NEAR EAST UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SCIENCES
CLINICAL PSYCHOLOGY
MASTER'S PROGRAMME

MASTER'S THESIS

RELATIONSHIP BETWEEN ACCEPTING THE PAST, HOPELESSNESS, DEATH ANXIETY, DEPRESSION AND SUICIDE RISK AMONG ELDERLY PEOPLE

Gözde ÇETİNKOL

NICOSIA
2016

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NICOSIA
2016

YAKIN DOĞU ÜNİVERSİTESİ
NEAR EAST UNIVERSITY
SOSYAL BİLİMLER ENSTİTÜSÜ
GRADUATE SCHOOL OF SOCIAL SCIENCES

Date: ...../...../....., Nicosia

20___/20___ Academic Year _____Semester

DECLARATION

Type of Thesis: Master ☒ Proficiency in Art ☐ PhD ☐

STUDENT NO : 20131358

PROGRAME : CLINICAL PSYCHOLOGY

I GÖZDE GETİNKOL, hereby declare that this dissertation entitled "RELATIONSHIP BETWEEN ACCEPTING THE PAST, HOPELESSNESS DEATH, ANXIETY, DEPRESSION AND SUICIDE RISK AMONG ELDERLY PEOPLE" has been prepared myself under the guidance and supervison of "Assoc. Prof. Dr. GÜLBAHAR BAŞTUĞ" in partial fulfilment of The Near East University, Graduate School of Social Sciences regulations and does not to the best of my knowledge breach any Law of Copyrights and has been tested for plagarism and a copy of the result can be found in the Thesis.

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RELATIONSHIP BETWEEN ACCEPTING THE PAST, HOPELESSNESS, DEATH ANXIETY, DEPRESSION AND SUICIDE RISK AMONG ELDERLY PEOPLE

We certify the thesis is satisfactory for the award of degree of
Master of CLINICAL PSYCHOLOGY

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Abstract

Relationship between Accepting the Past, Hopelessness, Death Anxiety, Depression and Suicide Risk among Elderly People

Prepared by: Gözde Çetinkol

June 2016, 94 pages

This study was conducted to analyze the relationship between accepting the past, hopelessness, death anxiety, suicide risk and depression among elderly people. The study sample comprises of 50 female and 49 male participants aged 50 and over who live in Turkish Republic of Northern Cyprus and Turkey. Socio-demographic Data Form, Standardized Mini Mental Test (SMMT), Beck Hopelessness Scale (BHS)), Meaningful Past Questionnaire (MPQ), Geriatric Depression Scale (GDS) and Death Anxiety Scale (DAS) were applied to the participants between July-October 2015 and the variables were determined. In the statistical analyses performed in line with the scores obtained from the scales, it was determined that age and gender did not have relationship with accepting the past, hopelessness, death anxiety and depression, while it was seen that accepting the past increased and depression and level of hopelessness decreased with increasing educational level. As long as the death anxiety increases, hopelessness and depression level increases. When depression predictors examined, it was seen that accepting the past and hopelessness influenced depression. Hopelessness increases and accepting the past decreases with increasing depression. Starting from these results, increase of public awareness about depression in elderly people, and increase of private healthcare services are suggested.

Key Words: Elderly people, accepting the past, hopelessness, death anxiety, depression

Öz

Yaşlı Kişilerde Geçmişi Anlamlandırma, Umutsuzluk, Ölüm Kaygısı, Depresyon ve İntihar Riski Arasındaki İlişki

Hazırlayan: Gözde Çetinkol

Haziran 2016, 94 sayfa

Bu araştırma yaşlı kişilerde geçmişi anlamlandırmanın umutsuzluk, ölüm kaygısı, intihar riski ve depresyon ile ilişkisini incelemek amacıyla yapılmıştır. Araştırmanın örneklemi Temmuz-Ekim 2015 tarihleri arasında, KKTC'de ve Türkiye'de yaşayan 50 yaş ve üstü, sağlıklı 50 kadın ve 49 erkek katılımcıdan oluşturulmuştur. Katılımcılara Sosyodemografik Veri Formu, Standardize Mini Mental Test (SMMT), Beck Umutsuzluk Ölçeği (BUÖ), Geçmişi Anlamlandırma Ölçeği (GAÖ), Geriatrik Depresyon Ölçeği (GDÖ) ve Ölüm Kaygısı Ölçeği (ÖKÖ) uygulanarak araştırmadaki değişkenlerin belirlenmesi sağlanmıştır. Ölçeklerden alınan puanlar doğrultusunda yapılan istatistiksel analizlerde yaş ve cinsiyetin geçmişi anlamlandırma, umutsuzluk, ölüm kaygısı ve depresyon ile hiçbir ilişkisinin olmadığı belirlenirken, eğitim düzeyi arttıkça geçmişi anlamlandırmanın arttığı, depresyon ve umutsuzluk düzeyinin ise azaldığı görülmüştür. Ölüm kaygısı arttıkça umutsuzluk ve depresyonda artmaktadır. Depresyonun yordayıcıları incelendiğinde ise geçmişi anlamlandırma ile umutsuzluğun, depresyonu yordadığı görülmüştür. Depresyon arttıkça umutsuzluk artmakta, geçmişi anlamlandırma azalmaktadır. Bu sonuçlardan yola çıkarak, yaşlı kişilerde görülen olumsuz durumların yaşanmasını önlemek amacıyla toplum farkındalığının ve yaşlılara özel sağlık hizmetlerinin arttırılması önerilmektedir.

Anahtar Kelimeler : Yaşlılar, geçmişi anlamlandırma, umutsuzluk, ölüm kaygısı, depresyon

ACKNOWLEDGMENTS

I would like to express my sincerest acknowledgments to my advisor Assoc. Prof. Dr. Gülbahar BAŞTUĞ for her full support, guidance, understanding and encouragement, throughout my study. Without her incredible patience and timely wisdom and counseling my thesis work would have been a frustrating and overwhelming pursuit. In addition, I would like to express my appreciation to Assoc. Prof. Dr. E. Tuğba Özel Kızıl for contributes to my thesis with her knowledge and experienced..

I would also like to appreciation to Assoc. Prof. Dr. Ebru Çakıcı, and Assist. Prof. Dr. Zihniye Okray and other dear my teachers for redound me in courses by being my instructors during my graduate years.

I would like to thanks for my parents Fatma Çetinkol, Suat Çetinkol and my brother Mert Çetinkol for their full support and unconditional love during all of my education life.

Gözde Çetinkol

July, 2016

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LIST OF ABBREVIATIONS

TRNC : Turkish Republic of Northern Cyprus

WHO : World Health Organization

TSI : Turkish Statistical Institution

SMMT : Standardized Mini Mental Test

DAS : Death Anxiety Scale

GDS : Geriatric Depression Scale

BHS : Beck Hopelessness Scale

MPQ : Meaningful Past Questionnaire

1. INTRODUCTION

1.1. Preliminary Information

There has been an increase in human population in the world and our country over the years. The elderly population also keeps growing in direct proportion to this increase. The primary reason for this is the rapid development of the health technologies and medical science in recent years (Palabıyıkoğlu, Haran, Yücat, & Köse, 1991, 26-31). Technological and scientific developments in the field of medicine have made the diagnoses and treatments of various diseases easier, particularly the methods against malignant diseases have been developed and mortalities were seen to have decreased in direct proportion to all these developments. Thus, an increase is seen in the elderly population in line with these developments which are seen to extend the average duration of human life (Bakar, 2012).

Advancements in the fields of technology and medicine led to a change in human thoughts and behaviors (Palabıyıkoğlu et al., 1991, 26-31). Gradually increasing economic problems, shrinkage of the housing with the transition to urbanization resulting in a reduction in the number of people living in a house, deterioration in the extended family structure and transition to nuclear family, difficulty in intergenerational communication arising from rapid developments in technology and negative change in youth's perspective to elderly people, increase of health problems cause to negative situations for elderly people (Üstüner Top, Saraç, & Yaşar, 2010, 14-22). Considering all these problems, it was seen that older individuals were excluded from the society and left alone and a society formed in which the interest and respect shown to older people decreased (Palabıyıkoğlu et al., 1991, 26-31).

Besides being the last of the developmental stages of human, elderliness is a period of loss revealing itself with some physical and mental differences with advancing chronological age when cognitive and social capabilities such as productivity and self-development decreased (Kaçan Softa, Ulaş Karaahmetoğlu, Erdoğan, & Yavuz, 2015, 12-21). Decreasing of functionality, productivity and life satisfaction level cause to psychological problems. Therefore, primarily depression but also other psychological disorders are seen in elderly people (Good, Vlachonikolis, & Griffiths, 1987, 463-470). These problems show that old people in society were the individuals who need psychological and physiological support (Konak & Çiğdem, 2005, 23-63).

Depression in the elderly is a very serious disorder and of prime importance. The reason for that is its occurrence in addition to other physical, cognitive and mental problems and negative effects on the individual's health and adaptation to the environment (Kurtoğlu & Rezaki, 1999, 173-179). Depression in the elderly may cause to decrease in the life quality of individuals, loss of cognitive abilities, various diseases and deaths resulting from such diseases. Hopelessness, one of the symptoms of depression, is seen as an important factor in terms of causing to suicidal ideas and suicide attempts (Hill, Gallagher, Thompson, & Ishida, 1988, 230-232). Depression carries the risk of suicide for people of all ages. But suicide attempts in old people result in death more than youngsters (Alexopoulos, Bruce, Hull, Sirey, & Kakuma, 1999, 1048-1053). Therefore, early diagnosis and treatment of depression in old people can prevent premature deaths and play a big role in reconnecting them to life and increasing their life quality (Hacıhasanoğlu & Yıldırım, 2009, 25-30).

Problems that can be faced in the old age depend on how person lives and gives the meaning to his/her past life. Old people who accept their pasts and give

positive meaning to them can protect themselves from the problems resulting from old age (Boyacıoğlu Şengül, 2006). According to Erikson, if an individual could draw positive conclusions from all of his/her successful or unsuccessful experiences in the past and satisfied from his/her past life, than he/she could reach to ego integrity and does not feel death anxiety, hopelessness and unhappiness (Rylands & Rickwood, 2001, 75-89).

Numerous studies have been carried out on what were the problems that maybe encountered during the old ages and how they could be prevented. In recent studies, it was determined that the social support shown to old people was an important factor in preventing stress. While the family support was particularly important for elder, it was also determined to be reducing the symptoms of depression (Gülseren et al., 2000, 133-140). Moreover, person to prepare himself to old age and be cautious against negative situations will ensure a healthy elderliness. Therefore, on the purpose of protecting old people from such problems, psychologists, social service specialists, psychological counsels and guides to support and protect these people are very important for all societies. Elderliness is a stage in human life to be experienced by everyone one day. All support and solidarity societies should cooperate to ensure a healthy, peaceful and happy elderliness (Demir Çelebi & Yukay Yüksel, 2014, 175-202).

In this sense, the present study will primarily describe and classify elderliness, and the next chapters will cover the physiological changes in elderliness, and psychological problems such as primarily the depression, suicide, fear of death, hopelessness and their relationship with accepting the past. In another aspect of the study, it is focused on Erikson's psychosocial theory and hopelessness against ego

integrity, which is the eighth of the development period. Studies on this subject will be covered in the next chapters.

2. LITERATURE REVIEW

2.1. Description and Classification of Elderliness

Aging and elderliness have different meanings. Aging is a natural process existing in the entire human life. Each human experience this process during the time starting from being born until death (Kalaoğlu Özturk, 2010). But elderliness is an irreversible, unstoppable and unpreventable period. In this process, old people lose their power and energy they had when they were young. With elderliness, some physiological properties decrease or get lost (Akdemir, 1997, 142-145). According to World Health Organization (WHO), elderliness means reduction of human's capability of adaptation to environment slowly with advancing age and describes a transition from an independency to dependency. Again, according to a report published by the WHO (1998), aging is an adaptation process caused by internal changes to resist against degeneration and stress from external environment (Bakar, 2012).

Although elderliness is a part of the development stages of human, it is the period of regression and losses because it is the last one of these stages (Kaçan Softa, Uçukoğlu, Ulaş Karaahmetoğlu, & Esen, 2011, 67-79). Aging cause to physical and cognitive changes in individual and this results in negative situations physically, biologically, socially and psychologically (Kalaoğlu Özturk, 2010).

The meaning of elderliness for person may vary with the meanings he/she gave to some values in past experiences. If person could give positive meanings to his/her past experiences, the meaning of elderliness will also be positive (Kalaoğlu Özturk, 2010). In this case, the person could accept his/her past and succeed to draw positive conclusions from past experiences (Öz, 2010, 12-18). Individual having a

successful elderliness is also healthy biologically and mentally, productive and strong-willed and competent cognitively and socially (Kalaoğlu Özturk, 2010).

Advanced age of an individual does not mean he/she got old. Elderliness is rather about how people felt themselves.

WHO (1983) divided elderliness into four sections according to chronological age groups. Accordingly, individuals between the ages of 45-59 were called as medium adults, between 60-74 as old, between 75-89 as elderly and more than 90 as very old (Demir Çelebi & Yukay Yüksel, 2014, 175-202).

Then, according to the elderliness classification accepted by scientists and WHO, the ages between 65-74 were defined as young old stage, between 75-84 as old stage and more than 85 as old old stage (Tümerdem, 2006, 195-196).

Aging includes many types of classification according to different points of view. Gerontologists analyzing the biological, psychological and social aspects of elderliness classified it in four different stages. The first one is the chronological aging depending only on the birth date of individual. The second one is the biological aging when some physical changes occur with the slowing down of organism. The third one is the psychological aging arising from psychological factors such as perceiving processes, sense organs and mental functions with advancing ages. And the last one is the social aging occurring with the change of roles in social structure and relationships with environment (Sucuoğlu, 2012). Besides, there are three more types of elderliness defined by different authors. These are normal elderliness covering the anatomical structure and physiological changes, pathological aging covering all pathological cases depending on health problems and economical aging arising from the change in life style with financial changes (Bakar, 2012).

Health problems are removed, mortalities decrease and elderly population increases with rapidly advancing technology and medical science in the world and our society. Therefore, elderliness is considered to become an issue which will interest society as a whole rather than individuals in the advancing years (Kaçan Softa et al., 2011, 67-79). According to studies performed, it is estimated that elderly population will constitute 22% of the general population in the world until 2020 (Hacıhasanoğlu & Yıldırım, 2009, 25-30).

The elderly population gradually increases in Turkey as is the case with the whole world. According to 2014 data of Turkish Statistical Institution (TSI), the number of elderly people living in Turkey was 6 million 192 thousand 962 and the rate of elderly population was determined to be 8% in the total population. Of all elderly population, 43.6% were males and 56.4% were females. In addition, the rate of elderly population is estimated to be 10.2% in 2023, 20.8% in 2050 and 27.7% in 2075. And old population constitutes 8.3% of the total population worldwide (TSI, 2015). According to 2006 Statistical Annual of the State Planning Organization, the rate of elderly population over 65 years constitutes 9.96% of the total population in Turkish Republic of Northern Cyprus (TRNC) (State Planning Organization, 2010, as cited in; Sucuoğlu, 2012).

According to a definition made by the United Nations, if the rate of elderly population of a country is between 80% and 10%, this shows that the country in question was "old". If this rate is more than 10%, then it means that the country was "too old". Therefore, it is estimated that the rate of elderly population in Turkey will increase up to 10.2% in 2023 and take part among the countries with "too old" populations (TSI 2014).

In this sense, this study is important in terms of welfare of old people in a country where elderly population keeps increasing. The next section will cover the physiological changes seen in elderly people.

2.1.1. Physiological Changes in Elderly People

Along with increasing age, some physical and moral changes are observed. Running in body functions starts to get slower and collapse. This situation causes an individual's lifestyle gets negatively affected physiologically, mentally, biologically, socially and psychologically (Kalaoğlu Öztürk, 2010).

As long as the individual gets older, some significant and perceivable alterations start to come into existence on his/her organism and body. The body reveals that it starts getting older with some problems such as prolapsus on skin, visual and hearing disorders, slowness of movements, absence of perception (Kaçan Softa et al., 2011, 67-79). Besides these alterations, some changes in the process of the organism also come into existence. Because heart muscles waste away, blood volume pumped in per contraction, number of each pulse, elastic characteristics of blood veins decrease and blood pressure increase, so these problems disturb the individual. Likewise, along with decrease of lung performance, breathing problems may be seen in the elderly people. Together with decrease of calcium and minerals, bones starts to get shorter, dilution or collapse on vertebrals can be seen. As the bones getting shorter, the individual has a difficulty in walking and moving and he/her starts to get tired quickly than in the past. As nervous system gets weaker, retardation in movements and reactions occurs and the individual starts to have a difficulty to do his/her daily living activities. Decline in sensual functioning may cause the individual to have visual and hearing disorders. These declines in the older individual's body result in various diseases such as in hypertension, cataract, diabetes, Parkinson

disease, Alzheimer disease, cardiac disease. Physiological alterations can also cause psychological problems in the elder (Bakar, 2012). On the next chapter, these alterations will be mentioned.

2.1.2. Psychological Disorders in Elderly People

Senility period is an era in which physical declines and losses are lived through besides psychological losses are experienced as well. It is a period in which the individual's productivity and creativity that he/her had while they were youth obviously decrease as well as regressions and losses in his/her social life, appearance, cognitive activities, circle of friends, sexual life, career, self-dependence start (Kaçan Softa et al., 2015, 12-21). Inadequacies and weakness occur in the individual's body functions and mental processes. Retardation in perception, reaction, consideration momentum and gathering attention can be seen, and the person starts to feel some sentiments such as unhappiness, guiltiness, anger, loss of self-confidence and anxiety (Bakar, 2012).

Presence of these regression and losses causes psychological disorders to be unavoidable. Because, the elder individual may feel weak, unproductive, inadequate, vulnerable and pessimistic. These sentiments lead the person to a negative state of mind, and so it brings other sentiments such as unhappiness, hopelessness, tiredness and weakness as well. Thus, these sentiments signify the beginning of some psychological disturbances (Tamam & Öner, 2001, 50-60).

Eventual psychological problems show some alterations according to character and persona of the elder, how he/she perceives the changes on himself/herself, and how the people around approach towards him or her. If the elder cannot be adapted to these changes, then he/she will encounter some psychological problems such as

irritability, reluctance, hopelessness, adductive, depression, anxiety and behavioral disorders (Kaçan Softa et al., 2011, 67-79).

Due to his/her physiological losses, the elder individual isolates himself/herself from other people and his/her neighbourhood. Having too much feeling of loneliness also brings together the sentiments of purposelessness and uselessness. This circumstance also provides a different basis for the psychological disturbances (Bahar, Bahar, & Savaş, 2009, 86-98).

To cope with the psychological disturbances are difficult for the elder compared to the young. Because the body processes of the young individuals are faster and more practical than the elderly people. Therefore, the elder individual experiences more serious, long standing, strong indication existent psychological disturbances. This situation demonstrates that the psychological disturbances experienced by the elder are more important than the disturbances experienced by the young (Boyacıoğlu & Saymaz, 2012, 220-228).

According to the researches, it has been detected that 25 per cent of the elder population, there are depression initially, and several psychiatric indications. In the old age, psychological problems such as depression, dementia, sleep disorders, anxiety disorders, suicide can frequently be encountered (Bakar, 2012). Dementia is one of the neuropsychiatric disorders occurring with the existence of cognitive disorders, personality changes and various behavioural symptoms emerging with elderliness (Şahin, Özer, Ölüç, & Tunç, 2005, 22-24). According to the researches, it is detected that prevalence of cognitive inefficiency in the elderly people who reside at eventide home in Turkey is % 20.5 - 43.3; prevalence of dementia in the elderly people who are in USA is % 15 (İlhan et al., 2006, 177-184). Sleep disorders may come into existence because of the fact that the individual cannot maintain his/her

daily life activities as a result of regressions in organism process along with the increasing age (Göktaş & Özkan, 2006, 226-233). And anxiety disorders generally come out of losses that are experienced during the senility period. However, it can usually be seen together with other psychiatric diseases and there are some difficulties in diagnosing it (Fuentes & Cox, 1997, 269-279). Possibility of emerge of depression triggers because of the fact that the psychological problems attach to the elder individual's physiological difficulties experienced.

2.1.2.1. Depression in Elderly People

Depression involves some indications such as cognitive inefficiencies accompanied with a sorrowful state of mind, communication problems, low self-esteem, loss of energy, sleep and eating disorders, weakness, reluctance, pessimism and tiredness. Depression is an important syndrome which makes the individual's life difficult in every aspect (Snowdon, 1997, 52-57).

Depressive indications are classified by two basic diagnostic systems. The first one is WHO's "International Classification of Diseases" (ICD-10); and the second classification is also "Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV). (Öztürk, 2003 as cited in; Sucuoğlu, 2012) As from 2013, since DSM-IV is no longer used, depression indication criteria have been explained considering DSM-5 Diagnostic Criteria (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition) which is already in use.

According to DSM-5, depression disorders are comprised of eight type of categories such as Depression Disorders Disruptive Mood Disorder, Major Depression Disorder, Ongoing Depression Disorder (Dysthymia), Premenstrual Dysphoria Disorder, Substance/Drug Originated Depression Disorder, Another Health Status Related Depression Disorder, Another Identified Depression Disorder, and

Unidentified Depression Disorder. Diagnosis Criteria for Major Depression Disorder are as on Table-1 (DSM-5, 2013, 459-508).

Table 1. Diagnosis Criteria for Major Depressive Disorder

A-	During the same two-week period, 5 (or more) of the indications below have been found. And there has been a change on previous functionality level and at least one of these indications is either depressed emotion situation or loss of attraction or having no pleasure at all.
1.	Depressed emotion situation, it exists almost every day, large part of the day, and this situation is reported by either the individual himself/herself or is observed by the others.
2.	Significant decrease in interest towards entire or almost all activities or situation of having no pleasure from those, it exist almost every day, large part of the day.
3.	As not to try to lose weight, losing so much weight or getting fatter or decrease or increase in demand of eating almost every day.
4.	Suffer from insomnia or having hypersomnia almost every day
5.	Psychokinetic provocation or retardation almost every day.
6.	Exhaustion or having no inner strength almost every day.
7.	Sentiments of unworthiness or excessive or inappropriate feelings of guiltiness almost every day.
8.	Having trouble with consideration or focusing or having instability almost every day.
9.	Repeater thoughts of death, without designing a private action repeater thoughts of killing himself/herself or committing suicide or designing a private action for killing himself/herself.

B-	These indications cause a significant distress or decrease in functionality of social, branches related to business or branches of other important functionality.
C-	This period does not link to affects related with a substance or other health situation has an impact with physiology.
D-	Emerge of a severe depression era, schizo-emotional disorder, schizophrenia, schizophrenic disorder, delusive disorder or as part of schizophrenia expansion and cannot be explained better with removing with psychosis other disorders identified or unidentified disorders.
E-	Never having a mania period or hypomania period experienced.

According to DSM-IV diagnosis criteria, major depression is seen in a part of % 1-3 of the general elder population in the world. Major depression is an everlasting disease which is also hard to get over for the elder individuals. Besides, aside from the major depression, in the researches, it can be seen that a part of 8-6 percentage of the elder population have clinically significant depressive indications as well (Cole & Yaffe, 1996, 157–161; Blazer, 2003, 249–265). According to some international researches, in practices examined with the aim of measuring the depressive indications in the elderly people, it is reported that the frequency of depressive indications seen in the elderly people is % 11.0 – 48.0 (NIH, 1992 as cited in; Tamam & Öner, 2001, 50-60).

Prevalence of depression in the elderly people also changes according to the place that person lives. In the researches, it is detected that the elderly people living at home have % 3.8 - 61.1 rate of depression while the elderly people hospitalised due to medical reasons have % 12; and the elderly people having cognitively healthy

condition but resides in nursing home have % 20 – 25 rate of depression (Bakar, 2012).

According to WHO's data, amongst diseases causing emotional, social and economic problems, the depression is ranked as the fourth place. However, it is estimated by WHO that the depression will rise to the second rank until 2020 in term of its frequency. For the reason of this circumstance, it is considered that negative incidents taking place in forthcoming years will affect the human lives more (Hacıhasanoğlu & Yıldırım, 2009, 25-30).

Some damaged functions in the elderly people cause delays in comprehension and perception, retardation in movements, some hitches restricting the life, and it may lead depressive symptoms to come into existence (Bahar et al., 2009, 86-98). The composed depressive indications may cause a regression in quality of life and productivity of the elderly people, including if he/she has a chronic illness, then it may lead these disease to get worse, furthermore it may cause the individual an economical loss (Nease & Malain, 2003, 118-124). In addition, presence of the depressive indications sparks off some feelings in the individuals such as unhappiness, hopelessness, reluctance and uselessness, and as a result it causes a depression. Hence, realising the depressive indications earlier and early diagnosis affect the treatment positively (Keskinoğlu et al., 2006, 21-26).

Depression in the elderly involves some differences compared to youngsters. While a depressive situation is seen lesser in the elderly people as compared to youngsters, but cognitive indications are encountered more frequently. It is frequently observed that the elder individuals generally have a loss of weight related to loss of appetite, sleep problems, somatic complaints, loss of attention and energy. Notwithstanding, the elder person may accuse himself/herself for the reasons of what

he/she did in the past and may also feel some sentiments such as hopelessness, hopelessness and worthlessness (Bakar, 2012). These indications differ from elder males to elder females. While insomnia is widely seen in the elder males, anxiety is distinctively encountered in the elder females, as different from the males (Yüksel, 1998, 19-23).

Depression in the elderly people has psychotic characteristics occasionally. Guiltiness, physical and nihilistic delirium can usually be seen in an elder who has a psychotic featured depression, and besides, along with the other kinds of delirium such as delusion of persecution (claims about caretakers stole his/her money etc.), hallucinations can seldom be seen either (Bakar, 2012).

Occurrence of depression in the individuals generally does not depend on only one reason. Various factors such as genetic factors, several environmental factors, past experiences and living conditions of the individual may cause depression (Öngider & Özışık Eyüpoğlu, 2013, 34-46). In addition to these; psychiatric disorders observed in the elderly people such as dementia, anxiety disorders, use of alcohol and substance disorders, sleep disorders, and presence of some physical diseases emerging or increasing its symptoms during the senility provide a basis for the depression. Due to the existence of a large number of diseases during the senility, there is a wide range of utilization of drugs, and side effect of the drugs used or using them too much also cause depression (Bakar, 2012).

Several researches done in our country, it is pointed out that factors such as in addition to the growing losses along with the chronological age that is getting on, unexpected negative living incidents such as loss of spouse or child, living alone, being divorced or widow, being female, deprivation of social support, family story, presence of various stress sources and medical disasters are main reasons of

depression in the elderly people (Sabancıoğulları, Kelleci, Aydın, & Doğan, 2006, 11-20). A part from these, reasons such as touchiness, feeling of uselessness, several dementia problems, imperceptions, absence of care and correspondingly emerged feeling of loneliness (Üstüner Top et al., 2010, 14-22) and low socioeconomic status may also cause depression (Blazer, 2003, 249–265).

Socioeconomic factors such as advanced age, low educational level and financial income, occupation of the person, form of life may make a way for depression in the elderly people (Kim, Choe, & Chae, 2009, 121–129). As the individual getting older, because he/she no longer has his/her earlier physical and mental strength, having some difficulties in several situations of living activities such as having a bath, making a food, dressing, that person may be obliged to live dependently being in need of assistance of someone else. This situation is also one of the reasons pushing the elder person to the depression as well (Topbaş, Yaris, Can, Kapuca, & Sayar, 2004, 57-60).

As contemplating in general, depression, regardless of which developmental stage in a person life, is an important emotional problem. However, as the difficulties the elderly people within, absences emerging with increasing age, regressions and losses are taking into consideration, the elder depression takes a different dimension. Entire of these changes may cause, fear of death particularly, several circumstances in the elder person (Turan, 2001).

Although the depression is one of the psychological diseases widely seen in the elderly people, this significant condition has been ignored because it has been considered as usual by the other people. The other people around the elderly people think that the elder people have depressive indications because of they use drugs and biological reasons, and those people regard this condition as usual. Thus, the

depressive indications that became unregarded and permanent also make the treatment difficult (Özen Çınar & Kartal, 2008, 399-404).

Some researches on senility and depression state that only % 20 of the elderly people who experience depression indications can be diagnosed as they are in depression and then treatment stage can be proceeded. Yet, there may be some difficulties in proceeding the treatment stage from the depression diagnosed. One of the reasons of that is increased healt expenses and treatment expenditures become more expensive nowadays. The elder individuals who cannot afford to pay the treatment expenditures try to self-healing. Several facts of life faced by the elder individual decrease his/her strength of struggle with the depression. Conceiving these circumstances demonstrates that how the depression during the senility is important as well as how the individual might be exposed to commit a suicide by that disease (Cole & Dendukuri, 2003, 1147–1156).

The depression in the elderly people is tried to be treated by various methods of treatments such as Electroconvulsive Therapy (ECT), medication, psychotherapy or providing social support. There are challenges in medication in the elderly people compared to youngsters. Because of the fact that other medical disasters are also frequently seen in the elderly people, so drugs interactions are observed as well. Side effects of the drugs often occur and these cannot be tolerated easily. Antidepressants are generally used for the treatment of depression in the elderly people (Sucuoğlu, 2012). Besides, psychotherapy has an important place in curing the depression in the elderly people as well. Especially cognitive behavioural therapy and interpersonal therapy are effectively applied. In addition, providing a social support to the individual and getting motivated from family members gathering by that person positively affect the treatment (Bakar, 2012).

On the next chapter, hopelessness, a subject matter which is closely related with the depression, will be emphasized.

2.1.2.2. Hopelessness in Elderly People

Hope means an individual's belief towards future. A hopeful person is not afraid of considering about his/her future. On the contrary, a hopeless person does not have a belief in his/her future, he/she does not think anything about the future. The hope is an important factor widely affecting an individual's life. A hopeful person struggles with wicked events happening to him/her, takes precautions and makes an effort to succeed in something. However, a hopeless person does not take care about any of these (İlhan et al., 2007, 49).

Hopelessness is defined as negative thoughts and beliefs about the person himself / herself and his/her future. These negative thoughts and beliefs are significant risk factors for depressive individuals who are 50 years old and older having notions of committing suicide or attempting to suicide that cause death (Britton et al., 2008, 736–741).

On his cognitive theory that he improved, Beck (1963) argues that the depression is based on hopelessness. Other concepts accompany with the hopelessness are sentiments such as worthlessness, hopelessness, indecision, weakness and uselessness. According to this theory, an individual in hopelessness is neither in a struggle for solving the problems he/she experiences, nor trying to succeed by accepting his/her failure. Although making no effort, that individual expects negative results by attributing negative meanings to his/her experiences even though he/she has no reality from all experiences that will be gained (as cited in; Özben, 2008, 136-151).

According to Erikson, a person, in his senility period, starts to review his/her life and questions about if the life is worth to life or not. At this point, by the time that person starts to think that his/her life has no meaning, he/she has got many things to change and has not enough time for it, then that individual faces off against the hopelessness. Erikson refers this situation as ego integrity versus despair (Özben, 2008, 136-151).

According to researches, hopelessness widely exists in the elder individuals and suicidal behaviors can be seen in the elder persons who are in hopelessness. Depressive indications and thoughts of hopelessness are interrelated to each other in the elder persons attempting to suicide. Thoughts and beliefs expressed with hopelessness may demonstrate that the person is in a huge depressive circumstance (Uncapher, Gallagher-Thompson, Osgood, & Bongar, 1998, 62-70).

2.1.2.3. Suicide in Elderly People

One of the pioneers of suicide, Durkheim (1897) defines the suicide as a death resulting directly or indirectly from an act of the victim himself / herself, which he knows will produce this result (as cited in; Aydemir, Vedin Temiz, Göka, 2002, 33-39). According to researches, % 25 of attempts of suicide are repeats and a serious rate as % 30 results in death (Odağ, 1995, 1-14). Idea of suicide has an importance as attempt of suicide, and its lifetime prevalence in a society is between % 13.5 – 35. A human may think about the idea of suicide but maintains his/her life without putting it into action. However, on the contrary, a person may suddenly attempt to suicide without thinking on it before. Attempts of suicide without an idea of committing generally take place as a result of spontaneous decision, and these attempts generally do not result in death. More death results are seen in the people planning the attempt of suicide in company with the idea of suicide (Aslan & Hocaoğlu, 2014, 294-309). A

person may execute his/her own death by attempting to suicide by having some thoughts such as getting rid of problems that cannot be solved, putting an end to his/her sorrows experienced, or having an idea that he/she will have a rest by killing himself / herself. Therefore, having sensibility, the attempt of suicide is a subject matter which requires serious researches (Odağ, 1995, 1-14). In the researches examines relationship between depression and suicide, it has been considered that suicide is related to hopelessness more than depression. If a person has some negative thoughts about his/her future, a risk of attempting to suicide of him/her also increases. It has been observed that hopelessness creates a connection between depression and suicide. Besides suicide has a relation with hopelessness and depression, the researches demonstrate that there is a strong connection between feeling of loneliness and low self-esteem (Aydemir et al., 2002, 33-39).

Because depression in the elderly people is a long-term and it gives heavy damages, it may lead the elder individual to have a thought and intention of suicide, or attempt to suicide, and the attempts of suicide may generally result in death (Tamam & Öner, 2001, 50-60). According to the researches, the elder individuals having an idea of suicide attempts to suicide more than the young do. The reason of this might be the depression is more severe in the elderly people. Because it is regarded that attempt of suicide is in direct proportion to intensity of the depression (Alexopoulos, 2005, 61-70). In one of their research, Henriksson et al., (1995) have detected that amongst people who died by committing suicide because of depressive indication, the number of individuals over 50 years of age is more than the younger individuals. Depression is the primary factor in attempts of suicide which is observed in the elderly people. It has been detected that there is a diagnosable psychopathology in % 76 of the suicides observed in the elderly people. % 54 of these have been

identified as major depression and % 11 of these have been identified as minor depression (Göktaş & Özkan, 2006, 30-37).

According to the researches, as long as the age gets along the rate of suicide increases, and it is argued that losses experienced in this period and psychological problems may cause this circumstance (Aslan & Hocaoğlu, 2014, 294-309). According to some researches in Turkey, it has been detected that frequency of suicide completed in advanced ages is at the lower level than other countries. In statistics of the year of 2003, it can be seen that the rate of deaths resulted from suicide amongst the age of 65-74 is at % 5.66, and amongst the age of 75 and over it is at % 3.77. At the same time, it has been observed that attempt of suicide in male persons is much more than the females amongst the elderly people (Özel Kızıl, Yolaç Yarpuz, Ekinci, Sorgun, & Turan, 2007, 57-60).

Hopelessness and suicide are from the depression related factors, and another situation that emerges depending upon physiological and psychological changes is fear of death. On the next chapter, the death anxiety and its relationship with the depression will be mentioned.

2.1.2.4. Death Anxiety in Elderly People

Life and death are inevitable truths of human life. Definition of death varies from society to society, from person to person according to variables such as age, gender, language, religion and culture (Karakuş, Öztürk, & Tamam, 2012, 42-79). For instance, while the death is regarded as a regression for a child in adolescence period, the elderly people take the death naturally. (Onur, 1992, 162-212) According to the existentialist approach in psychology, death is the ultimate dilemma for humans. The death that every human being has to experience and which existence also cannot solve

is regarded as a meaning of life. Every living creature will experience the death weather he/she asks or not. (Yanbastı, 1990)

By a general definition, the death anxiety is a type of anxiety existing as from an individual's moment of birth, continuing throughout his/her life, being the main reason of all anxieties in his/her life, in which that person will lose his/her existence entirety, a feeling towards the reality of an unavoidable annihilation by that person (Karakuş et al., 2012, 42-79). That a person knows that one day he/she will die may be a huge source of fear for him/her. Reason of this is that the death is out of control of the person. A person is anxious about his/her life will be over in such a way that he/she cannot control, and this circumstance means a strong indication for the depression as well (Öngider & Özışık Eyüpoğlu, 2013, 34-46).

While death anxiety is regarded as not be able to realize the plans about the future, not be able to achieve goals and to lose their healthy bodies for the young; however it occurs in the form of anxiety as not be able to applied responsibilities towards the people around, not be able to complete the unfinished business for median age and the elderly people. However, as the age gets on, a thought of getting closer to the death demonstrates that the elderly people have the thought of death more than the young. In spite of these, some researches has shown that the death anxiety is closely related with other factors such as life story of the individual, socio-demographic and socioeconomic condition as well as the age factor of him/her (Karakuş et al., 2012, 42-79).

An elder person may think about the death more than everybody else. The reason of this is that the person has now come to an end of his/her life and he/she is now so close to death. Every passing day is a messenger of that the death gets closer to himself / herself more for an elderly person. Physical and cognitive problems and

difficulties occurring along with the person's getting elder consolidate the idea that the person is close to death. If these thoughts frequently and intensively come into existence on the elderly person's mind, this situation may cause that the person might experience a depression along with psychological problems. Therefore, to be able keep the idea of death under control and to be able to determine its size are very crucial (Üstüner Top et al., 2010, 14-22).

There are several factors affecting the death anxiety and different researches have been done for each of them in the literature. Factors such as age, gender, educational status, marital status, occupation, cultural differences, degree of religiousness, health problems generate alterations and diversities on the death anxiety (Karakuş et al., 2012, 42-79). According to the researches done, it has been observed that females have the death anxiety much more than males. According to Florian and Mikulincer (1997), when women lose someone they love, then they experience the fear towards death more than men do. However, in some researches, it has been detected that the death anxiety has no relation with gender in the elder population as well. If a person has a health problem, then it also affects the degree of the death anxiety. According to researches, the individuals having chronic diseases feel the death anxiety more than healthy individuals (Azaiza, Ron, Shoham, & Tinsky-Roimi, 2011, 610-624).

Relationship between religiousness and the death anxiety has been searched. It might be considered that devoutly religious people have the death anxiety lesser than less religious people. Reason for this is religious people accept the death due to the belief in God and life after death. In a research, Fortner and Neimeyer (1999) argued that because religiousness is seen as a consistent term in senility, the death anxiety and religiousness are the terms which are distant from each other (as cited in; Azaiza

et al., 2011, 610-624). In a research done by Hökenekli (1991), relationship between religion and death anxiety was studied, and it was detected that because the religious persons dwell upon the subjects about the death, they accept the death and their anxiety level is low.

The death anxiety is comprised of three different components such as emotional, cognitive and motivational. As the death becomes a threat against existence of the individual, emotional memory areas become active. In terms of cognition, the individual consider about everything related to the death and the death anxiety in a lifetime, and it is considered that the individual feels lesser anxiety towards the death in virtue of a cognitive structure as a result of life experiences. As motivational, behaviors of the individual are influenced due to awareness towards the death anxiety and so a motivation is provided towards the life (Kalaoğlu Özturk, 2010).

One of the first studies psychologically examining the term of the death anxiety in Turkey has been done by Ünver (1938). In this research, writings on Turkish sepulchral monuments and epitaphs were studied, and thoughts and attitudes about death were analyzed. In consequence of the research, it was confirmed that the death was easily accepted and the death was not be feared so much (Akça & Köse, 2008, 7-16). Another research done by Şenol (1989), the factors affecting anxieties and fears of the elderly people residing in nursing home felt towards death were examined. Templer's (1970) Death Anxiety Scale (DAS) was used in the research. In this research, death anxiety in the elderly people has been found at the medium level, and it has been detected that level of death anxiety in the individuals at the age between 60-64 is higher than those who are above the age of 70 (Şenol, 1989).

Taken place on the top in the literature about the subject of the death anxiety, Templer (1970) considered that that subject matter was not researched enough and it was seen as a taboo by the researchers of that time, so in order to bridge the gap, Templer developed DAS. Measuring the level of death anxiety of individuals was provided with that scale. Şenol (1989) prepared a Turkish adaptation of the scale. Later, Akça and Köse (2008) have researched the validity and the reliability of the Turkish adaptation by re-evaluating in different groups according to Turkish culture

As looking at the other researches done about this subject in rest of the world, Fortner and Neimeyer (1999) have done a meta-analysis by examining 49 researches related with death anxiety in the elderly people prepared between 1996 and 1999. As a result of the meta-analysis, it has been determined that there is a positive correlation between death anxiety with caring conditions and physical and psychological problems; also there is a negative correlation between death anxiety and ego entirety, however its' any relation with age and gender cannot be found.

Galt and Hayslip (1998) have done a research examining the relationship between age and death anxiety, and they have detected that level of death anxiety in the elderly people is higher than the young.

According to Erikson, as the individual gets old, then he/she encounters with happiness or unhappiness and hopelessness. To be happy and peaceful in senility, the individual has to acknowledge negative incidents experienced in the past and has to draw positive outcomes from these events. If the person succeeds this, then he/she is happy with his/her life and so he/she does not any fear of death. However, if the person does not acknowledge the past experiences and encounters with hopelessness in the senility, so fear of death is unavoidable for him/her (Aydın, İşleyen, 2004, 19).

2.1.2.5. Relation between Death Anxiety and Depression

Depression is not always seen alone in the individual, it can be seen along with a different disease or a different indication. While indications occurred in depression examined, it has been detected that the indication which is most frequently observed is anxiety. Thereupon, a relation between depression and anxiety was started to be researched, relation between various types of depression and anxiety has been observed, and it has been seen that death anxiety has a huge role on depression (Öngider & Özışık Eyüpoğlu, 2013, 34-46). In a research examines the relation between death anxiety and depression, many patients who were about to die were interviewed. In this research done for examining psychological dimension of phenomenon of the death, it was concluded that people from different ages waiting for their deaths got through five consecutive periods in that era. These are the periods which start with denying, after a stage of anger and bargain, carry on with the depression, and finally end with accepting (Kubler-Ross, 1997, 57).

Unavoidable thought of death for an elder person, considering levels of frequency and intensity, may cause him/her go into depression by disinclining him/her, and decreasing his/her desire to live and joy of life (Topbaş et al., 2004, 57-60). Besides, as the age gets on, a growing individual may accept the thought of death more than the young, and if that person has some physical diseases might regard the death as a salvation for getting rid of these, and might be get away from feeling an death anxiety. In some researches, it has been observed that the young individuals have death anxiety more than the elder individuals (Karakuş et al., 2012, 42-79).

According to Erikson (1963), if a person can provide the ego integrity in the era of ego integrity versus hopelessness which is the last stage of psychosocial development, then he/she may look at the future hopefully and has no death anxiety.

However, an elder who cannot achieve ego integrity is hopeless and it is inevitable for that person to experience death anxiety along with depression (Boylin, Susan, & Milton, 1976, 118-124). On the next chapter of the study, Erikson's views and ego psychology theory based on Erikson's idea will be described.

2.2. Ego Psychology

In recent years, several theories related with ways of learning and developmental stages duration a life time of human beings from birth to death have been put forward. One of the thinkers putting forward the most important one amongst these theories is Erikson. Erikson (1963) developed a theory of psychosocial developmental stages which contains all stages of human beings including from birth to death (Gürses & Kılavuz, 2011, 153-166).

The theory of psychosocial developmental stages represents different reflections in different ages of a human being's life time experienced psychological, social and cultural qualities. The point that Erikson tried to emphasize is that personality characteristics emerged as a result of genetic, biological and cognitive effects proceed for a life time (Özgüngör & Acun Kapıkıran, 2011, 114-126). This theory in general, as distinct from Freud's theory of psychosexual development, points out that the human's personality development continues throughout the life, but it does not start and end in the early years of life (Gürses & Kılavuz, 2011, 153-166). According to Erikson, every individual gets through varied crisis periods through his/her life, and a lifelong personality development and maturation of the individual depend on whether these crisis periods are successfully got over or not (Arslan & Arı, 2005). Erikson (1963) argues that a human being gets through eight different developmental periods in a lifetime. Each period involves several experiences, goals, passions, difficulties and conflicts. If a person demands to achieve his/her goals,

he/she has to overcome conflicts and difficulties in that period (Gürses & Kılavuz, 2011, 153-166).

Theory of psychosocial developmental periods demonstrates that experiences having in periods of childhood and adolescence may affect behaviours in adulthood periods; moreover behaviours and experiences during adulthood may affect thoughts and behaviours during senility; in fact each period is interrelated with each other (Gürses & Kılavuz, 2011, 153-166). Therefore, each of these eight different period depends on solving conflicts in previous developmental period successfully, and this situation shows that the individual can achieve his/her goals in later periods as well. However, so that the individual cannot solve the conflicts past developmental period leads him/her to experience problems on forthcoming periods, but it is possible to be compensated (Rylands & Rickwood, 2001, 75-89). Seventh of these stages, stage of stagnation versus productivity is closely related to eight and the last stage which is stage of ego integrity versus hopelessness. Seventh period is the era involving adult individuals. If a person believes that he/she is fertile and productive for himself/herself and those around him/her in seventh period, as coming to eighth period, namely in senility period, he/she will be able to achieve ego integrity and will be able to have a good senility. However, if a reverse situation occurs, if that person cannot protect his/her productivity and cannot be productive for those around him/her, then that person will feel that he/she experienced the previous period for nothing as coming to senility, so that individual will not achieve the ego integrity (Zarrett & James, 2006, 61-75).

Erikson (1963) advocates that an individual experiences his/her past experiences, stage of personality evaluation and acceptance as coming to end of the development. Erikson names this period which is the last of the psychosocial

developmental periods and comes across to senility of the individual as "ego integrity versus ego-despair" (Rylands & Rickwood, 2001, 75-89). As coming to that period, the person will experience one of two opposite situations. Either he/she will achieve previous seven periods successfully and start to have a happy life by gaining his/her ego, or he/she will go on to his/her life in unhappiness and hopelessness along with conflicts that cannot be solved during the previous periods (Gürses & Kılavuz, 2011, 153-166; Zarrett & James, 2006, 61-75). Ego integrity means that the individual accepts all successes and failures, feels like an important part of a huge story in his/her own life, that he/she considers that he/she grows mature along with his/her age getting along, having no death anxiety, being happy and peaceful. However, an individual who is not happy with his/her past and does not want to accept the past experiences gets desperate and become unhappy because of having no enough time for living the past once again or restoring the experiences (Rylands & Rickwood, 2001, 75-89).

Reason of anxieties lived by an individual is to protect the young generation and being productive as far as being remembered in the future. That person feels like being able to carry out what he/she has produced to the future, and therefore he/she tries to establish positive ego integrity during the senility (Boylin et al., 1976, 118-124). The period of ego integrity versus despair is designated as that the elder person accepts the death and maintain a happy life, because of satisfying with having a life that is full of productivity, and it also designated with conflict between thought about living a life for nothing and hopelessness as a result of not to use the productivity and having no production for the next generations (Gürses & Kılavuz, 2011, 153-166; Zarrett & James, 2006, 61-75).

According to Erikson's theory, the most important thing is psychological health of the individual. Feelings of an individual in senility towards the death is related with how he/she evaluates his/her acquisitions, losses, to be able to achieve the goals or not. Interpreting the past is related with whether the individual can achieve his/her ego integrity or not, and it changes depending on whether he/she lived his/her life significantly and better (Boylin et al., 1976, 118-124). Moreover, Santor and Zaroff (1994) advocates that there is a connection between ego integrity and accepting the past that was put forward by Erikson. Erikson's theory of psychosocial developmental periods has been considered as an important theory for the societies. Because, in this theory, Erikson aimed that people can make an intergeneration contact easily, understand each other better, and spend common time with each other more (Gürses & Kılavuz, 2011, 153-166).

The next chapter of the study will be the concept of giving meaning to past, developed on the basis on Erikson's theory.

2.3. Giving Meaning to Past

Every individual interprets the life according to his/her own livings, concepts, and way of perception. In every period, life is perceived differently by individuals. During the senility, individuals evaluate their lives according to their personalities, rules and life experiences. As a result of these evaluations, they interpret their past lives properly to their own worlds (İçli, 2010, 1-13).

Giving meaning to past is studied in two sub-dimensions as acceptance of the past and reminiscence of the past. Composition of these two situations shows that how the elder individual interprets his/her own past living. A good giving meaning to the past is possible with a good psychology. Therefore, a good giving meaning to the past ensures the elder individual to have a good sensility period. Thus, depressive

indications observed in the elder individual and occurance of depression can be avoided (Boyacıoglu Şengül, 2006).

To be able to interpret the past life for the elder individual, to be able to maintain his/her aims and goals and to be able to accept the responsibility of the past life shows that that person's life satisfaction is at a high level. Life satisfaction is also an important factor affecting the individual's mental health and adaptation to the senility in direct proportion. Therefore, that life satisfaction is at a high level has an importance for the elder individual's psychological health (Kaçan Softa et al., 2015, 12-21).

The elder persons may be glad to tell about their past lives from time to time, sharing their memories with the others may make them feel relaxed. They give meaning to their memories by telling them. That giving meaning provides them to maintain their characteristic features by accepting their own livings as what they are and to be able to raise their self-respect. So, while the elder person's life quality get higher, then his/her joy of life and excitement continues but never ends. This ensures to have a strong physiology which is away from psychological and physiological problems in the senility as well (İçli, 2010, 1-13).

2.3.1. Acceptance the Past

Concept of acceptance of past was put forward by Santor and Zuroff (1994). According to them, acceptance the past means that the individual to have a positive representation about his/her own past by internalizing it (Boyacıoğlu & Sümer, 2011, 105-118).

Acceptance the past means accepting all experiences had in the past. However, accepting all experiences does not mean that either everything experienced in the past is positive or being happy all the time. So, it might be some negative experiences had

in the past and hard times might be got through (Boyacıoğlu, Şengül, 2006). So that the individual is able to accept his/her own past does not require him/her to ignore negative incidents he/she experienced in the past or to forget them. The person might have some negative events and might consider these negative incidents and question them. However, at this point, a human being who is able to accept the past cannot experience negative sentiments, disappointments or anxiety towards negative events he/she had (Boyacıoğlu & Sümer, 2011, 105-118). Here, what important is to be able to accept the experiences had in the past and to be able to make beneficial inferences from each experience. Thus, the past experiences will not maintain their impacts by just having experienced. It is a crucial element for the individual to accept the past for his/her psychological health (Boyacıoğlu, Şengül, 2006).

The individuals who cannot accept their past have a negative representation towards their past. The individual has stuck in his/her own past. He/she always considers negative events had in the past, and while thinking these, he/she experiences various anxieties and intensive negative feelings. This circumstance brings the individual to the risk of confrontation with depression (Boyacıoğlu & Sümer, 2011, 105-118). However, if the individual is able to accept all disappointments and negative incidents experienced in his/her own past, then it means he/she is able to accept his/her own past. In the life of the person, a negative sentiment from the past no longer exists. So, a possible depression problem that maybe will occur during the senility can be avoided (Boyacıoğlu, Şengül, 2006).

According to Erikson (1963), in the ego integrity versus hopelessness, which is last stage of the living from psychosocial developmental stages, the elder takes his/her past under review and questions himself/herself. As a result of these evaluations, if he/she finds past livings as successful and accepts them, then that

person may attain the ego integrity. According to Butler (1963), while getting older, the person starts to investigate his/her past, and the rule of having a successful senility depends on the investigations to result in success (as cited in; Boyacıoğlu & Saymaz, 2012, 220-228).

2.3.2. Reminiscence the Past

According to reminiscence of the past which is another dimension of interpreting of the past, if a human being does not want to remember his/her own past, it means he/she experienced some incomplete events in the past. The incomplete events are not accepted by the individual and make him/her feel unhappiness, hopelessness and weakness. All of these negative feelings appear as depressive indications during the senility. Since, these sentiments trigger the depression. Therefore, two elder persons may trigger depressive indications by considering negative incidents in the past. But if a person can finish and accept all events in the past, then he/she will not experience any problem during the senility (Boyacıoğlu, Şengül, 2006).

2.4. The Importance and Aim of the Study

Senility is the period that will be experienced before dying by every creature going on living. As the time goes on, the world keeps developing, and as the world develops technology and medical science progress. This situation decreases rate of death, avoids the diseases, and ensures life time to extend. In the years proceeding in this direction, it is predicted that the rate of senility in the world population. Therefore, senility is a crucial period concerning the whole humanity.

Along with increase of the elder population, emerging physical and psychological diseases also increase in this group. One of the psychological diseases widely seen during the senility is depression. This disease that leads the individual's

life to different difficulties in each period of life also causes bigger difficulties during the senility and therefore it has an importance. Depression carries on longer and more severe in the senility compared to previous periods. Indications occurred with the depression affect the elder person deeply. Besides, the depression in senility results in attempt to suicide and these attempts also end with death generally. Reason of this is that the treatment of the depression proceeding in long duration and strongly is difficult. The elder person no longer has a strong and vigorous body and mind as once he/she had in the youth, and he/she has a difficulty in struggling with the depression, so possibility of recovery decreases as well. Therefore, this study has an importance for the sake of detecting psychological problems observed in the elderly people. Decline of the problems also avoids the risk of the depression and may increase life quality of the person.

The existence of the depression in healthy people above the age of 50 in the society has been researched in this study. Furthermore, accepting the past and its relation with hopelessness, death anxiety, risk of suicide with the depression has been investigated. Besides, the relations between accepting the past and these variables examined in the direction of Erikson's theory have been researched as well. As the literature examined, no study including these subject matters researched together observed.

Hypothesis of this study are;

i. Do depression in the elderly, hopelessness, accepting the past and death anxiety differ in terms of gender?

ii. Do the elderly people identifying or non-identifying themselves as religious differ from each other in terms of depression, hopelessness, accepting the past and death anxiety?

iii. Do depression in the elderly, hopelessness, accepting the past and death anxiety differ in terms of age?

iv. Do depression in the elderly, hopelessness, accepting the past and death anxiety differ in terms of educational level?

v. Does death anxiety in the elderly people have a relation with depression, hopelessness and accepting the past?

vi. Does depression in the elderly people have a relation with hopelessness and accepting the past?

vii. While the elderly people having depression and the elderly people having no depression are compared, is there any difference between variables?

viii. Do accepting the past and hopelessness predict the depression in the elderly people?

Limitations

1. It is a limitation that participants in the sample filled self-report scales about depression, hopelessness, death anxiety and accepting the past. They may have not specify the actual situation because of social desirability concern.
2. Primarily participants intended to create from TRNC and 65 years and over elderly but after included participants that from Turkey and between 50-65 years because of understanding that could not achieve enough person number.

3. METHOD

This research has been studied to examine relationship between accepting the past in the elderly people living in in the society, hopelessness, depression, death anxiety and risk of suicide. This chapter includes the details of socio-demographic characteristics of participants, measuring instruments used, process of data acquisition, statistical processes used.

3.1. Sample

Universe of the research is comprised by citizens of Republic of Turkey who reside in TRNC and Konya. The sample has been picked by snowball sampling method. The research consists of 50 female and 50 male, 100 participants in total, who are above the age of 50. Besides, the participants who are literate and voluntarily join to the research as well as who do not have any sight-disable or disable of hearing and cognitive disorder such as dementia during the study is examined are included to the research. From the answers given to the socio-demographic data form, it has been detected that one participant had a severe psychiatric disaster and used drugs, and therefore he/she was excluded from the study.

Average age of the participants is 64.38 (SD=6.6) and range of age is 50-82. In addition to this, it has been determined that the most of the participants are married, living with their families and having no physical or psychiatric disaster.

Socio-demographic form includes some questions considered to be associated with hypothesis of the research in addition to scales, except the individual's socio-demographic characteristics. Furthermore, it has been observed that majority of the participants are those who consider that life is worth to live, having no purpose of will of dying, thought of suicide, intention of suicide and attempt of suicide. In the sample, it was learned that 3 of the participants committed and attempted to suicide by drugs

as a question of "have you ever committed to suicide?" was asked. Socio-demographic characteristics of the sample are summarized on the Table 2.

Table 2. Socio-Demographic Characteristics of the Subjects

Variables		n (%)	Mean (Sd)	Range
Gender				
	Female	50 (50.5)		
	Male	49 (49.5)		
Age			64.38 ± 6.6	50-82
Years of education			11.81 ± 3.23	5-15
Marital status				
	Single	5 (5.1)		
	Married	86 (86.9)		
	Divorced	3 (3.0)		
	Widowed	5 (5.1)		
Current employment				
	Employee	41 (41.4)		
	Not employee	43 (43.4)		
	Housewife	15 (15.2)		
People lived together				
	Single	6 (6.1)		
	With family	93 (93.9)		
Number of children				
	No children	12 (12.1)		
	1	12 (12.1)		
	2	38 (38.4)		
	3	23 (23.2)		
	4	8 (8.1)		
	5	4 (4.0)		
Nationality				
	Turkey	35 (35.4)		
	TRNC	64 (64.6)		
Having a physical illness				
	Yes	7 (7.1)		
	No	92 (92.9)		
Having a psychiatric illness				
	Yes	1 (1)		
	No	99 (99)		
Describing himself/herself as a religiouse				
	Yes	47 (47.5)		
	No	52 (52.5)		
The life is not worthy living				
	Yes	17 (17.2)		
	No	82 (82.8)		
Willing of death				
	Yes	19 (19.2)		
	No	80 (80.8)		
Suicidal Ideation				
	Yes	6 (6.1)		
	No	93 (93.9)		
Suicidal Intent				
	Yes	6 (6.1)		
	No	93 (93.9)		
Suicidal attempt				
	Yes	3.0 (3)		
	No	96.0 (97)		

Table 3. demonstrates the comparison of the participants from Turkey and TRNC in terms of socio-demographic characteristics and clinic scales. Accordingly, amongst the groups of Turkey and TRNC, it has been identified that there is a significant difference in terms of average of age, but there is no difference between educational level, SMMT, DAS, GDS, BHS, MPQ mean values. Therefore, next analyses have been made as only one group by getting the groups combined.

Table 3. Comparison of Age, Education Status, The Standardized Mini Mental Test, and All Scales between subjects from TRNC and Turkey

Nationality	TRNC (n=64)	Turkey (n=35)	t df p
Variables and Scales' Scores	**m±sd**	**m±sd**	
Age	67.07 ± 5.39	59.45 ± 5.75	-6.565 97 < 0.001*
Education Status	11.53 ± 3.14	12.31 ± 3.37	1.155 97 0.25
SMMT	27.01 ± 2.27	26.17 ± 2.8	-1.626 97 0.11
DAS	7.2± 3.15	7.54 ± 3.32	0.503 97 0.62
GDS	8.06± 6.00	9.08± 5.84	0.818 97 0.42
BHS	5.84 ± 4.54	6.22± 4.74	0.396 97 0.69
MPQ	116.37± 20.63	121.42± 21.87	1.14 97 0.26

***p < 0.05**

SMMT= Standardized Mini Mental Test, DAS= Death Anxiety Scale, GDS= Geriatric Depression Scale, BHS= Beck Hopelessness Scale, MPQ= Meaningful Past Questionnaire.

3.2. Instruments

3.2.1. Socio-Demographic Information Form

It is a form prepared by researchers on the purpose of determining socio-demographic characteristics of the elderly people participated to the research. This form is composed of 18 items including peculiarities and such as gender, age, home city, occupation, educational level, marital status, number of children, who does he/she live with, besides it includes some open ended questions such as if he/she has any physical or psychiatric diseases or not, if he/she considers himself/herself as a religious person or not, if he/she considers the life is worth to live or not, if he/she wants to die or not, if he/she has a thought or intension or attempt of suicide or not, if he/she had, how many times he/she had and which method he/she used.

3.2.2. Standardized Mini Mental Test (SMMT)

Mini Mental Test was developed by Folstein ,Folstein and McHugh (1975). The test has been applied to measure dementia and delirium level in the elder individuals. A standardized version and practice instruction of the Mini Mental Test have been formed by Molloy and Standish (1997). It was translated into Turkish by Güngen, Ertan and Eker (2002), and in this translated version, it was aimed that avoidance of differences that may possibly occur due to application in several persons by applying in company with instruction. The purpose of development of the test is that other methods used within the compass of neuropsychiatry examination methods aiming to measure cognitive talents and dementia stage of the elder persons are long-duration and complicated and it is hard to evaluate. Compared to the other methods that are used in this scope, SMMT is a test that is completed in a short period of time. Moreover, SMMT is composed by 11 items. The purpose of the test is to measure general cognitive functions. It is comprised of five main topics such as memory

record, orientation, attention and calculation, recall, and language. The highest mark that can be got from the test is 30. Cut-off score for the educated is 25. Those who can get mark of 25 and above are regarded as mentally healthy in terms of dementia. It has been detected that sensibility of Turkish version of the scale is .91, specificity of is .95, positive and negative precursor values are .90 and .95 high. At the same time, it has been observed that on inter-users reliability analysis, high correlation is detected as r=.99 and kappa value is detected as .92 (Akdemir, Cangöz, Örsel, & Selekler, 2007, 118-128).

3.2.3. Beck Hopelessness Scale (BHS)

Beck Hopelessness Scale has been developed by Beck, Weissman, Lester and Trexler (1974). Beck and his friends researched that subject matter because they thought that there was a close relationship between depression, suicide and hopelessness. They developed that scale with the purpose of objectively determining people's level of hopelessness as numerically as a result of long-continued examinations and observations. The scale was developed to measure the individual's negative expectations about the future and to ensure the individual to evaluate himself/herself. It is a scale which has a high validity and reliability and widely used in the literature (Durak, 1994, 1-11).

The scale is composed of questions involving emotional, motivational, cognitive subjects. It is a self-report type scale which is comprised of three basic factors such as emotions about the future, loss of motivation, and expectations about the future. It is formed by 20 items. Items 1, 6, 13, 15, 19 involve emotions about the future; items 2, 3, 9, 11, 12, 16, 17, 20 refer to loss of motivation; and items 4, 7, 8, 14, 18 represent expectations about the future. Each item is answered as 'yes-no', and the answers are marked between 0-1. Maximum mark that can be get is 20. While the

answer of 'no' in the questions of numbers 1, 3, 6 , 8, 10, 13, 15, 19 get 1 point; the answer of 'yes' in the questions of numbers 2, 4, 7, 9, 11, 12, 14, 16, 17, 18, 20 get 1 point. Reason of this is that the scale has some items supporting and non-supporting the hopelessness. While in the items supporting the hopelessness, answer of 'yes' gets 1 point, answer of 'no' gets 0 point; in the items non-supporting the hopelessness, answer of 'yes' gets 0 point, answer of 'no' gets 1 point (Seber, Dilbaz, Kaptanoğlu, & Tekin, 1993, 139-142). In other words, each answer supporting the hopelessness gets 1 point, and total point demonstrates the individual's level of hopelessness. As the result comes out how a high level, so the person's hopelessness is also such a high level as well (Beck et al., 1974, 861-874).

The scale's adaptation to Turkish is prepared by Seber (1991). Validity and reliability studies are prepared by Seber (1991) and Durak (1994). In reliability studies of the scale, Seber et al. (1993) have found internal consistency coefficient as .86; total-item correlations as .07 with .72; test-retest reliability coefficients as .74. Durak (1994) who have done similar studies, have also detected that internal consistency coefficient as Cronbach alpha .85; total-item correlations are between .31 and .67. (Şahin, 2009, 271 -286).

3.2.4. Geriatric Depression Scale (GDS)

The scale was developed by Yesavage et al., (1983). It is used in measuring depressive symptoms in the elderly people and it aims to find depression risk. It is formed of 30 questions. Each question is answered in the form of 'yes-no'. In the scale, items 3, 4, 5, 6, 8, 10, 11, 12, 13, 14, 16, 17, 18, 20, 22, 23, 24, 25, 26 and 28 include a reverse expression. All answers supporting the depression is graded with 1 point, the other are also graded with 0 point. Total point is approved as a depression degree. Hereunder, 14 point is approved as cut-off score, and grades above 14 point

show that the individual is in depression. Validity and reliability study of Turkish form of the scale have been prepared by Ertan, Eker, & Şar (1997).

The purpose of development of Geriatric Depression Scale is to examine the presence of depression in depression patients on geriatric population in general. Depressive symptoms such as sleep disorder, loss of energy, decrease of libido are widely observed in the elder persons who have no depression. Thoughts of death and hopelessness about the future have different meanings for the elderly people. Moreover, decrease in motor retardation and activity level because of chronic medical disasters widely seen in the elderly people along with presence of dementia accompanying to these affect the cognitive processes. Due to all of these reasons, in order to evaluate the depression in the elderly people, different symptom definitions are required. Geriatric Depression Scale is privately designed to be understandable and applicable easily for the elderly people to apply the scale easily. While the scale measures the depression, it was formed as regarding the differences between the elder and non-elder people. Items designed according to this involve decreased affection, declination in sense of self, declination of motivation, tendency towards past instead of future, cognitive problems, obsessive characteristics and agitation (Kılınç & Torun, 2011, 39-47).

3.2.5. Meaningful Past Questionnaire (MPQ)

The scale was developed by Santor and Zuroff (1994). It was examined as two subtitles as acceptance the past and reminiscence the past. Santor and Zuroff identify the acceptance the past as a positive indicator of the person's past life. Reminiscence the past means to be able to discuss and consider about the past as well. Psychometric characteristics of the scale and its study of validity and reliability have been tested by Santor and Zuroff. Cronbach alpha value have been found 86 for the acceptance the

past; and found 72 for reminiscence the past. The scale is formed by 27 items, 16 items are about acceptance the past and 11 items are about reminiscence the past either. Turkish study of validity and reliability have been prepared by Boyacioglu (Boyacioglu Sengul, 2006).

3.2.6. Death Anxiety Scale (DAS)

The subject of death anxiety has been researched by many researchers and several scales have been developed in this scope. Amongst these researches, the scale that comes into prominence recently is Death Anxiety Scale which is developed by Templer (1970). According to Templer, fear of death is evaluated as a subject matter which had been considered as a taboo by behavioral scientists and health professionals in the middle of the 1960s. Therefore, Templer felt the need of developing Death Anxiety Scale. Reason for this scale to be preferred which is widely encountered in the literature is that the scale is understandable and short. Besides, the reason for the scale being widely preferred is that it is appropriate to be used in wide scopes such as age, gender, cultural differences, physical disorders and mental disorders. Due to these reasons, Templer's Death Anxiety Scale has been used in this research. The scale measures individual's thought about death, attitudes towards death, and anxiety towards post-mortem or death itself. Furthermore, the scale was separately applied to patient and normal groups which are from different ages, different genders, different occupations, and as a result, it was detected that anxiety scores average acquired by the sample is 4.5 - 7.0. At the same time, it was observed that females, patient groups and the young people have anxiety level more. According to this research, as long as the age gets on, level of anxiety decreases (Akça & Köse, 2008, 7-16).

The scale has been adapted to Turkish by Senol (1989). Later, validity and reliability studies have been examined by Akça and Köse (2008). Test-retest reliability of the scale has been calculated as .79. At the same time, its reliability has been found as .75 by the Kurder-Richardson formula. According to original findings in Templer's (1970) study of the scale, Test-retest reliability has been found as .83; its reliability calculated with Kurder-Richardson formula has been found as .76 as well (Akça & Köse, 2008, 7-16).

The scale is formed by 15 items. It is answered as "correct-incorrect" in the form of dual likert scale. In its scoring, while the answers given as "correct" get 1 point, the other answers get 0 point. (Templer, 1970) Score interval of the test is between 0-15. It has been evaluated in the way of that as the point obtained gets higher, death anxiety is also gets higher. Hereunder, 7 point is approved as the limit, and it has been considered that those who get 7-15 points have a high death anxiety (Akça & Köse, 2008, 7-16).

3.3. Procedure

The study protocol was approved by the Committee on Ethics and Human Research of Near East University, in compliance with the Code of Ethics of the World Medical Association (Declaration of Helsinki).

The scales were applied to the participants at their homes or in their offices by holding face to face interviews. First of all, the purpose of the research was told to the participants. Informed approval form was read and signed by them. All participants gave written informed consents. After the participant approved that form, he was applied a face to face SMMT by the practitioner. That scale was applied in order to determine if the participants have dementia, and if they have any cognitive disorder or not which may be an obstacle to participate to the research. Cut off point of the scale

is 24 (for the illiterate), and is 25 (for the literate), those after 20 means serious cognitive loss. Those who do not have a serious cognitive loss, in a sense, the elder individuals who do not get below 20 points from the SMMT have been taken to the sample and other self-report measures were filled by the participants themselves. The sampling participants, after SMMT, were given a socio-demographic data form which had already been prepared. Later on, other scales such as BHS, MPQ, GDS, DAS were applied to the participants in different order. The reason of its appliance in different orders is to avoid consecutive test affect and to provide a counter balance. Application of all scales was taken approximately half an hour. Collection of data was completed between July and October 2015.

3.4. Statistical Analysis

Evaluation of scale applications in the research has been carried out by Statistical Program for Social Sciences (SPSS version 22 for Windows).

In total 100 participants, with the aim of searching hypotheses of the research, initially SMMT, the other four scales applied such as DAS, GDS, BHS and MPQ were analyzed by taking the effects of socio-demographic characteristics into consideration. 1 participant was determined that he/she had a serious psychiatric disease and was using drugs and excluded from the study. As a result of this, total sample was analyzed with 99 persons. All data were examined, data cleaning was done, missing values were determined, and they were put in their locations. Besides, that if the data indicate a normal distribution was evaluated by skewness and kurtosis. For the data determined indicating a normal distribution, Pearson correlation test was used in correlation analysis, in comparison of groups in terms of independent variables ANOVA or independent sample test was used.

4. RESULTS

This section of the study covers the analysis about the questions of the research.

4.1. Scores Obtained from All Scales

Primarily, the mean and standard deviation values belonging to the clinical scale scores obtained from the sample of 99 people were given in Table 4.

Table 4. Means, Standart Deviations and Ranges of All Clinical Measures Used in The Study

Scales	Mean	S.D.	Range (Min-Max)
SMMT	26.72	2.49	21 - 30
DAS	7.32	3.20	1 – 14
GDS	8.42	5.94	0 – 25
BHS	5.98	4.60	0 – 19
MPQ	118.16	21.11	62 – 177

SMMT= Standardized Mini Mental Test, DAS= Death Anxiety Scale, GDS= Geriatric Depression Scale, BHS= Beck Hopelessness Scale, MPQ= Meaningful Past Questionnaire.

4.2. Comparison of Scores Obtained from All Scales by Gender

The mean values and standard deviations and statistical comparisons of the scale scores of female and male participants were given in Table 5. Accordingly, no difference was found between the two genders in terms of scales.

Table 5. Comparison of The Present Scales Between Male and Female Subjects

Gender	**Male (n=49)**	**Female (n=50)**	**t** **df**
The Scales	**M ± S.D.**	**M ± S.D.**	**p**
DAS	6.80 ± 2.86	7.84 ± 3.46	-1.64 97 0.11
GDS	7.31 ± 5.16	9.52 ± 6.48	-1.88 97 0.06
BHS	5.24 ± 3.94	6.70 ± 5.10	-1.59 97 0.12
MPQ	121.06 ± 18.68	115.32 ± 23.09	1.36 97 0.18

*$p < 0.05$

DAS= Death Anxiety Scale, GDS= Geriatric Depression Scale, BHS= Beck Hopelessness Scale, MPQ= Meaningful Past Questionnaire.

4.3. Comparison of Groups that Describe Themselves as Religious and Nonreligious

It was analyzed whether or not there was a difference between the participants who describe themselves as religious and nonreligious in terms of clinical scales and the findings were summarized in Table 6. Accordingly, no difference was determined between the religious and nonreligious participants in terms of clinical scales, educational level and age.

Table 6. Comparison of the present Scales, The Age and The Education Status Between Religious and Not-Relegious Groups

	Religious (n=47)	Not-Religious (n=52)	t df p
	M ± S.D.	**M ± S.D.**	
Age	62.87 ± 7.56	65.75 ± 5.31	2.21 97 0.30
Education Status	11.40 ± 3.65	12.17 ± 2.79	1.19 97 0.24
DAS	7.32 ± 3.07	7.33 ± 3.35	0.01 97 0.99
GDS	8.30 ± 5.69	8.54 ± 6.21	0.20 97 0.84
BHS	5.72 ± 4.14	6.21 ± 5.01	0.53 97 0.60
MPQ	120.49 ± 21.42	116.06 ± 20.81	-1.04 97 0.30

*$p < 0.05$

DAS= Death Anxiety Scale, GDS= Geriatric Depression Scale, BHS= Beck Hopelessness Scale, MPQ= Meaningful Past Questionnaire.

4.4. Relationships between Variables

Relationships between the scores obtained from age, educational level and clinical scales were analyzed and the results were summarized in table 7.

Table 7. Correlations Between Age, Education Status and The Scores of Scales

	Education Status	DAS	GDS	BHS	MPQ
Age	r= -0.10 p= 0.34	r= 0.04 p= 0.68	r= -0.05 p= 0.63	r= -0.08 p= 0.42	r= -0.12 p= 0.22
Education Status		r= -0.07 p= 0.52	r= -0.22 p= 0.03*	r= -0.27 p= 0.008**	r= 0.22 p= 0.03*
DAS			r= 0.33 p=0.001**	r= 0.22 p= 0.03*	r= -0.17 p= 0.10
GDS				r= 0.67 p< 0.001**	r= -0.52 p< 0.001**
BHS					r= -0.42 p< 0.001**

*p<0.05, **p<0.001

DAS= Death Anxiety Scale, GDS= Geriatric Depression Scale, BHS= Beck Hopelessness Scale, MPQ= Meaningful Past Questionnaire.

No statistically significant relationship was found between the total scores obtained from ages and scales. But however, statistically a significant relationship was found between the educational level and GDS, BHS and MPQ. While a negative relationship was determined between the education level and GDS and BHS, a

positive relationship was determined with MPQ. In other words, the higher the educational levels of individuals, the lower their levels of hopelessness and depression. No significant relationship was found between DAS and educational level. No significant relationship was found between DAS and MPQ in the examination of the correlations between the scales. However, statistically significant correlations were found between DAS and GDS and BHS. Accordingly, it was found that the higher the death anxiety, the lower the level of hopelessness. Significant correlations were found between GDS and BHS and MPQ as well. GDS has positive correlation with BHS and negative correlation with MPQ. A significant relationship was found also between BHS and MPQ. In a word, while accepting the past decreases, depression and hopelessness levels increase.

4.5. Comparison of Groups with and without Depression

Among the participants, those who got high scores from GDS (14 points and above) and low scores (under 14 points) were analyzed in two different groups. While those who carried the risk of depression constituted a part of 20.2% (N=20), those who did not carry risk constituted a part of 79.8% (N=79). When two groups were analyzed in terms of gender, no difference was seen between females and males ($\chi^2(1.99)= 0.904$, $p= 0.34$). Females constituted 60% (N=12) and males constituted 40% (N=8) of 20 people who were accepted to be depressed.

The Stepwise Linear Regression analysis was performed related to three predictors, total educational level, accepting the past and level of hopelessness, which were determine to be significant in the inter-variables correlation analysis of the depression level in participants. But, the total education time was excluded from the model. As a result of this analysis, it was seen that the accepting the past and hopelessness predicted the depression scores significantly. The depression level

increases with increasing hopelessness (β= 13.99, t(95)= 4.75, p< 0.001). Besides, the variance of hopelessness in the depression scores was stated to be at a significant rate (R^2= 51, F(1.95)= 50.45, p< 0.001).

5. DISCUSSION

In this chapter, findings of the research purposing to designate the relationship with accepting the past, hopelessness, death anxiety and suicide and depression in the elderly people have been discussed by being a compared with other studies in the literature. Gender, religiousness, age, educational level and other variables examined consecutively and between each other.

5.1. Comparison of Other Variables in Terms of Gender

Death anxiety is a type of anxiety existing in either females or males. As looking at the literature, although difference between genders in terms of death anxiety is usually seen, studies determining about there is no difference also exist. In this research, if death anxiety differs from gender is examined and a significant difference cannot be found statistically. Reason for this, as Erikson (1963) mentioned in his developmental stages theory, it might be considered that death anxiety is related to the past experiences in the individuals who are arrived at the last stage of their lives (ego-integrity versus despair), so it might be thought that death anxiety is not related with gender. Kokurcan, Özel-Kızıl, and Kırıcı (2013), in a research that they examined death anxiety in the elderly people, cannot find a significant difference between female and male in terms of death anxiety. Fortner and Neimeyer (1999), in a meta-analysis studied between 1996 and 1999, investigate gender's effect on the death anxiety and as a result they detected that there is not any significant different amongst them. Likewise, Öngider and Özışık Eyüpoğlu (2013), searched for death anxiety on 135 patients, who were between 18 and 60 range of age and diagnosed by depression, and they could not find a significant different between gender and death anxiety.

In literature, it can be observed that females have death anxiety more compared to males in the most of the researches conveying there is a significant different between gender and death anxiety. Erdoğdu and Özkan (2007), in a research examining relationship between death anxiety and socio-demographic characteristics, detected that females have death anxiety more compared to males. Özen (2008), in his research examining death anxiety in the elderly people who reside at nursing home, states that females have death anxiety more compared to males. Madnawat and Kachhawa (2007) also specified that death anxiety increases along with the age getting on in the females.

In the literature, there are researches examining that if hopelessness level differs according to gender. In this study, it was examined that if there is a relation between gender and hopelessness and it was determined that there is no statistically significant difference. Similarly, while Özben (2008), in his research examining hopelessness in the elderly people, cannot find a significant difference between genders of the elder and hopelessness. Özmen, Dündar, Çetinkaya, Taşkın, and Özmen (2008), in their researches examining level of hopelessness in adolescents, confirmed that males have a higher level of hopelessness than females.

In this study, it was investigated that if level of depression differs between females and males. Although level of depression average in the females is a little much higher than males, this difference could not be statistically significant. Besides, amongst 20 persons having risk of depression, it was detected that 12 persons of them are females, and 8 of them are males. Although the number of females is more than of males, due to that number is very few, making a statistical comparison could not be possible. Similarly to that study, Kekovalı, Baybek, Eksen, and Aslaner (2002) notified that level of depression does not have a significant difference in terms of

gender in their study. In the same way, Kuey and Uçku (1992) also supported that there is no any significant difference between two variables. Conversely, there are some studies demonstrating that gender has an important role in depression in the literature. Sabancıoğulları et al. (2006), in a research about depression, detected that prevalence of depression highly exists in females than males. Özen Çınar and Kartal (2008), in their study examining relationship between depressive indications in the elderly people and socio-demographic characteristics, determined that females have more depressive indications than males. Hacıhasanoğlu and Yıldırım (2009), in their study examining depression and risk factors in the elderly people, specified that females have a higher depression rate than males. Dişçigil, Gemalmaz, Başak, Gürel, and Tekin (2005) reached the same result in their studies. Similar to this, various studies in the literature demonstrate that prevalence of depression highly exist in females compared to males (Ünal & Özcan, 2000, 41-45; Kocataş, Güler, & Güler 2004; Güleç et al., 2005, 281-286; Heun & Hein, 2005, 199-204; Kim et al., 2009, 121–129). Nevertheless, Morinho et al. (2010) detected that it is observed that males have more depression indications compared to females. On this study, reason of that might be there is no differentiation in rate of depression according to gender might be that the sample is basically composed of the elder persons and that some difficulties and regressions brought by aging independently emerge from gender.

5.2. Relations between Age and Other Variables

Human beings live different developmental stages in different ages, and each period has a distinct experience in its own ways. It is normal for a person to experience levels of a distinct hopelessness, depression, death anxiety or accepting the past. On this research, relationship between age and other variables has been examined, and as a result, a statistical significant difference between depression,

hopelessness, death anxiety, and accepting the past at the range of age between 50 and 82 could not be found. Reason for this could be considered as the places the participants are located in have unique living conditions, and the persons, identifying themselves with those conditions, shape their sentiments and thoughts up to that, and it reduces importance of age factor.

In the literature, it can be seen that there are various researches examining if age factor have a relationship with several variables such as depression, hopelessness, death anxiety. Bailey and Snyder (2007), in a study, signified that hopelessness highly exists in the elderly people compared to the young. Özben (2008), in the research examining hopelessness, determined that age and hopelessness are significantly related to each other on a positive direction.

Templer (1970) stated that there is no difference between age and death anxiety in his research. Kokurcan et al. (2013), in the study examining death anxiety, identified that there is no a significant relationship between age and death anxiety. In one of Kalaoğlu Özturk's (2010) study investigating death anxiety in the elder individuals, a difference between age and death anxiety could not be found. Fortner and Neimeyer (1999), in a meta-analysis they made, signified that there is no difference between age and death anxiety. Öngider and Özışık Eyüpoğlu (2013) could not found a significant difference between age and death anxiety in their research. Şenol (1989), in his study examining death anxiety on the several age groups, found that level of death anxiety of the individuals at the range of age between 60 and 64 is at significantly high level compared to level of the death anxiety of the individuals at the range of age between 65-69 and 70 and above. In the literature, similarly, there are studies examining about as age gets longer, death anxiety decreases (Nelson, 1979, 123-133; Stevens, Cooper, & Thomas, 1980, 205-206). Thorson and Powell (1988) in

their studies researched that if there is a relationship between level of death anxiety and age of the participants at the age of range between 16 and 60 who were determined by them, and as a result they noticed that death anxiety highly exists in the young participants compared to the elderly people. On the other hand, in a study they did, Galt and Hayslip (1998), unlike the most of the studies, determined that as the age gets along, then death anxiety increases. In a study which is formed by 46 participants at the range of age between 17-25, and 40 participants above the age of 60, Templer's Death Anxiety Scale was applied, and level of the death anxiety of the participants above the age of 60 was significantly found at the high level. Erdoğdu and Özkan (2007), in studies they did with persons who were above the age of 16, signified that level of the death anxiety of the individuals above age of 60 is significantly high compared to other ages. Except few studies, it can be argued that there is no relationship between senility and death anxiety, in general. This situation may be comprehended as death anxiety is frequently seen in the young, and it reduces in the elderly people. In this study, that there is no relationship between age and death anxiety might be considered as the elder individuals composing the group of sample do not have fear of death, and do not get preoccupied with that subject matter as well.

There are several studies detecting that depression indications increase along with the age getting on (Murata, Kondo, Hirai, Ichida, & Ojima, 2008, 406-414; Heun & Hein, 2005, 199-204; Roberts, Roberts, & Chen, 1997, 95-110). Similar to these findings, in the literature, Bingöl et al. (2010) with Özen Çınar and Kartal (2008) detected that there is no significant difference between age and depression. Likewise, Kekovalı et al. (2002), in the study examining depression indications in the elderly people who reside in nursing home, could not found a statistically significant difference between age and depression. Naoki et al. (2008), in a research examining

depression prevalence, indicated that the depression indications observed during advanced senility period (% 11.) are too much than the depression indications observed during young senility period (% 10.6). Nevertheless, Öngider and Özışık Eyüpoğlu (2013), in their studies examined the range of age between 18 and 60, detected that the depression level of the patients at the range of age between 18 and 20 are significantly high. Altay and Avcı (2009), in the study examining depression in the elderly people, identified that depression scores average in the elderly people is low. In that study, a statistically significant difference between age and depression could not be found. Reason of this might be considered as that sample is composed by the individuals at the age of 50 and above, but not the young and the elderly people, and besides there is no two distinct group of age to make a comparison.

5.3. Relationship between Educational Level and Other Variables

It is well known that educational level in the individuals has an influence on situations such as death anxiety, hopelessness, depression. In this research, these variables have been researched and it is determined that there is no significant difference between educational level and death anxiety, so it is signified that there are significant correlations between educational level and hopelessness, with depression and accepting the past. It was found that educational level and accepting the past are associated in directly proportional, besides hopelessness and depression are associated in inversely proportional. A proper education ensures the individual acquisitions such as a proper business life, career, a conscious circle, and materiality. The person may think that these acquisitions along with a proper accepting the past may decrease the hopelessness and the risk of depression. In this study, as the level of education increases, then the level of hopelessness decreases. Similarly, in Özben's (2008)

work, it was identified that there is a negative relationship between educational level and hopelessness.

In this research, a difference between educational level and death anxiety could not be found. Similar studies are available in the literature. Yıldız (1998), in a work studying death anxiety, detected that there is no relationship between educational level and death anxiety. Identically, in one of Şenol's (1989) studies done with the elderly people residing in nursing home, it was specified that there is no relationship between level of education and level of anxiety as well. However, in a research done by Erdoğdu and Özkan (2007), it reported that there is a negative relationship between level of education and death anxiety. Likewise, in Kalaoğlu Öztürk's (2010) study, it was designated that there is significant negative relationship between educational level and death anxiety at the lower level.

According to Stevens (2005), despite the depression is observed at each educational level, it emerges as inversely proportional, as long as educational level increases, then prevalence of the depression decreases. Similar studies are available in the literature. In their works, Öngider and Özışık Eyüpoğlu (2013) indicated that prevalence of depression is significantly high in the high-school graduated individuals compared to the university graduated individuals. Sabancıoğulları, Tel, and Tel (2007), in their works based on depression in the elderly people, confirmed that low educational level is one of the factors that affect the depression. As a result, low educational level is identified as a risk factor for the depression in various researches (Alexopoulos, Kiosses, Klimstra, Kalayam, & Bruce, 2002, 98-106; Tezel, İçağasıoğlu, Karabulut, Kolukısa, & Keskin 2004, 206-210; Karadağ, 2008; Murata et al., 2008, 406-414; Morinho et al., 2010, 151–155). Divergently, in a study done by Kurtoğlu and Rezaki (1999), it was detected that there is no significant correlation

between depression and educational level. As in many researches, in this study, a statistically significant negative correlation between educational level and depression has been found either. As long as educational level increases, level of depression decreases.

5.4. Differences in Terms of Religiousness

Describing or non-describing himself/herself as religious may change the individual's thoughts and behaviors. In this research, it was observed that the if participants describing or non-describing themselves as religious differ from each other in terms of age, level of education and other variables, as a result, any difference of meaning could not be found amongst these two groups. According to this outcome, it may be considered that describing himself/herself does not cause a huge alteration in the individual's life, feelings or behaviors. In a study done with university students, Kimter (2006) confirmed that there is a positively significant relation between religiousness and hopelessness. However, in a study examining the relationship between loneliness, hopelessness and religiousness done by Kızılgeçit (2011), it was observed that there is a negatively significant relationship between religiousness with loneliness and hopelessness. According to Erikson, religiousness is a phenomenon emerging during childhood, improving with love of mother and father. As the person grows old, if he/she could not ensure ego-integrity, then he/she experiences hopelessness and death anxiety. However, these types of circumstances do not occur in religious persons (Gürses & Kılavuz, 2011, 153-166).

5.5. Depression Prevalence

Amongst mental problems observed in the elderly people, the most often problem is depression (Mulsant & Ganguli,1999, 9-15). In the 2007 report of National Institute of Mental Health, it was stated that the frequency of depression indications

observed in the elderly people in USA is between % 13 and 27 (Sucuoğlu, 2012). Wada et al. (2004) did distinct studies in three countries measuring depression prevalence, it was confirmed that depression indications in the elderly individuals are % 11.7 in Indonesia, % 4.7 in Vietnam, % 10.7 in Japan. Depression prevalence in Turkey alters between %24.3 and % 61.1 (Hacıhasanoğlu & Türkleş, 2008, 55-60). On a study done by applying GDS, Şahin and Yalçın (2003) detected significant high scores such as % 34.2 in the elderly people living their own houses, % 48.1 in the elderly people residing in nursing home. According to findings of this research, while depression is seen in % 20.2 of the participants, but it was observed that % 79.8 of them have no depression. Hereunder, although most of the participants have no risk of depression, it is remarkable that % 20.2 carries this risk. These findings have been found as a low according to the works in the literature. This difference may be stemmed from the fact that the sample is formed by limited number of person.

5.6. Correlations between Variables

Another hypothesis in the study is on depression, hopelessness, death anxiety and risk of suicide in the individuals is positively correlated, level of accepting the past is negatively correlated. As a result of analyzing correlations between variables, significant relations confirming the hypothesis have been found. Hereunder, as the individual's accepting the past decreases, the his/her level of depression and level hopelessness increase; as level of depression and hopelessness increases, then level of death anxiety increases as well. These findings correspond to Erikson's (1963) theory. According to Erikson, when growing old, if the person have a problem in accepting his past, in other words, if his/her accepting the past is negative, feeling of hopelessness emerges in the person. Hopelessness experienced during the senility period is a feeling of that too little time left for him/her to restore some things. An

anxiety that is felt with the consideration of remaining time will not be enough is death anxiety (Gürses & Kılavuz, 2011, 153-166). In their studies, Brown and Lowis (2003) questioned the existence of ninth stage in Erikson's psychosocial development stages, and a result, they statistically supported the ninth stage that, in his/her age of 80s and 90s that is advanced senility period, elderly person has a confidence, tranquility, comfort towards the people around. How the elder person interprets his/her past living is important. It is considered that a positive past representation with a negative past representation determine how the elderly will spend his/her senility period. The findings in this research bolster that hypothesis. As the individuals level of accepting the past decrease, his/her level of hopelessness and depression significantly increase. In other words, as the individual represents his/her past negatively, so his/her level of hopelessness increases, hence level of depressive indications increase as well. Reason of this, there is a relation between hopelessness and depression in positive direction. This situation is also supported in this study either. Boyacıoğlu and Saymaz (2012), who did some significant studies on accepting the past in the literature, in the study examining depression and acceptance the past, the way of representing the past has a significant relationship with depression in a negative direction. In their studies, Santor and Zuroff (1994) identified that acceptance the past obviously decreases depressive indications even in the individuals experienced negative things in their past. However, a significant relationship between accepting the past and death anxiety could not be found in that study. It may be considered that the reason for this is that thoughts on death are mostly related to other variables aside from the person's past. Death anxiety might be an anxiety that is felt towards the future brought by hopelessness and depression. In the direction of this thought, it might be regarded that death anxiety that the individual experiences is

related to hopelessness and depression. Correlations have been researched in this study, and as a result, statistically significant relationships in positive direction have been found.

The death anxiety, hopelessness and depression level change directly proportionally and others increase as long as one of them increases. This confirms the hypothesis of the study. This positive correlation can be explained with psychosocial stages defined by Erikson (1963). Erikson claims that individuals who could not reach to ego integrity, is the last development stage in the elderliness period, experienced hopelessness and therefore faced with death anxiety and they carried more risk to be depressed. There are similar conclusions in the literature. Templer (1970) researched the relationship between depression and death anxiety and stated a positive significant relationship between them. Kalaoğlu Öztürk (2010) determined that patients with high depression scores had higher mean scores of death anxiety. Neimeyer et al. (2004) and Ongider and Özışık Eyüpoğlu (2013) similarly found that depression and death anxiety correlated positively.

Bahadır Yılmaz and Ergun (2010) determined that the death anxiety increased the level of hopelessness in their study where they research the death anxiety and depression in patients with coronary failure. Murray, Kendall, Boyd, Worth, & Benton (2004) and Evangelista, Kagawa-Singer, & Dracup (2001) determined that the death anxiety increased the level of hopelessness. Seber et al. (1993) claimed that the level of hopelessness was high in depression patients. But however, Kokurcan et al. (2013) found no significant difference between the death anxiety and depression.

Significant predictions were determined through regression analyses performed between some variables found in this study. Hopelessness and accepting the past predict depression in the population participated in this study. In fact,

although the time of education was also found efficiently, it did not take part in the model as a result of the regression analysis performed. Nevertheless, due to increasing hopelessness and decreasing accepting of the past, education period has an indirect additive effect on depression.

Our hypothesis, elderly people with high level of depression have a high risk of suicide, could not be evaluated due to there is not sufficient number of participants with the thought, intent and attempt of suicide. However, there are many studies in the literature showing that depression is closely related to suicide. Weissman's work (1974) is an example for this. In their study where they researched depression, hopelessness and suicide in patients with psychiatric disorder, Raineri et al. (1987) determined that both hopelessness and depression were related to suicide, but hopelessness was a larger risk factor rather than depression for suicide. Similarly, Cole (1988) determined that hopelessness was more influential than depression as a suicide factor. The reason for this can be considered as individual not to have any reason to live to have the same meaning with hopelessness and ultimately want to die deeming the life worthless.

6. CONCLUSION AND RECOMMENDATIONS

In this study, the relationship between depression, hopelessness, accepting the past and death anxiety in elderly people and the relationship between these variables and sociodemographic features (gender, religiousness, age, educational status) were examined.

As a result of the analyses performed, no statistically significant difference was found according to gender in terms of depression, hopelessness, accepting the past and death anxiety. Likewise, it was determined that these variables showed no difference in persons who describe themselves as religious and nonreligious. Considering the relationship between age and other variables, it was seen that the age factor had no influence on the variables. Significant differences were determined when the relationships between the educational level and the variables. While no relationship was found between the educational level and the death anxiety, it was determined that accepting the past increased and depression and hopelessness level reduced with increasing educational level.

Significant results were found considering the relationships between the variables of the study. While there was no statistically significant relationship between accepting the past and death anxiety, depression and hopelessness increase with increasing death anxiety in elderly people. Depression level increases and accepting the past decreases as the hopelessness increased. As long as the level of hopelessness increased, accepting the past decreased.

Individuals with and without depression among the participants were compared, and the variables effecting depression were analyzed. Consequently, while there was no difference between females and males, it was seen that accepting the past and hopelessness significantly affected the level of depression.

According to these results, negative situations in elderliness such as hopelessness and depression may be prevented by increasing the level of education of individuals forming our society and interpreting the past positively. Considering the physical health statuses of elderly people, several institutions may be established to provide psychological support. These institutions can be various social service organizations and foundations where elderly people may engage in social activities and interact with the environment. Seminars, meetings and conferences may be conducted to train, teach, inform and raise awareness of elderly people.

Number of geriatrics hospitals and policlinics may be increased on the purpose of according with increasing old population. It is known that early diagnosis accelerated the treatment process in elderly people. Therefore, application of routing health and depression controls is important. In case of depression, depressed person must be brought under control and the treatment program must be started rapidly. In addition to medications, application of positive psychotherapy may accelerate treatment process and help in prevention of negative situations during the depression process.

Programs can be conducted which will ensure middle-aged individuals and youngsters gain awareness about elderliness.

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APPENDİXES

Appendix 1

ARAŞTIRMA AMAÇLI ÇALIŞMA İÇİN AYDINLATILMIŞ ONAM FORMU

Yaşlı kişilerde geçmişi anlamlandırmanın etkileri ile ilgili bir araştırma yapmaktayız. Araştırmanın ismi "Yaşlı Kişilerde Geçmişi Anlamlandırmanın Umutsuzluk, Ölüm Kaygısı, İntihar Riski ve Depresyon ile İlişkisi"dir.

Sizin de bu araştırmaya katılmanızı öneriyoruz. Bu araştırmaya katılıp katılmamakta serbestsiniz. Çalışmaya katılım gönüllülük esasına dayalıdır. Kararınızdan önce araştırma hakkında sizi bilgilendirmek istiyoruz. Bu bilgileri okuyup anladıktan sonra araştırmaya katılmak isterseniz formu imzalayınız.

Bu araştırmayı yapmak istememizin nedeni, bireylerin, yaşlılık döneminde geçmişi anlamlandırmasının neleri etkilediğini görmek ve yaşlı bireylerde en sık görülen psikolojik rahatsızlık olan depresyonun nedenlerini bularak, çözümlemesine katkıda bulunabilmektir. Yakın Doğu Üniversitesi Psikoloji Anabilim Dalı Uygulamalı Klinik Psikoloji Yüksek Lisans ortak katılımı ile gerçekleştirilecek bu çalışmaya katılımınız araştırmanın başarısı için önemlidir.

Eğer araştırmaya katılmayı kabul ederseniz sizinle yüzyüze görüşme yapılacaktır. Tüm ölçekler yaklaşık yarım saat içinde tamamlanacaktır. Bu formu onaylayıp imzaladıktan sonra ilk olarak Standardize Mini Mental Test uygulanacaktır. Bu ölçekte araştırmamız için yeterli puan alındığı takdirde diğer ölçekler uygulanacaktır. Devamında hazırlamış olduğumuz sosyo–demografik form verilecektir. Daha sonra Beck Umutsuzluk Ölçeği, Geçmişi Anlamlandırma Ölçeği, Geriatrik Depresyon Ölçeği, Ölüm Kaygısı Ölçeği ve Kısa Anksiyete ve Depresyon Ölçeği katılımcılara uygulanacaktır.

Bu çalışmaya katılmanız için sizden herhangi bir ücret istenmeyecektir. Çalışmaya katıldığınız için size ek bir ödeme de yapılmayacaktır.

Sizinle ilgili tıbbi bilgiler gizli tutulacak, ancak çalışmanın kalitesini denetleyen görevliler, etik kurullar ya da resmi makamlarca gereği halinde incelenebilecektir.

Bu çalışmaya katılmayı reddedebilirsiniz. Bu araştırmaya katılmak tamamen isteğe bağlıdır. Yine çalışmanın herhangi bir aşamasında onayınızı çekmek hakkına da sahipsiniz.

Katılımcı	**Görüşme Tanığı**	**Araştırmacı**
Adı, soyadı:	Adı, soyadı:	Adı, soyadı:
Adres:	Adres:	Adres:
Tel.	Tel.	Tel.
İmza:	İmza:	İmza:

ARAŞTIRMA AMAÇLI ÇALIŞMA İÇİN AYDINLATILMIŞ ONAM FORMU

(Katılımcının / Hastanın Beyanı)

Sayın Gözde Çetinkol tarafından Psikoloji Anabilim Dalları'nda yaşlı kişilerde geçmişi anlamlandırmanın etkileri konusunda bir araştırma yapılacağı belirtilerek bu araştırma ile ilgili yukarıdaki bilgiler bana aktarıldı. Bu bilgilerden sonra böyle bir araştırmaya "katılımcı" olarak davet edildim.

Eğer bu araştırmaya katılırsam araştırmacı ile aramda kalması gereken bana ait bilgilerin gizliliğine bu araştırma sırasında da büyük özen ve saygı ile yaklaşılacağına inanıyorum. Araştırma sonuçlarının eğitim ve bilimsel amaçlarla kullanımı sırasında kişisel bilgilerimin ihtimamla korunacağı konusunda bana yeterli güvence verildi.

Projenin yürütülmesi sırasında herhangi bir sebep göstermeden araştırmadan çekilebilirim. (Ancak araştırmacıları zor durumda bırakmamak için araştırmadan çekileceğimi önceden bildirmemim uygun olacağının bilincindeyim) Ayrıca tıbbi durumuma herhangi bir zarar verilmemesi koşuluyla araştırmacı tarafından araştırma dışı tutulabilirim.

Araştırma için yapılacak harcamalarla ilgili herhangi bir parasal sorumluluk altına girmiyorum. Bana da bir ödeme yapılmayacaktır.

İster doğrudan, ister dolaylı olsun araştırma uygulamasından kaynaklanan nedenlerle meydana gelebilecek herhangi bir sağlık sorunumun ortaya çıkması halinde, her türlü tıbbi müdahalenin sağlanacağı konusunda gerekli güvence verildi. (Bu tıbbi müdahalelerle ilgili olarak da parasal bir yük altına girmeyeceğim).

Araştırma sırasında bir sağlık sorunu ile karşılaştığımda; herhangi bir saatte, Gözde Çetinkol'u 0533 873 3319 (cep) no'lu telefondan arayabileceğimi biliyorum. Bu araştırmaya katılmak zorunda değilim ve katılmayabilirim. Araştırmaya katılmam konusunda zorlayıcı bir davranışla karşılaşmış değilim. Eğer katılmayı reddedersem, bu durumun tıbbi bakımıma ve hekim ile olan ilişkime herhangi bir zarar getirmeyeceğini de biliyorum.

Bana yapılan tüm açıklamaları ayrıntılarıyla anlamış bulunmaktayım. Kendi başıma belli bir düşünme süresi sonunda adı geçen bu araştırma projesinde "katılımcı" olarak yer alma kararını aldım. Bu konuda yapılan daveti kabul ediyorum.

İmzalı bu form kâğıdının bir kopyası bana verilecektir.

Katılımcı	**Görüşme Tanığı**	**Araştırmacı**
Adı, soyadı:	Adı, soyadı:	Adı, soyadı:
Adres:	Adres:	Adres:
Tel.	Tel.	Tel.
İmza:	İmza:	İmza:

Appendix 2

SOSYO-DEMOGRAFİK VERİ FORMU

Bu araştırma, geçmişi anlamlandırmanın yaşlılar üzerindeki etkilerini değerlendirmek üzere yapılmaktadır. Bu etkileri daha iyi incelemek üzere sizden, aşağıda bazı soru ve ifadelerden oluşan bir anket setini doldurmanız istenmektedir. Alınan bilgiler, kişisel olarak değerlendirilmeyecek, sadece bilimsel araştırma amacıyla kullanılacaktır. Araştırmaya katılmanız, depresyonun yaşlılar üzerindeki etkisini görme anlamında büyük önem taşımaktadır; bu nedenle, cevap verirken samimi ve dürüst olunuz. Katıldığınız için teşekkür ediyoruz.

Cinsiyetiniz: Kadın ( ) Erkek ( )

Yaşınız: _____ **Şu an yaşadığınız yer:**_____

Medeni Durumunuz: _____ (evli, bekar, boşanmış, dul)

Mesleğiniz : _____

Çocuğunuz var mı? Var ( ) Yok ( ) Var ise sayısı: _____

Eğitim Durumunuz:

Okuma yazma bilmiyor	( )	Okuma yazma biliyor	( )
İlkokul mezunu	( )	Ortaokul mezunu	( )
Lise mezunu	( )	Üniversite mezunu	( )
Yüksek lisans/Doktora	( )		

Kiminle yaşıyorsunuz? Yalnız ( ) Ailesiyle ( ) Diğer ( )

Herhangi bir fiziksel hastalığınız var mı?

Evet (belirtiniz:_____) Hayır ( )

Varsa, bunun için şu an bir tedavi görüyor musunuz?

Evet (belirtiniz:_____) Hayır ( )

Herhangi bir psikiyatrik rahatsızlığınız var mı?

Evet (belirtiniz:_____) Hayır ( )

Varsa, bunun için şu anda bir ilaç kullanıyor musunuz?

Evet (belirtiniz: _____) Hayır ( )

Kendinizi dindar birisi olarak düşünüyor musunuz? Evet ( ) Hayır ( )

Hayatın yaşamaya değer olmadığını düşündüğünüz oldu mu? Evet ( ) Hayır ( )

Hiç ölmeyi istediğiniz oldu mu? Evet ( ) Hayır ( )

Şimdiye kadar hiç intihar düşünceniz oldu mu? Evet ( ) Hayır ( )

Şimdiye kadar hiç intihar niyetiniz oldu mu? Evet ( ) Hayır ( )

Şimdiye kadar hiç intihar girişiminiz oldu mu? Evet ( ) Hayır ( )

Olduysa kaç kere oldu ? _____

Hangi yöntemle oldu?

İlaç içerek ( ) bileklerini keserek ( ) asma yöntemi ile ( )

yüksekten atlama ( ) diğer _____

Appendix 3

Standardize Mini Mental Test

Ad Soyad: Tarih: Yaş:

Eğitim (yıl): T. Puan: Meslek:

Aktif El:

YÖNELİM (Toplam puan 10)

Hangi yıl içindeyiz.....( )

Hangi mevsimdeyiz .....( )

Hangi aydayız .....( )

Bu gün ayın kaçı .....( )

Hangi gündeyiz .....( )

Hangi ülkede yaşıyoruz .....( )

Şu an hangi şehirde bulunmaktasınız .....( )

Şu an bulunduğunuz semt neresidir .....( )

Şu an bulunduğunuz bina neresidir .....( )

Şu an bu binada kaçıncı kattasınız .....( )

KAYIT HAFIZASI (Toplam puan 3)

Size birazdan söyleyeceğim üç ismi dikkatlice dinleyip ben bitirdikten sonra tekrarlayın

(Masa, Bayrak, Elbise) (20 sn süre tanınır) Her doğru isim 1 puan .....( )

DİKKAT ve HESAP YAPMA (Toplam puan 5)

100'den geriye doğru 7 çıkartarak gidin. Dur deyinceye kadar devam edin.

Her doğru işlem 1 puan. (100, 93, 86, 79, 72, 65) .....( )

HATIRLAMA (Toplam puan 3)

Yukarıda tekrar ettiğiniz kelimeleri hatırlıyor musunuz? Hatırladıklarınızı söyleyin.

(Masa, Bayrak,

Elbise).....( )

LİSAN (Toplam puan 9)

a) Bu gördüğünüz nesnelerin isimleri nedir? (saat, kalem) 2 puan (20 sn tut)

.....( )

b) Şimdi size söyleyeceğim cümleyi dikkatle dinleyin ve ben bitirdikten sonra tekrar edin.

"Eğer ve fakat istemiyorum" (10 sn tut) 1 puan.....( )

c) Şimdi sizden bir şey yapmanızı isteyeceğim, beni dikkatle dinleyin ve söylediğimi yapın.

"Masada duran kağıdı sağ/sol elinizle alın, iki elinizle ikiye katlayın ve yere bırakın lütfen"

Toplam puan 3, süre 30 sn, her bir doğru işlem 1 puan.....( )

c) Şimdi size bir cümle vereceğim. Okuyun ve yazıda söylenen şeyi yapın. (1 puan) (arka sayfada)

d) "GÖZLERİNİZİ KAPATIN" .....( )

e) Şimdi vereceğim kağıda aklınıza gelen anlamlı bir cümleyi yazın. (1 puan)...( )

f) Size göstereceğim şeklin aynısını çizin. (1 puan) ....( )

Appendix 4

BECK UMUTSUZLUK ÖLÇEĞİ

Aşağıda geleceğe ait düşünceleri ifade eden bazı cümleler verilmiştir. Lütfen herbir ifadeyi okuyarak, bunların size ne kadar uygun olduğuna karar veriniz. Size uygun olanlar için "Evet", uygun olmayanlar için ise "Hayır" sütununun altındaki kutuyu işaretleyiniz.

		Evet	Hayır
1.	Geleceğe umut ve coşku ile bakıyorum.		
2.	Kendimle ilgili şeyleri düzeltemediğime göre çabalamayı bıraksam iyi olur.		
3.	İşler kötüye giderken bile herşeyin hep böyle kalmayacağını bilmek beni rahatlatıyor.		
4.	Gelecek on yıl içinde hayatımın nasıl olacağını hayal bile edemiyorum.		
5.	Yapmayı en çok istediğim şeyleri gerçekleştirmek için yeterli zamanım var.		
6.	Benim için çok önemli konularda ileride başarılı olacağımı umuyorum.		
7.	Geleceğimi karanlık görüyorum.		
8.	Dünya nimetlerinden sıradan bir insandan daha çok yararlanacağımı umuyorum.		
9.	İyi fırsatlar yakalayamıyorum. Gelecekte yakalayacağıma inanmam için de hiçbir neden yok.		
10.	Geçmiş deneyimlerim beni geleceğe iyi hazırladı.		
11.	Gelecek, benim için hoş şeylerden çok tatsızlıklarla dolu görünüyor.		
12.	Gerçekten özlediğim şeylere kavuşabileceğimi ummuyorum.		
13.	Geleceğe baktığımda şimdikine oranla daha mutlu olacağımı umuyorum.		
14.	İşler bir türlü benim istediğim gibi gitmiyor.		
15.	Geleceğe büyük inancım var.		
16.	Arzu ettiğim şeyleri elde edemediğime göre birşeyler istemek aptallık olur.		
17.	Gelecekte gerçek doyuma ulaşmam olanaksız gibi.		
18.	Gelecek bana bulanık ve belirsiz görünüyor.		
19.	Kötü günlerden çok, iyi günler bekliyorum.		
20.	İstediğim her şeyi elde etmek için çaba göstermenin gerçekten yararı yok, nasıl olsa onu elde edemeyeceğim.		

Appendix 5

GERİATRİK DEPRESYON ÖLÇEĞİ

Lütfen yaşamınızın son bir haftasında kendinizi nasıl hissettiğinize ilişkin aşağıdaki soruları kendiniz için uygun olan yanıtı işaretleyerek yanıtlayınız.

		Evet	Hayır
1.	Yaşamınızdan temelde memnun musunuz?		
2.	Kişisel etkinlik ve ilgi alanlarınızın çoğunu halen sürdürüyor musunuz?		
3.	Yaşamınızın bomboş olduğunu hissediyor musunuz?		
4.	Sık sık canınız sıkılır mı?		
5.	Gelecekten umutsuz musunuz?		
6.	Kafanızdan atamadığınız düşünceler nedeniyle rahatsızlık duyduğunuz olur mu?		
7.	Genellikle keyfiniz yerinde midir?		
8.	Başınıza kötü birşey geleceğinden korkuyor musunuz?		
9.	Çoğunlukla kendinizi mutlu hissediyor musunuz?		
10.	Sık sık kendinizi çaresiz hissediyor musunuz?		
11.	Sık sık huzursuz ve yerinde duramayan biri olur musunuz?		
12.	Dışarıya çıkıp yeni birşeyler yapmaktansa, evde kalmayı tercih eder misiniz?		
13.	Sıklıkla gelecekten endişe duyuyor musunuz?		
14.	Hafızanızın çoğu kişiden zayıf olduğunu hissediyor musunuz?		
15.	Sizce şu anda yaşıyor olmak çok güzel birşey midir?		
16.	Kendinizi sıklıkla kederli ve hüzünlü hissediyor musunuz?		
17.	Kendinizi şu andaki halinizle değersiz hissediyor musunuz?		
18.	Geçmişle ilgili olarak çokça üzülüyor musunuz?		
19.	Yaşamı zevk ve heyecan verici buluyor musunuz?		
20.	Yeni projelere başlamak sizin için zor mudur?		
21.	Kendinizi enerji dolu hissediyor musunuz?		
22.	Çözümsüz bir durum içinde bulunduğunuzu düşünüyor musunuz?		
23.	Çoğu kişinin sizden daha iyi durumda olduğunu düşünüyor musunuz?		
24.	Sık sık küçük şeylerden dolayı üzülür müsünüz?		
25.	Sık sık kendinizi ağlayacakmış gibi hisseder misiniz?		
26.	Dikkatinizi toplamakta güçlük çekiyor musunuz?		
27.	Sabahları güne başlamak hoşunuza gidiyor mu?		
28.	Sosyal toplantılara katılmaktan kaçınır mısınız?		
29.	Karar vermek sizin için kolay oluyor mu?		
30.	Zihniniz eskiden olduğu kadar berrak mıdır?		

Appendix 6

Geçmişi Anlamlandırma Ölçeği

Bu ölçekteki sorular kişilerin geçmişlerini nasıl değerlendirdiklerini anlamak amacı ile hazırlanmıştır. Aşağıda, geçmişte yaşanılanlar hakkında hissedilenlere ilişkin örnekler bulunmaktadır. Sizden istenilen her bir maddeyi dikkatli bir şekilde okuyarak, ifadeye ne derece katılıp katılmadığınıza karar vermenizdir. Kararınızı aşağıdaki 7 aralıklı cetvel üzerinde size uygun olan seçeneği işaretleyerek veriniz. Örneğin, verilen ifadeyle tümüyle hemfikirseniz 7'yi, verilen ifadeye hiç katılmıyorsanız 1'i ya da emin değilseniz 4'ü işaretleyiniz.

1	2	3	4	5	6	7
Hiç katılmıyorum	Oldukça katılmıyorum	Biraz Katılmıyorum	Kararsızım	Biraz katılıyorum	Oldukça katılıyorum	Tümüyle katılıyorum

1. Geçmişim hakkında düşünmek bana mutluluktan çok acı verir (A)*.	1	2	3	4	5	6	7
2. Geçmişteki şeylerden çok bugünkü şeylerden bahsetmeyi tercih ederim (R)*.	1	2	3	4	5	6	7
3. Geçmişte yaptığım şeylerden bahsederken kendimi rahat hissederim (A).	1	2	3	4	5	6	7
4. Bazen hayatımı hiç yaşama şansı bulamadığım hissine kapılıyorum (A)*.	1	2	3	4	5	6	7
5. Geçmişimin zorlu dönemlerini görmezden gelirim (R)*.	1	2	3	4	5	6	7
6. Gerçek anlamda mutlu olmam için geçmişimdeki bazı şeyleri düzeltmem, yerli yerine koymam gerekiyor (A)*.	1	2	3	4	5	6	7
7. Geçmişimdeki yaşantılarımı pek sık düşünmem (R)*.	1	2	3	4	5	6	7
8. Geçmişimde beni korkutan şeyler var (A)*.	1	2	3	4	5	6	7
9. Geçmişimin zorlu dönemleriyle uğraşmak yerine onları görmezden gelmeyi tercih ederim (R)*.	1	2	3	4	5	6	7
10. Geçmiş yaşantılarım benim için önemli olsa da, onlar hakkında düşünmemeyi tercih ederim (R)*.	1	2	3	4	5	6	7
11. Hayatımda, asla kabullenemeyeceğim hayal kırıklıklarım var (A)*.	1	2	3	4	5	6	7
12. Önceki kimi kişisel yaşantılarımı (anılarımı) düşünmek hala çok zor (A)*.	1	2	3	4	5	6	7
13. Genel olarak baktığımda, yaşamımın geldiği noktadan memnunum (A).	1	2	3	4	5	6	7
14. Yaşamımla ilgili kabullenmekte zorlandığım şeyler var (A)*.	1	2	3	4	5	6	7
15. Çok anlamlı bir hayat sürmedim (A)*.	1	2	3	4	5	6	7
16. Yapmış olduğum şeylere bir tatmin duygusuyla geri dönüp bakarım (A).	1	2	3	4	5	6	7
17. Geçmişim hakkında düşünmeye dair hiç isteğim yok (R)*.	1	2	3	4	5	6	7
18. Geçmiş yaşantılarım hakkında sıklıkla düşünürüm (R).	1	2	3	4	5	6	7
19. Her şeyi hesaba kattığımda, geçmişteki tercihlerimle ilgili içim rahat (A).	1	2	3	4	5	6	7
20. Geçmişe dönüp baktığımda doyum hissediyorum (A).	1	2	3	4	5	6	7
21. Geçmişimi anımsamayı seviyorum (R).	1	2	3	4	5	6	7
22. Bazı çocukluk yaşantılarım hakkında halen kızgınlık hissediyorum (A)*.	1	2	3	4	5	6	7
23. Geçmişimdeki hem iyi hem kötü yaşantılarımdan mümkün olduğunca çok şey hatırlamaya çalışırım (R).	1	2	3	4	5	6	7
24. Geçmişimi ne reddediyorum, ne de kabulleniyorum. Sadece geçmişimi geçmişte bıraktım (R)*.	1	2	3	4	5	6	7
25. Çok uzun zaman önce olmuş şeyler için üzülmem (A).	1	2	3	4	5	6	7
26. Geçmişimdeki yaşantılarımı sık sık başkalarına anlatırım (R).	1	2	3	4	5	6	7
27. Şimdiye kadar yaptığım şeylerden genellikle tatmin olmuş hissederim (A).	1	2	3	4	5	6	7

Appendix 7

Ölüm Kaygısı Ölçeği

Lütfen herbir ifadeyi okuyarak, bunların size ne kadar uygun olduğuna karar veriniz. Size uygun olanlar için "Evet" (E), uygun olmayanlar için ise "Hayır" (H) seçeneğini işaretleyiniz.

(E) (H) **1.** Ölmekten çok korkuyorum.

(E) (H) **2.** Zamanın böyle hızlı geçmesi bana çoğu zaman sıkıntı verir.

(E) (H) **3.** Ameliyat olacağımı düşündüğümde çok korkarım.

(E) (H) **4.** Sık sık hayatın gerçekte ne kadar kısa olduğunu düşünürüm.

(E) (H) **5.** Ölümden sonraki hayat beni büyük ölçüde kaygılandırır.

(E) (H) **6.** Kalp krizi geçirmekten gerçekten korkarım.

(E) (H) **7.** Bir cesedin görüntüsü bana dehşet verir.

(E) (H) **8.** Çıkacak bir dünya savasından söz edilmesi beni korkutur.

(E) (H) **9.** Acı çekerek ölmekten korkarım.

(E) (H) **10.** Ölmekten hiç korkmuyorum.

(E) (H) **11.** Gelecekte benim için korkulacak hiçbir şey olmadığını hissediyorum.

(E) (H) **12.** Kansere yakalanmaktan özel bir korku duymuyorum.

(E) (H) **13.** İnsanların ölüm hakkındaki konuşmaları beni tedirgin etmez.

(E) (H) **14.** Ölüm düşüncesi beni hiçbir zaman kaygılandırmaz.

(E) (H) **15.** Ölüm düşüncesi ara sıra aklıma gelir.

Appendix 8

CIRRICULUM VITAE

1. PERSONAL INFORMATION

NAME, SURNAME: **DATE OF BIRTH, PLACE:**	Gözde Çetinkol 29.08.1989, Bursa
JOB: **TELEPHONE:** **E-MAIL:**	Psychologist 0 507 413 09 33 Gozde_cetinkol@hotmail.com

1. EDUCATION

YEAR	DEGREE	UNIVERSITY	EDUCATION AREA
2008-2012	2.46	Girne American University	Psychology (undergraduate)
2013-2016		Near East University	Applied (Clinical) Psychology. (Postgraduate).

2. PROFESSIONAL EXPERIENCE

PERIOD OF DUTY	TITLE	FIELD	PLACE of WORK
Kasım, 2012 & ağustos, 2013	Psychologist	Psychology	Pırlanta Özel Eğitim ve Rehabilitasyon Mrkezi
Şubat, 2014 & Mart, 2014	Intern Clinical Psychologist	Clinical Psychology	Konya Numune Hastanesi
Hazitan, 2014 & Temmuz, 2015	Intern Clinical Psychologist	Clinical Psychology	Beyhekim Ruh ve Sinir Hastalıklıkları Eğitim Araştırma Hastanesi
Temmuz, 2014 & Eylül, 2015	Intern Clinical Psychologist	Clinical Psychology	Dokuz Eylül Üniversitesi Hastanesi
Eylül, 2014 & Şubat, 2015	Intern Clinical Psychologist	Clinical Psychology	Psychology Depertmant of Near East University

EK: 311-2015

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BİLİMSEL ARAŞTIRMALAR DEĞERLENDİRME ETİK KURULU

YAKIN DOĞU ÜNİVERSİTESİ BİLİMSEL ARAŞTIRMALAR DEĞERLENDİRME ETİK KURULU

ARAŞTIRMA PROJESİ DEĞERLENDİRME RAPORU

Toplantı Tarihi : 30.04.2015
Toplantı No : 2015/29
Proje No : 199

Yakın Doğu Üniversitesi Psikoloji Bölümü öğretim üyelerinden Doç. Dr. Gülbahar Baştuğ'un sorumlu araştırmacısı olduğu, YDU/2015/29-199 proje numaralı ve ***"Yaşlı Kişilerde Geçmişi Anlamlandırmanın Umutsuzluk, Ölüm Kaygısı, İntihar Riski ve Depresyon ile İlişkisi"*** başlıklı proje önerisi kurulumuzca değerlendirilmiş olup, etik olarak uygun bulunmuştur.

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

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