?

Evet( ) Hayır( )

Cevap evet ise, aşağıdaki soruları cevaplayınız.

12-Kayıp(eş,çocuk kaybı) yaşadınız mı?

Evet( ) Hayır( )

13-Boşanma yaşadınız mı?

Evet( ) Hayır( )

14-İşten çıkarılma durumu yaşadınız mı?

Evet ( ) Hayır( )

15-Kronik hastalık yaşadınız mı?

Evet( ) Hayır( )

16-Ciddi hastalık tanısı aldınız mı?

Evet( ) Hayır( )

17-Diğer

Evet( ) Hayır( )

**EK-2**

**GERİATRİK DEPRESYON ÖLÇEĞİ**

Toplam Puan: .....

Lütfen yaşamınızın son bir haftasında kendinizi nasıl hissettiğinize ilişkin aşağıdaki sorularda uygun olan yanıtı daire içine alınız

1) Yaşamınızdan temelde memnun musunuz ?

Evet Hayır .....

2) Kişisel etkinlik ve ilgi alanlarınızın çoğunu halen sürdürüyor musunuz ?

Evet Hayır .....

3) Yaşamınızın bomboş olduğunu hissediyor musunuz ?

Evet Hayır .....

4) Sık sık canınız sıkılır mı?

Evet Hayır .....

5) Gelecekten umutsuz musunuz?

Evet Hayır .....

6) Kafanızdan atamadığınız düşünceler nedeniyle rahatsızlık duyduğunuz olur mu?

Evet Hayır .....

7) Genellikle keyfiniz yerinde midir?

Evet Hayır .....

8) Başınıza kötü birşey geleceğinden korkuyor musunuz?

Evet Hayır .....

9) Çoğunlukla kendinizi mutlu hissediyor musunuz?

Evet Hayır .....

10) Sık sık kendinizi çaresiz hissediyor musunuz?

Evet Hayır .....

11) Sık sık huzursuz ve yerinde duramayan biri olur musunuz?

Evet Hayır .....

12) Dışarıya çıkıp yeni birşeyler yapmaktansa, evde kalmayı tercih eder misiniz?

Evet Hayır .....

13) Sıklıkla gelecekten endişe duyuyor musunuz?

Evet Hayır .....

14) Hafızanızın çoğu kişiden zayıf olduğunu hissediyor musunuz?

Evet Hayır .....

15) Sizce şu anda yaşıyor olmak çok güzel birşey midir?

Evet Hayır .....

**EK-3**

**YAŞAM DOYUM ÖLÇEĞİ**

Aşağıda beş cümle ve her bir cümlenin yanında da cevaplarınızı işaretlemeniz için 1'den 7'ye kadar rakamlar verilmiştir. Her cümle de söylenenin sizin için ne kadar önemli olduğunu veya olmadığını belirtmek için o cümlenin yanındaki rakamlardan yalnız bir tanesini daire içine alarak işaretleyiniz. Bu şekilde beş cümlenin her birine bir işaret koyarak cevaplarınızı veriniz.

| | **Kesinlikle Katılmıyorum** | **Katılmıyorum** | **Kısmen** | **Kararsızım** | **Kısmen** | **Katılıyorum** | **Kesinlikle Katılıyorum** |
|---|---|---|---|---|---|---|---|
| **1 -**Hayatımideallerime yakın bir yaşamım var. | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **2 -**Hayat şartlarım mükemmel. | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **3 -**Hayatımdan memnunum. | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **4 -**Hayatımda şimdiye kadar önemli şeyleri elde ettim. | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **5-** Eğer hayata yeniden başlasaydım hemen hemen hiçbir şeyi değiştirmezdim**.** | **1** | **2** | **3** | **4** | **5** | **6** | **7** |

**EK-4**

**TRAVMA SONRASI GELİŞİM ÖLÇEĞİ**

Aşağıda ciddi yaşam olaylarından sonra ortaya çıkabilecek bazı değişikler verilmektedir. Her cümleyi dikkatle okuyunuz ve ciddi hastalık tanısı alma, boşanma, eş veya ebeveyn kaybı, iş kaybı sonrası belirtilen değişikliğin sizin için ne derece gerçekleştiğini aşağıdaki ölçeği kullanarak belirtiniz.

1= yaşamadım
2= çok az derecede yaşadım
3= az derecede yaşadım
4= orta derecede yaşadım
5= oldukça fazla derecede yaşadım
6= aşırı derecede yaşadım

| | **Hiç** | | | | | **Aşırı derece** |
|---|---|---|---|---|---|---|
| 1. Hayatıma verdiğim değer arttı. | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. Hayatımın kıymetini anladım. | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. Yeni ilgi alanları geliştirdim. | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. Kendime güvenim arttı. | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. Manevi konuları daha iyi anladım. | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. Zor zamanlarda başkalarına güvenebileceğimi anladım. | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. Hayatıma yeni bir yön verdim. | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. Kendimi diğer insanlara daha yakın hissetmeye başladım. | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. Duygularımı ifade etme isteğim arttı. | 1 | 2 | 3 | 4 | 5 | 6 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 10. Zorluklarla başa çıkabileceğimi anladım. | 1 | 2 | 3 | 4 | 5 | 6 |
| 11. Hayatımı daha iyi şeyler yaparak geçirebileceğimi anladım. | 1 | 2 | 3 | 4 | 5 | 6 |
| 12. Olayları olduğu gibi kabullenmeyi öğrendim. | 1 | 2 | 3 | 4 | 5 | 6 |
| 13. Yaşadığım her günün değerini anladım. | 1 | 2 | 3 | 4 | 5 | 6 |
| 14. Hastalığımdan sonra benim için yeni fırsatlar doğdu. | 1 | 2 | 3 | 4 | 5 | 6 |
| 15. Başkalarına karşı şefkat hislerim arttı. | 1 | 2 | 3 | 4 | 5 | 6 |
| 16. İnsanlarla ilişkilerimde daha fazla gayret göstermeye başladım. | 1 | 2 | 3 | 4 | 5 | 6 |
| 17. Değişmesi gereken şeyleri değiştirmek için daha fazla gayret göstermeye başladım. | 1 | 2 | 3 | 4 | 5 | 6 |
| 18. Dini inancım daha da güçlendi. | 1 | 2 | 3 | 4 | 5 | 6 |
| 19. Düşündüğümden daha güçlü olduğumu anladım. | 1 | 2 | 3 | 4 | 5 | 6 |
| 20. İnsanların ne kadar iyi olduğu konusunda çok şey öğrendim. | 1 | 2 | 3 | 4 | 5 | 6 |
| 21. Başkalarına ihtiyacım olabileceğini kabul etmeyi öğrendim. | 1 | 2 | 3 | 4 | 5 | 6 |

YAKIN DOĞU ÜNİVERSİTESİ

Ek: 334 - 2015

# YAKIN DOĞU ÜNİVERSİTESİ BİLİMSEL ARAŞTIRMALAR DEĞERLENDİRME ETİK KURULU

## ARAŞTIRMA PROJESİ DEĞERLENDİRME RAPORU

**Toplantı Tarihi** : 17.09.2015
**Toplantı No** : 2015/32
**Proje No** : 219

Yakın Doğu Üniversitesi Psikoloji Bölümü öğretim üyelerinden Yrd. Doç. Dr. İrem Erdem Atak'ın sorumlu araştırmacısı olduğu, YDU 2015 32-219 proje numaralı ve **"Farklı alanlarda yaşayan yaşlılarda geçirilmiş travma durumlarına gore yaşam doyumu depresyon ve travma sonrası gelişimin incelenmesi"** başlıklı proje önerisi kurulumuzca değerlendirilmiş olup, etik olarak uygun bulunmuştur.

1. Prof. Dr. Rüştü Onur (BAŞKAN)
2. Prof. Dr. Tumay Sozen (ÜYE)
3. Prof. Dr. Nerin Bahçeciler Önder (ÜYE)
4. Prof. Dr. Tamer Yılmaz (ÜYE)
5. Prof. Dr. Hasan Besim (ÜYE)
6. Prof. Dr. Şahan Saygı (ÜYE)
7. Prof. Dr. Şanda Çalı (ÜYE) KATILMADI
8. Doç. Dr. Ümran Dal (ÜYE)
9. Doç. Dr. Çetin Lutfi Baydar (ÜYE)
10. Yrd. Doç. Dr. Emil Mammadov (ÜYE)

# ÖZGEÇMİŞ

## KİŞİSEL BİLGİLER

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## EĞİTİM BİLGİLERİ

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## PSİKOTERAPİ EĞİTİMİ

Assoc.Prof Dr. Ebru ÇAKICI.MD.PhD Cyprus Mental Health Institute, Positive Psychotherapy Center Pozitif Psikoterapi(2014-2015)Temel Eğitim Programı

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## İŞ TECRÜBESİ

**İmece Özel Eğitim (Adana)- 2011**

Psikolog

**Balcalı Hastanesi (Adana) -2012**

Psikolog

**Ekrem Tok Ruh ve Sinir Hastalıkları Hastanesi (Adana) 2013-2015**

Psikolog

**Rehberlik ve Psikolojik Danışmanlık alanında çalışılan yaş grubu:3-18**

- Dikkat dağınıklığı
- Sınav Heyecanı
- Stresle baş etme
- Aile içi iletişim sorunları
- Cinsellikle ilgili kaygılar
- Ergenlikte psikolojik ve fizyolojik değişimlere uyum danışmanlığı
- Duygusal ve davranışsal sorunlar ( kaygı ve çökkünlük, öfke,içe dönüklük,kendine zarar verme,özgüven eksikliği)
- Sosyal uyum sorunları (arkadaş ilişkileri, otorite çatışmaları,sosyal uyumsuzluk)
- Ergen ve travma
- Ergen ve bağımlılık
- Kariyer Danışmanlığı
- Aile Danışmanlığı

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Psikiyatrist Prof Dr. Lut Tamam Çukurova Üniversitesi Balcalı HastanesiPsikiyatri Servisi Stajı ve Eğitimi (2012)

Psikolog Levent Bekir Telli Çukurova Üniversitesi Balcalı HastanesiPsikiyatri Servisi Stajı ve Eğitimi (2012)

Psikiyatrist Sinan Özer Ekrem Tok Ruh ve Sinir Hastalıkları Hastanesi Psikiyatri Servisi (2013-2015)

**SERTİFİKALAR:**

- ‘İletişim Çağında İletişimsizlik’ 14. Ulusal Psikoloji Öğrencileri Kongresi Ankara Üniversitesi 10-13 Temmuz 2010
- V. Kıbrıs Psikanaliz Günleri 18-19 Ekim 2014 ‘’ Kayıp Nesne’’ 2014
- 6. Ruh Sağlığı Sempozyumu 6-7 Aralık 2014 ‘’ Günlük Yaşamda Şiddet’’2013
- 5. Ruh Sağlığı Sempozyumu 5-6 Aralık 2013 ‘’Ruh Sağlığı Alanında Adli ve Etik Uygulamaları’’2013
- II. Yakın Doğu Üniversitesi Psikoloji Günleri “RUHSAL TRAVMA” 20-22 Mayıs 2015
- 4. Ruh Sağlığı Sempozyumu Yakın Doğu Üniversitesi ‘kayıplar ve yas’ 7 Aralık 2012
- Psikodramanın bireysel psikoterapilerde kullanılması' Kıbrıs Ruh Sağlığı Derneği' 20 Mart 2013
- ‘Kendin olabilmek’ Kıbrıs Psikodrama Sempozyumu 4 Ekim 2013