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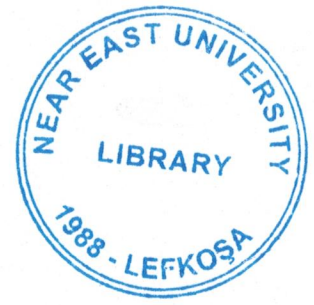CLINICAL PSYCHOLOGY
MASTER'S PROGRAMME

MASTER'S THESIS

PREVALENCE AND RISK FACTORS OF MAJOR DEPRESSION IN TURKISH
REPUBLIC OF NORTHERN CYPRUS

Özlem GÖKÇE

NICOSIA
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2016

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NEAR EAST UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SCIENCES

Clinical Psychology Master Program
Thesis Defence

Prevalence and Risk Factors of Major Depression in Turkish Republic of Northern Cyprus

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

Prepared by
Özlem GÖKÇE

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ABSTRACT

Prevalence and Risk Factors of Major Depression in Turkish Republic of Northern Cyprus, Özlem Gökçe, June 2016, p: 1-83.

Depression is individual's loss of enjoying life, being in depressed mood, negative thoughts for past and future like guilt, remorse, dominated mood disorder. Aim of this study is defining Major Depression prevalence and risk factors, Between April 2016 - June 2016, individuals between 18-88 years of age living in Northern Cyprus. Multi-stage stratified (randomised) quota used in the survey and 978 people selected according to the 2011 census. Demographic Information Form and Beck Depression Inventory scales used. Major Depression prevalence stated 23,4% for North Cyprus. Being women, widow, unemployed, housewive, low education level, low income level, having physical illness, living single or with a relative, using substance defined as risk factors of depreesion. Major Depression prevalence defined above the world average. Lots of risk factors defined albeit, in basics, having war history in recent years, outbreak of despair explains the high prevalence rate.

Key Words: Prevalence, Major Depression, North Cyprus, Risk Factors

ÖZ

Kuzey Kıbrıs Türk Cumhuriyeti'nde Majör Depresyonun Yaygınlı ı ve Risk Faktörleri,

Özlem Gökçe,

Haziran 2016, s: 1-83

Depresyon ki inin hayattan zevk alamaması, çökkün duygulanım içerisinde olması, pi manlık suçluluk gibi geçmi e ve gelece e yönelik olumsuz dü üncelerin hakim oldu u bir duygudurum bozuklu udur. Bu çalı mada amaç Kuzey Kıbrıs'taki majör depresyonun yaygınlı ını bulmak ve risk faktörlerini tespit etmektir. Nisan 2016-Haziran 2016 tarihleri arasında Kuzey Kıbrıs'ta 18-88 ya arasında 2011 nüfus sayımı verilerine göre kotalı çok basamaklı tabakalandırılmı seçkisiz (randomize) örneklem yöntemi ile seçilen 978 ki i çalı maya alınmı tır. Demografik Bilgi Formu ve Beck Depresyon Envanteri (BDE) ölçekleri kullanılmı tır. Kuzey Kıbrıs'ta majör depresyonun yaygınlı ı %23.4 olarak bulunmu tur. Kadın olmak, dul olmak, i siz olmak, ev kadını olmak, dü ük e itim seviyesi, dü ük gelir seviyesi, fiziksel hastalı a sahip olmak, yalnız veya akrabasıyla ya ıyor olmak, madde kullanıyor olmak major depresyonun risk faktörleri olarak saptanmı tır. Kuzey Kıbrıs'ta major depresyon yaygınlı ı, dünya ortalamasının üstünde bulunmu tur. Birçok risk faktörü bulunmu olup temelde, yakın zaman içerisinde sava geçmi i olan bir toplum olması, çaresizlik ba göstermesi, major depresyon oranının yüksek çıkmasını açıklar niteliktedir.

Anahtar Kelimeler: Yaygınlık, Majör Depresyon, Kuzey Kıbrıs, Risk Faktörleri.

ACKNOWLEDGEMENTS

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ABBREVIATIONS

BDI: Beck Depression Inventory

DSM: Diagnostic and Statistical Manual of Mental Disorders

MDD: Major Depressive Disorder

OPS: Other Psychoactive Drugs

TRNC: Turkish Republic of North Cyprus

1. INTRODUCTION

Depression is a serious yet common mood disorder. Its symptoms affect your feelings, thinking and the way you handle your daily activities, such as sleeping, eating, or working (Stewart-Sandusky, 2016). Depression is a disease with the reduced joy of life, causing individual to feel himself in a deep grief, retrospective regret, guilt, gloomy and pessimistic feeling about the future, death thoughts along with suicidal ideation; causing physiological disorders, such as appetite loss, sleep and willing (Çevik & Volkan, 1993).

According to APA Dictionary of Psychology (2015) depression is;

> A negative affective state, ranging from unhappiness and discontent to an extreme feeling of sadness, pessimism, and despondency that interferes with daily life. Various physical, cognitive, and social changes also tend to co-occur, including altered eating or sleeping habits, lack of energy or motivation, difficulty concentrating or making decisions, and withdrawal from social activities (American Psychological Association, 2015, p.784).

Depression can define an affective experience (mood state), a complaint (reported as a symptom) in addition as a syndrome defined by operational criteria. As an affective experience of sadness, it is common among the humans; as a symptom, it is present in several mental and physical illnesses and, as a syndrome, it is associated with specific mental and physical disorders (Maj & Sartorius, 2002). Patients with depression describe their feelings as a "black cloud on my head" or "numbing feeling" (Blackburn, 1992).

Depression can be seen in every age group, it is also common and a reason of disability (Üstün, et al., 2004). According to World Health Organization (WHO) researches, people who visited a doctor due to depression symptoms are between 10% - 17%. In recent years, findings show us that these numbers increased (Christodoulou, 2012).

1.1. Description of the Depression

Generally, patients with depression have evident face and forehead lines, sunken shoulders and a sad face expression in general view. If the patient has a mild or moderate depression, it is easy to have a communication but in major depression it is difficult to be able to have a communication with them because the patient has a low voice and speaks too slow (WHO, 2016). Mutism can be seen in severe depression. The consciousness of the people who were depressed is open but time, location, individual disorientation can't be observed. Although in severe depression, confusion can be observed as well as amnesia (Öztürk & Ulu ahin, 2014). Psychomotor retardation, agitation, tearful look, the facial expressions are blunt, euphony is uniform, they give short answers and the answers they give show their lack of will and they don't pay attention to their personal appearance (Özkürkçügil & Kırlı, 1998). If we investigate the idea content of the mood disorder, we can observe that the patients see themselves as inadequate, unsuccessful, and insufficient. Furthermore, they can bring back the past memories in while blame and unforgiven themselves. They feel like a sinner (Blackbum, 1992). The resemblance between depression and the low mood of normals has led to the concept that the pathology is simply an exaggeration of the normal. On the surface, this view seems plausible. Each symptom of depression may be graded in intensity along a dimension, and the milder intensities are certainly similar to the phenomena observed in normal individuals who are feeling blue (Beck & Alford, 2009).

Depressed individuals have difficulties about remembering events and especially to remember vague feelings that trigger depression. In memory researches, depressed people remember warped, negative memories more easily than positive ones (Liggan, 2015).

If we divide the depression according to terms of severity and cause; major depression, dysthyrnia (depressive neurosis) as may be considered. Major depression is classified according to the severity of depression and named as heavy medium and light (Alper, 2012).

1.1.1. Depressive Mood - Major Depression

Depressed moods symptoms line up with attitude and lack of interest, pleasure and energy. The typical symptoms are combined with the additional ones in many patterns, each one of them determining the clinical picture of a depressive episode at the individual's level (Maj & Sartorius, 2002).

1.2 History of Depression

Descriptions of depression and depression-related mental disorders date back to antiquity (Summerian and Egyptian documents date back to 2600 BC) (Maj & Sartorius, 2002). "Aretaeus, a physician living in the second century A.D., described the melancholic patient as sad, dismayed, sleepless(...). They become thin by their agitation and loss of refreshing sleep (...).Ata more advanced stage, they complain of a thousand futilities and desire death" (Beck & Alford, 2009, s. 7). Although the first explanatory thoughts on depression and systematic studies can be traced to Hippocrates era (B.C. 460-357). In the ancient times, depressive disorder was explained with "Black Bile". Nowadays it is explained with neuroimaging and molecular biology (Balcıo_lu, 1999). Aristotale (B.C. 384- 322) identified human soul in 3 dimensions; animal, rational and vegetal. He explained spiritual experiences of human beings as the transition from one to another state of mind; he also stated that individuals ensure adaptation, stabilization and order through this transition. However, the desire for immediate gratification, delay or prevention of gratification will create conflict and this leads to the disruption of harmony among the animal-like, rational and vegetal dimensions. Also remaining in the animal-like state causes melancholia. Platon (B.C. 424-347) claimed that depression occurs because of the gods and supernational powers and defined 4 types of melancholia which occurred because of the anger of gods such as Dionysus, Apollo and Eros. Like Hippocrates,

Galen explained 4 types of bodily fluids which influence the personality; sanguine, choleric, melancholic and phlegmatic (Köknel, 2000).

In India, B.C. 1400-1500's, it was believed that there were 7 types of demon. Enterance of one of the demons to the human soul would cause depression. According to them, only cause of depression was the demon. Platon, attributed depression and other diseases to the nature and supernatural powers (Aktay, 2014).

The root of the depression word which is 'depress', comes from the Latin word 'depressus' (Öztürk, 2008). bni Sina (Avienca) referred to depression as 'manic depressive psychosis' (Öztürk & Ulu ahin, 2014). In 16-17tlLcenturies, Versalius explained the cause of depression with the tumors in the brain or in other organs. Again in the 1? century, Willis thought that the reason of depression is the oversalinization of the bodily liquids (Büyükı ık, 2008).

In France, Femel (A.D. 1497-1558) stated that factors that affect the structure of the pallium and cerebral ventricles are the causes of mental ilnesses and he divided these into 3 groups. First group includes headaches, the second one includes mania, mental fog and febrile ilnesses, lastly the third one includes epilepsy, nightmares, tremors, paralysis, dizziness and melancholy (Köknel, 2000).

1.3 Major Depression

Depression is also often accompanied by the physical symptoms of anxiety (Andover, et al., 2011). Some depressed people experience a sense of physical restlessness or nervousness, demonstrated by fidgeting or aimless pacing. Also suicide and suicidal thoughts are risk in major depression. Approximately 10 percent of those, whom suffering from major depressive disorder, attempts suicide. Abnormal sleep patterns are another hallmark of major depressive disorder (Hockenbury, 2015).

As we stated in 1.2 History of Depression, depression is identified in various ways through the history and these identifications also evaluated the importance of it. As a result of this,

diagonistic criterias changed for Major Depression through the time. We have to analyse current and old DSM in order to have a better understanding about this context.

In first DSM, which was published in 1952 and covered 106 disorders, depression presented under depressive reactions. Disorders were referred as "reactions" in DSM because of Adolf Meyer. In DSM-IV-TR, it is stated that Meyer's "psychobiological view was; mental disorders represented reactions of the personality to psychological, social and biological factors". Depression presented under 000-xlü section. DSM-II published in 1968, which covered 182 disorders and the term of 'reactions' eliminated". Depression submitted under, 296. Major Affective. This group of psychoses characterised by a single disorder of mood, either extreme depression or elation, that dominates the mental life of the patient and is responsible for whatever loss of contact he has with his environment (American Psychiatric Association, 1975). As it can be seen from quotation, while the "reaction" term eliminated, "neuroses" and "psychophysiological disorders" remained same.

This progress gained a significant shift with DSM-III, which was published in 1980 and covered 494 pages with 265 diagnostic categories, "Major depression" term first found a place in DSM-III and analysed under "Major Depressive Episode.". In DSM-III Depression defined as:

> The essential feature is either a dysphoric mood, usually depression, or loss of interest or pleasure in all or almost all usual activities and pastimes. This disturbance is prominent, relatively persistent, and associated with other symptoms of the depressive syndrome. These symptoms include appetite disturbance, change in weight, sleep disturbance, psychomotor agitation or retardation, decreased energy, feelings of worthlessness or guilt, difficulty concentrating or thinking, and thoughts of death or suicide or suicidal attempts (Hoffman, 1993, p.277).

In DSM-IV, major depression presented under depressive disorders and specifiers included describing the current major depressive episode. These are; mild, moderate, severe without psychotic features, severe with psychotic features, in partial remission, in full remission. Major

depression defined in APA Dictionary of Psychology as: "in DSM–IV–TR and DSM-5, "a mood disorder characterized by persistent sadness and other symptoms of a major depressive episode but without accompanying episodes of mania or hypomania or mixed episodes of depressive and manic or hypomanic symptoms. Also called major depression" (American Psychological Association, 2015, p.618).

1.3.1. DSM-V Diagnostic Criterias

Nowadays, DSM-V is used for the most valid and common diagnostic criterias for major depression (ireli, 2012).

A. During a two weeks period, 5 or more of the symptoms listed below are present or show difference from the previous functionality. More than one of the symptoms must have depressed mood or loss of pleasure and/or interest. Also the symptoms must not include the symptoms which clearly derive from another illness.

1. Person's mood is depressed most of the days. The despressed mood, such as feeling sad, empty or hopeless is present almost all of the day. The indication of the depressed mood is either objective (observed by others) or subjective (reported by the person). This mood can differ in children and adolescents with short-tempered mood

2. Prominent lose of interest or pleasure from all or most of the activities which is present during the day or most of the day (objectively or subjectively reported).

3. Gaining weight while not trying to gain weight or loosing weight (for example, loosing or gaining 5% of the weight in a month) or, increse or decrease of the appetite in most days. In children, being unable to make the expected weight also must be considered.

4. Being unable to sleep or over sleeping in most days.

5. Retardation or psychomotor agitation almost every day (this must be observable by other people and should not be only subjective feelings).

6. Loss of energy or feeling exhausted almost every day.

7. Feeling excessive, inappropriate or unworthy almost all the time which can be merely delusional.

8. Having difficulties in thinking, concentrating or making decisions nearly all the time (can be reported subjectively or objectively).

9. Repetitive thoughts of death (not only fear of death), repetitive thoughts of suicide without a suicide plan, suicide attempt or making/having a plan in order to commit suicide.

B. These symptoms influence different aspects of life such as social and occuptional which cause clinically significant distress or impairments in the areas of functioning in life.

C. This period is not because direct effects of a substance or any other physical health condition.

Note: A-C diagnostic criterias forms the dominant depression period.

Note: Personal reactions to an important loss (breavement) bankruptcy (financial breakdown), loosing someone in result of a natural disaster or a serious diseaseora disability may be similar to the symptoms of depression (such intense sadness, thinking a lot about the loss, insomnia, loss of appetite, loosing weight and etc). Even though such symptoms can be understood or can be seen as appropriate to the loss, however it must be taken into consideration that the symptoms might be the signs of an intense depression period. This decision should be given by comparing person's story and grief with the cultural expression of grief.

D. Appearance of intense depression period cannot be explained with other mental illnesses such as schizophrenia, schizo-affective disorder, delusional disorder or schizophrenia expansion or with any other defined or undefined disorders.

E. There has never been a mania or hypomania period.

Note: This exclusion does not apply unless there is a physical health problem causing these periods or if the mania or hypomania periods are caused by substance use (DSM, p.160-161, 2014).

1.4. Theories of Depression

Depression first theoretically introduced with Freud's Mourning and Melancholia (1917) book. In this episode of our research, we will analyse psychoanalytic, cognitive and behavioural theories in this context with the consecutive frame.

1.4.1. Psychoanalytic theory of depression

Sigmund Freud, an Austrian physician, developed psychoanalytic theory in the early 1900s. According to Freud's theory, conscious experience is only a small part of our psychological makeup and experience. He argued that much of our behavior is motivated by the unconscious, a part of the personality that contains the memories, knowledge, beliefs, feelings, urges, drives, and instincts of which the individual is not aware (Feldman, 2011). Psychodynamic oriented depression is based on ego psychology. According to this, preventing to satisfy or not to satisfy

the needs of a baby in the oral stage of childhood will result in anger and anxiety in the baby. If this obstruction continues, feelings such as helplessness and exhaustion will arise and in the early childhood stage, it will settle to the child's ego. In the adulthood, this negative condition in the ego will revive and result in decrease of the self-esteem (Güleç, 1993).

Freud, assimilated the symptoms of grief with the symptoms of depression. Freud described melancholy with the current depression defitinition and he associated it with the Oedipus complex. In this period, children have hostile urges (willing them to be dead) against same-sex parent and later they develop pathological insecurity against the sovereign. In this case, these feelings only will be suppressed by compassion towards parents when the parents are sick or dead. However, a person who condemns himself/herself; will be punishing himself/herself like a hysterical person which is similar to griefing. Identification of grief with depression is merely a mode of thought (Freud, 1917).

In depresion, losing someone may feel like losing the object of true love and patient might feel abandoned. This feeling is related to unconsciousness. A person who is in depression lose his/her self-esteem by thinking the person and the love that is lost. On the other hand, a person who is griefing, does not lose self-esteem. This is the difference between grief and depression (Öztürk & Ulu ahin, 2014).

Edward Bibring defines depression as directing aggressive feelings towars self as a result of desperation of the ego. Anything that contradicts the self-respect causes narcissistic self-esteem damage, thus causes depression. Anything that contradicts the self-respect causes narcissistic self-esteem damage, thus cause depression. In short, clashing ego with itself, which means ego couldn't achieve its goal, leads a down in self-respect which causes depression (Özmen, 2001). Unsatisfied narcissistic needs of self-respect needs such as feeling beloved, precious, powerful, well-being, and the lack of necessary things when needed causes depression (Güleç, 1993).

In 1945, Fenichel claimed that depression is interrelated with self-esteem and depression caused by damaged self-esteem. Bibring, distinctively from Fenichel and Freud, emphasized that loss of self-esteem cannot be the only cause of depression and he claimed that there must be despair and hopelessness that must accompany to self-esteem (Dilbaz & Seber, 1993).

According to the Ortodox perspective, depression arises because of the inhibition of libido. It is claimed that, if a person has to give up sexual satisfaction or cannot reach to sexual satisfaction, that person will perceive himself/herself as unlovable (Özmen, 2001).

1.4.2. Cognitive Theory of Depression

Aaron T. Beck developed the cognitive therapy in the early 1960s at the University of Pennsylvania as a structured, short-term, present-oriented psychotherapy for depression, focusing on solving current problems and modifying dysfunctional thinking and behavior (Eden, 2015). Cognitive therapy stands on the cognitive model. In cognitive model, people's behaviours and emotions, which induced by their perception of events. It is not a context in and of itself that determines what people feel instead rather the way in which they construe a situation (Öztürk & Ulu ahin, 2014).

Depressive people might not be able to do cognitive control, so they form 'automatic thoughts' such as; 'I can not do anything'. After the formation of this automatic thought, reaction will be formed; the person feels sad. This reaction accompanies the behavior; curling up and sitting. Understanding depression with the cognitive perspective makes the depressed person to feel better. Patients with depression have negative thoughts like; "Im insufficient, "I'm unsuccessful" etc. and problematic behaviours like isolating himself, spending unproductive time have to be defined. In the second stage, perception-affecting factors have to defined. In the third stage, primary developmental events and events that pushed the individual to depression set in negative interpretation pattern (Beck, 2014).

According to the Kendall and Dobson, ego carves out with rationalisation of cognitive generalisations and scheme which generalised with ego to the past experience and similar memories (Tosun, 2006).

1.4.3. Behavioral Theory of Depression

Behavioral activation therapy (BA) for depression has a history reaching back to the early behaviorists in American academic psychology, as well as to the philosophy of pragmatism (Kazantzis et all., 2010).

Throughout the years, several behavioural theories were introduced. One of the most important theory is Seligman's. Seligman suggested that, the phenomenon of "learned helplessness" in animal models might be meaningfully analogous to clinical depression in humans (Beck & Alford, 2009). Seligman reached this through after series of experiments on animals and generalised the findings through the theory that inescapable punishment could be the factitive reason in the lifes of those who become clinically depressed (Öztürk & Ulu ahin, 2014). The situation of not being able to escape from bad stimuli, not knowing how to survive and as a result of these conditions feeling helpless (Abramson & Seligman, 1978).

There is a debate going on literature whether cognitive therapy and behavioural therapy can be used together or not. In this context, analysing their mutual relationship will enrich the literature of our research. Cognitive-behavioral therapy has been used in the treatment of children, adolescents, and the elderly. Studies have shown that cognitive-behavioral therapy is a very effective treatment for many disorders, including major depressive disorder, eating disorders, substance use disorders, and anxiety disorders (Cohen & Janicki-Deverts, 2010).

1.5. Types of Depression

There are different types of depression such as; premenstrual dysphoric disorder, dysthymia, Atypical depression, seasonal depression, substance induced depression, melancholic depression, postpartum depression, pscyhotic depression and chronic depression.

1.5.1. Seasonal Depression

Seasonal depression is a type of depression which appears in the autmn and winter times when the sun light is less. Depression symptoms can be observed with the seasonal depression however, seasonal depression episodes only begin and disappear depending on the season (Ekinci et al., 2005). Diagnostic criteria should be recurrent in depression periods at least for two years while not-seasonal periods should be observed too (Köro lu, 2015). Full remission from depression (or change to mania or hypomania) in the spring or somewhat later, and the seasonal depressive episodes outnumbering the lifetime major depressive episodes without seasonal pattern are two of the qualifying criteria for inclusion in this disorder (Maj & Sartorius, 2002).

1.5.2. Melancholic depression

The mood of inability to enjoy activities and remaining unresponsive to pleasing stimuli are the essential, decisive elements of melancholic depression. In addition to these, at least 3 of these is enough for diagnosis: depressive mood with a different feature, feeling worst at mornings, waking 2 hours earlier than usual, agitation or psychomotor retardation, loss of appetite and weight loss, and inappropriate guilt feel (Sadock & Sadock, 2009). People, who suffer from melancholic depression, mood changes can be observed by the others and always dynamic changes presence (Köro lu, 2015). This sub-type of depression is resistant to treatment. In people with melancholic depression, there is more biological features of depression than other features (Casher & Bess, 2010).

1.5.3. Atypical depression

Atypical depression is phenomena of observing opposite of the biologic symptoms. In atypical depression, excessive eating, excessive sleep and extreme fatigue symptoms can be seen. Also, this patient group has a sensitivity against being rejected (Gögü , 2000). If proper conditions met, the mood could stay as positive for a long time. Atypical depression appears with excessive eating and gaining weight and characterised-with excessive sleep (more than 10 hours) and foeling a heavy weight burden in legs. This feeling can be perceived at least 1 hours, and even it continues hours sometimes (Köro lu, 2015). Males face with atypical depression more than 2-3 times more than females (Sadock & Sadock, 2009). Atypical depression with reverse vegetative signs shares many of the characteristics of bipolar II with borderline features. The overlap may be as high as 70% (Perugi, et al., 1998).

1.5.4. Dysthymic Disorder

Also identified as persistent depressive disorder in DSM-5. Also called dysthymia (American Psychological Association, 2015). Dysthymia is a chronic depressed mood for most of the day for more days that persists for at least two years. When you suffer from the same symptoms for longer than two weeks, it's called a mild depression, which, if ignored, often eventually turns into dysthymia (Michael & Lang, 2006). The most significant difference in persistent depression disorder is: lows happen most or significant period of the day. Moods of dysthymia are introversion and sadness (Köro lu, 2015). DSM-III introduced the term 'dysthymia' to describe a chronic depressive state with symptoms of less severity than major depression (Kirby, et al., 1999).

1.5.5. Chronic Depression

Chronic depression is a type of depression in which the depressive symptoms contiunes at least for 2 years and recovery does not continue for more than 2 months (Demirarslan, et al., 1999).

Akiskal (1983) divided chronic depression into 3 groups. Early onset chronic depression was named as "characterology depression" and Akiskal drew attention to early object relations as well. Chronic secondary dysphoria was discussed as changeable onset neurotic disorders whereas late onset primary depression was discussed as chronic depression (Akiskal, 1983).

1.5.6. Psychotic Depression

Deliria and hallucinations are available in depression period. Psychosis features can be compatible or incompatible with the mood. Person might think that she/he deserves to be accused, or to be ill, dead, inadequate or punished. On the other hand, psychosis which is compatible with the mood, shows mood that complicated with the symptoms above (Köro lu, 2015).

> Psychotic depression is highly dangerous. The patients' thinking becomes so delusive that, having lost contact with reality, they contemplate suicidal behavior, taking poison perhaps to kill off the hallucinated bug infestation (although it kills them). (...). In psychotic depressive illness we are therefore discussing a variety of endogenous depression, depressions that may end up in hospital. Reactive depressions, on the other hand, come on slowly, under stress, and are filled with anxiety, anger, or dissatisfaction. The symptoms ofreactive depression stend to bevague, formless, andprimarily subjective. In today's psychiatry, reactive distress tends to be called by a range of terms that are really all over the map, from adjustment reaction, major depression, depression "not otherwise specified," or dysthymia, to the whole anxiety spectrum, such as generalized anxiety disorder or some other anxiety diagnosis, to personality disorders such as borderline personality, or even dissociative disorder (Swartz & Shorter, 2007, p.7).

The switch rate from psychotic depression in adults was 3%; it was 28% in adolescents. However, as with major depression, bipolar disorder in children is highly comorbid, less so in

adolescents. Treatment implications are similar. Data would suggest that lithium responsivity is poorer in people of any age with comorbidity (Maj & Sartorius, 2002).

1.5.7. Catatonic depression

As in depression, withdrawal, negativism, psychomotor retardation, blunted emotions, taking and holding positions and waxy flexibility can be seen with Catatonic depression (Sadock & Sadock, 2009). In catatonic depression, the extreme form of which is stupor, movement and speech are slowed (Swartz & Shorter, 2007).

1.5.8. Premenstrual Dysphoric Disorder

It is still debated whether symptoms which occur during the last week of luteal phase and remit a few days after menses constitute a distinct syndrome or are either part of or superimposed on other depressive and mental disorders (Maj & Sartorius, 2002).

Premenstrual dysphoric disorder starts before the menstruation period and moderates shortly after the period. Mood changes, irritability, anxiety and dysphoria are the most significant features of premenstural dysphoric disorder (Köro lu, 2015). Grievance ratio at the prementrual period is 60% with the people who have depressive disorder (Coppen, 1965). Depressive mood can be observed in women in association with the changing hormones because of the menstrual cycle or giving birth. Severe premenstrual syndrome is a risk factor for premenstrual dysphoric disorder, postpartum depression and perimenopause depression (Casher & Bess, 2010). Women with premenstrual dysphoric disorder has 14 times more risk for major depression (Hartlage, et al., 2001).

1.5.9. Postpartum Depression

Postpartum depression with psychotic features, occurs in about one out of 1000 mothers. In this form of postnatal depression, the first month after delivery is characterized, in addition to Depressive Episode/Major Depression symptomatology, by psychotic features among which

are delusional thoughts, mainly concerning the newborn, in association with severe crying spells, guilt feelings, suicidal ideation and occasionally with hallucinatory experiences (Maj & Sartorius, 2002).

Mood disorders can appear during pregnancy or after giving birth. Anxiety and panic atack symptoms are seen at the time of birth with women who experience severe depression periods. Psychosis features can be observed with at the time of birth as well. This can lead to the observation of auditory hallucinations about killing her baby or that the baby is possesed by the satan (Köro lu, 2015). It is stated that postpartum depression automatically disappears in women who do not get any treatment. Rapid physiological changes has an important role on postpartum depression. Risk factors of can be; death, seperation, being unemployed, problems related to marriage, unexpected pregnancy, miscourage experiences (Kara, et al., 2001).

Postpartum depression, which is the most common complication of fertility, effects 10-15% of women. Most powerful determinatives are , depression ciuring pregnancy, anxiety, stressful life events during early postpartum period, low social support. These are founded as risk factors (Robertson, et al., 2004).

1.5.10. Substance induced depression

Substance induced depression shows the signs of intense depression disorder, however, the symptoms arise by intaking, inhaling or injecting substance. If the signs of the depression do not merely revive while drunk or while not deprived, substance induced depression must be considere (Köro lu, 2015). Depressive mood is accompanied by loss of interest towards heart-warming activities and increased expansive or irritable mood, these are quite important clues for diagnostic criterias. If there is no accurate information that a depression is related to drug use, determinant criterias will be having a withdrawal period longer than one month or appearance of the symptoms before the usage of the substance (Klamen & Toy, 2007).

1.6. Risk Factors of Depression

Any factors that accelerates the influences of formation of a disorder are called risk factors. According to the previous studies, risk factors of depression are genetic features, depressive personality, family history, education level, social environment, childhood experiences, marital status, negative life events, age, and some physical illnesses, sleep disorder, low social support (Sadock & Sadock, 2005; Herndon, 2001; Cole & Dendukuri, 2003).

According to Eckenrode and Reich et al.(1984), small and negative events that piles up for a day, week or a month might result in experiencing difficulties in adaptation, also might reflect to the community which will lead to negative feelings in the normal population (Eckenrode, 1984). Many researchers argue that there is a relation between life events and depression. However, some researchers claimed that negative life events set up a substructure and triggers depression but do not directly develop depression (Do an, 2000). So there are people who defends that stressful life events cause depression but also there are people who defends that these events only have a trigger role on depression. Negative life events are related to how good people's coping abilities with these events (Balcıo lu, 1999). Onsets of major depression attacks related with stressful life events. When these stressful life events exposed, genetic factors affected thus increases the tendency ratio of major depression (Kendler, et al., 1999).

A fall in the hierarchy of needs can lead to chronic stress or even rewarding situations may lead to depression. Social values and socio-cultural characteristics are important risk factors of depression. In addition to this, H. S. Sullivan emphasized that interpersonal relationships have strong influence on depression (Balcıo lu, 1999).

Previous studies show that people who develop depression, generally experiences several serious life events and that, there is a direct corralation between depression and life events but it is not too strong (Tu rul, 2000).

In women, negative life events, having a child who has disabilities, having menapause between the ages 30-39, or not having any social securities are some of the risk factors of depression (Ünsal, et al., 2008). High depression rate encountered in, low life standarts, low financial condition in men and people, who dont work where he will, and who lives alone (Ball, et al., 2010).

Risk of developing depression is higher for people who are above the age 55. Body functions, hormonal secretions and metabolic activities are decreased with age which also decrease the quality of life in general. Thoughts of being dead and medical problems that occur in one's life lead-to depression (Yan, et al., 2011; Mossie, et al., 2016; Klonoff & Landrine, 2001; Acierno, et al., 1996).

Studies show that smoking is another factor that triggers depression. It is determined that risk of having depression is 3 times more for the smokers (Mossie, et al., 2016; Klonoff & Landrine, 2001; Acierno, et al., 1996).

Genetic and environmental factors also cause depression by causing functional and structural changes in the brain (Akif, 2015). External causes of depression are psychosocial, biological and genetic factors (Yemez & Alptekin, 1998).

1.6.1. Biological Factors

It is found that depression seems together with diseases like Huntington, Parkinson, epilepsy, Alzheimer, stroke, head trauma and vascular dementia (Cummings & Trimble, 2003).

It is suggested that for people who have mood disorders there is a disorder in heterogeneous arrangement in biogenic amines based on the findings in blood, urine and cerebrospinal fluid (BOS) homovalinic asid (HVA) (which is occurred by dopamine), 5 hydroxyindolacetic asid (5 - HIAA) (which is occurred by serotonin) and 3 methoxy-4-hydroxyphenyl glycol (MHPG) (which is occurred by norepinephrine) . Decrease in serotonin is linked with depression, low levels of 5-HIAA is linked with violence and suicide, activity of dopamine can be decrease in depression and increase in mania (Sadock& Sadock, 2009, p.145).

In depression, prefrontal cortex, cingulated gyrus, amigdala, hypocampus, thalamus and hypothalamus is affected in the brain. These areas of brain control biological needs of the body like motivation, sleep, eating and drinking, energy level, circadian rhythm (Mossie, et al., 2016). In recent studies it is found that there is a structural change in the brains of people who have mood disorders, and there are decreases in the amount of glia cells (Gürpınar, et al., 2007).

In depression disorder, magnetic resonance (MR) is a technique used in brain studies. It is known that for the healthy people and animals, prefrontal lobe is linked with emotional experiences and dorsolateral part is linked with motor and cognitive activities. For patients with depression, it is seen that they have increase in activity in emotional part of the brain and they have decrease in activity in motor and cognitive part (Öztürk, 2014).

1.6.2. Genetics

In the etiology of depression there are four analyze techniques; family, adaption, twins and connection studies are made to understand the genetic factors (Büyükışık, 2008).

For the people whose family members experienced a depression in their life, experiencing a depression risk is higher than other people. Especially having a patient with depression in the first degree relatives will increase risk to 2 or 3 times higher (Do an, 2000). For the children whose family members have depression, major depressionis 3 times higher than other people (Hammen, et al., 1990). It is found that heredity has more effects on early onset and iterated depressions. It is found that in the appearance of the depression, there are lots of genes which may affect even they have nominal effects (Öztürk & Ulu ahin, 2014). A focus on clinical samples, or more severe community cases, leads to higher estimates of the heritability of major depression than general population studies. The heritability index in severe samples is only slightly less than the 80% figure usually quoted for schizophrenia or bipolar disorder (Guffin, et al., 2007).

For the children whose family has a depression history, it is thought that the risk of depression prevalence is between 15% and 45% (Beardslee, et al., 1988). Developing the heredity of depressive disorders in the child is 10-13% for parent, 50% for identical twins, 10-15% for non identical twins (Sadock & Sadock, 2009). In the studies of adoption it is found that biological families of depressed children have depression risks and also families in the families of non-depressed children there is no risk factor for depression (Balcıo lu, 1999).

1.6.3. Psychosocial Factors and Personality Factors

Mental and social factors have significant importance in depression: economic problems, family crisis, insatiability, business life problems, loss oflov~object,job loss, retirement, health problems and damaging ego can cause depression. While ev~ryone who are exposed to these factors doesn't experience depression these factors can triggerfü~ people who have a tendency. First depression period started by.a significant event (Öztiirl<.&J.Jlµ ahin, 2014).

While depression can observe more frequent in single and. divorçedpeople, It less likely to seen in married people. There is no difference between socio-economic statuses, religious group or race related depression (Sadock & Sadock, 2009).

Personality factors also play a significant role in depression. Personality factors like heavily dependent on relationships, conscientious, perfectionist, with strict rules and not realistic, sensitive for disappointing about expectations himself or people around him can be all examples (Küey, 1998).

A shock caused by someone close's death like mother, father, partner can increase the tendency of depression. Medical disease like stroke and heart diseases can prepare the ground for major depression (Köro lu, 2009).

Saenger analysed patients from USA and Holland to correlate the depression symptoms and culture in 1968. While the USA originated patients anxiety, aggression, irritability, suicidal

thoughts were in the foreground, apathy, stagnation, indifference and guilt was in the foreground for Dutch patients (Köknel, 1989).

1.7. Depression in Children and Adolescents

If we have to look the prevalence of depressive disorders in children and adolescents; prevalence was found between 0,4-8,3%. We have to consider these researches as field studies (Fleming & Offord, 1990).

In a 1998 dated study, which aimed to found out the annual prevalence of depression in adolescents, pointed the annual prevalence between 2-20%. In these years, as a consequence of depression disorder, suicide attempts were 10-20 times higlıı!rJhan any other years (World Health Report, 1998). Depression symptoms in children have siınilae.effects which observed in adults. As a masked depression, symptoms like running awayfro111home, somatization, school phobia and substance abuse can be seen and suicides can be at stake (Sadock & Sadock, 2009). Early painful life events experienced during childhood may leave permanent scars in the brain and may predispose to depression (Öztürk & Ulu ahin, 2014).

1.8. Depression in Elder People

Depression is a serious health problem in older people, reducesthe quality of people's lives, and prevents the chances predictions for physical ailments. Somatic gripes of depressed mood lead the doctors to focus on physical disorders and fail to notice the depression diagnosis due to the thought of depression symptoms caused by physical diseases and dementia (Yüksel, 1998).

Depression is frequently observed in elder people but diagnosing it, is hard. Depression seen in elder people, who stays in hospital with a health problem or disabilities. Age-induced depression with cognitive impairment may be a sign of early dementia (Öztürk & Ulu ahin,

2014). Depression prevalence of elder people differs from 1-60% according to the method and the aim of the study (Tamam & Öner, 2001).

1.9. Treatment of Depression

Major depression 70-80% of the patients can cure with drugs and psychotherapy. 15% of the patients attempt suicide if depression doesn't cure. This depression period can last for ten months if it didn't cure (Sadock & Sadock, 2009).

Treatment methods in depression are cognitive therapy and interpersonal therapy. In cognitive therapy it is aimed to find out the pessimistic and wrong schemas about person's self, future or world and changing those negative autonomic thougths to alternative ones. In interpersonal therapy, a rise in person's interpersonal relationships and social environment was expected cure depression. It disrupts the harmony of depressed patients, founds alternative ways to the faulty communication and aims to improve social skills (Öztürk, 2008).

1.9.1. Antidepressant Drugs

Most antidepressants work by increasing the availability of monoamine neurotransmitters such as norepinephrine, serotonin, or dopamine, although they do so by different routes. The monoamine oxidase inhibitors (MAOis) work by inhibiting monoamine oxidase, one of the principal enzymes that metabolise these neurotransmitters. Most of the other antidepressants, including the tricyclic antidepressants (TCAs) and the selective serotonin reuptake inhibitors, inhibit the reuptake of serotonin or norepinephrine (and to a much lesser degree dopamine) into the presynaptic neurone. Either process leaves more of the neurotransmitter free to bind with postsynaptic receptors, initiating a series of events in the postsynaptic neurone that is thought to produce the actual therapeutic effect (American Psychological Association, 2015).

In Turkey; for the treatment of depression, tricyclics, selective serotonin reuptake inhibitors, serotonin and noradrenaline reuptake inhibitors, noradrenergic and selective

serotonin reuptake inhibitors, noradrenaline reuptake inhibitors, serotonin modulators, dopamine and noradrenaline reuptake inhibitors, and reversible relief of mono amino oxidases are used as antidepressant drugs (Öztürk &Ulu ahin, 2011).

Also some sources refer St. John's Wort, DHEA, Omega-3 Oils, SAM-e as antidepressant alternatives (Mitchell & Triggle, 2009).

1.9.2. Psychotherapy Techniques

Cognitive therapy, which is a short term therapy, is intended to fix the negative thoughts which cause depression by giving home works and work on cognitive distortions and unconscious judgements underneath it. It is aimed to change cognitive triad, namely helpless and hopeless of oneself self image, future and past (Sadock & Sadock, 2009). Cognitive behavioural therapy will last between 6 to 14 seances for patients with depression (Beck, 2014).

Aims of cognitive theory are listed below as:

1. Finding negative automatic thoughts and changing those thoughts.

2. Finding new alternatives for those negative automatic thoughts

3. Identifying relations between cognitions, moods and behaviour

4. Changing twisted autonomic thoughts with realistic, acceptable commemsIkölgnel, 2005).

In psychoanalytic psychotherapy depression is studied by looking for the topics which may harm or protect self respect on their history and by this way the "traumas which lived by psychologically or physically and introjections assemblies can be understand. After that topics which support self respect will taken to agenda and then durability of ego defence mechanisms, expectations and structure of ego ideals are evaluate and real expectations will clarified (Güleç, 1993).

1.9.3 Electroconvulsive Therapy (ECT)

First introduced in the 1930s, electroconvulsive therapy (ECT) is a procedure used in the treatment of severe depression. In the procedure, an electric current of 70- 150 volts is briefly administered to a patient's head, which causes a loss of consciousness and often causes seizures (Feldman, 2011).

Electroconvulsive therapy is used for treatment of several psychological disorders. Brain tissue is stimulated by an electric current and it is a psychiatric method which causes common convulsions. ECT is an effective treatment modality for the treatment of depressive disorders (Abrams, 2002). ECT is accepted as a clinical application in evidence based medicine approach. This approach comes forward from other treatment methods with early effects and wide using areas (Zeren, et al., 2003). ECT is an effective treatment method for major depression. ECT, which is as effective as drugs, is used for patients who have insufficient or partial responses from other methods (Tomruk & Oral, 2007).

Cardiovascular accidents are most likely to occur if there is preexisting pathology. Transient cardiac arrhythmias may occur but their incidence may be reduced by premedication with acetycholine-blocking agents (Beck & Alford, 2009). One new and promising alternative to ECT is transcranial magnetic stimulation {TMS). TMS creates a precise magnetic pulse in a specific area of the brain. By activating particular neurons, TMS has been effective in relieving the symptoms of major depression in a number of controlled experiments (Feldman, 2011).

1.9.4. Phototeraphy (Special A Light Therapy)

The photophysical act of light absorption initiates a sequence of actions and reactions that can lead to a remarkable diversity of physiological endpoints, for example, plant growth, animal vision, circadian rhythms, and sunburn. Thus, these effects used as a theraphy, which is called Phototheraphy (Grossweiner, 2005).

According to APA Dictionary of Psychology phototherapy defined as;

exposure to ultraviolet or infrared light used for treating certain medical conditions (e.g., jaundice, psoriasis), depression, and other disorders. For example, in phototherapy for seasonal affective disorder, a specially designed lamp that delivers 5,000 to 10,000 lx of light is shone on the retina, and a signal is transmitted via the optic nerve to the pineal gland, which secretes melatonin in response to darkness. Inhibition of melatonin release by bright light relieves the symptoms of SAD. Also called bright light therapy (American Psychological Association, 2015, s. 794).

1.10. Aim and Importance of the Study

This study is made to find out the prevalence of major depression in Turkish Republic of Norhem Cyprus, and risk factors of major depression. Aim of this study is describing events linked to depression, measuring frequency, causes of depression and changes for place, time and persons. Main aims of this study can be listed as contributing scientific data to find out causes of depression and progress and results of it in the means of environmental factors and giving information to professions in the field in TRNC about every dimension of major depression. This study will also help to improve, evaluate and describe the psychological health politics in TRNC.

Results of this study like prevalence of depression and risk factors and data according to this study will contribute to clinical practice, general psychiatry education and psychopathology of depression. Knowing the prevalence of depression in TRNC will help to professions for knowing the risk factors like who will live a depression, effects of gender on depression, frequency of psychological disorders in the family, use of cigarette or alcohol, marital status, briefly the risk factors to live a depression in TRNC.

1.11. Hypothesis of the Study

The depression rate will be high in TRNC. Women will have higher depression rates compared to men. People with physical illnesses will have higher depression rates.

2. LITERATURE REVIEW

Depression has the highest frequency of likelihood to happen amongst the psychiatric disorders. Prevalence of depression is between 13% and 20% in the world and 10% in Turkey. 1 out of 5 in the world can be in depression at least once. Depressive ictus of women stated as 2 times higher than men (Özer, et all., 2015). In epidemiological studies, the prevalence of major depression and dysthymia reported as 2,2-5,4% in females and 1,2-2,6% in males. Clinical frequency of depression in Turkey is 10% while spot frequency is 13-20% (Kılınç & Torun, 2011). Approximately 15-20% of people show random depressive symptoms and the 20% of them are severe enough to be treated. 20% of the adults tend to have mood disorders in any time of their life. Also, depression rose 10-20 times in recent 25 years (Alper, 2012). According to the studies in Turkey, prevalence of physical symptoms 24% while simple depression is 21%, specific symptoms of depression is 10%, prevalence of primary depression is 10%, prevalence of secondary depression 5%, chronic depression 32% and prevalence of lifetime depression stated 20% (Küey, 1998).

World Health Organization measured the prevalence of depression in North America, Latin America, Europe, Germany, Holland and Turkey. The sample size of this research was more than 37000 attendants, prevalence rate of depression in a life time was found different in every country such as 3% in Japan and 16.9% in the USA, but most of the countries had 8 to 12 percent prevalence rate. 12 months life time prevalence was 40-55%, 30 days/12 months prevalence rate was 45-65% and in most of the countries, starting age of depression was between 20-25 (Andrade, et al., 2003).

Weissman and friends conducted research about the lifelong prevalence of major depression, which includes ten countries and 38.000 people. In Taiwan its 1.5%, 19% in Beirut, 0,9% in the US, 0,6% in Edmonton, Alberta, also 0,6% in Puerto Rico, 0,5% in West Germany, 0,4% in Korea. Annual prevalence is 0,8% in Taiwan, 5,8% in New Zealand, 0,8% in USA,

0,8%, 5,2% in Edmonton, Alberta, 3% in Puerto Rico, 4,5% in Pads, France, 5% in West Germany and 2,3 in Korea respectively (Weissman, et al., 1996). 13% in a research, which Wells and Friends conducted with DIS (Wells et al., 1989), and 17,1 % NCS rate found in Kessler and friends research (Kesler, et al., 1994).

In Nepal, a research conducted by Risal and Friends about depression and anxiety prevalence in which 2100 people participated (861 male, 1239 female), depression prevalence was found 11,7% (Risal, et al., 2016).

39 depression prevalence study analysed by Lei and Friensa, which was held between 1997-2015 in China. 32694 university students had attended-in-this research where depression prevalence was between 3,0% and 80,6% and summed prevalence founded 23,8% (Lei, et al., 2016).

EMBASE, ERIC, MEDLINE and PsycINFO databases-was searched for specified articles reference list between 1963-2015 by Mata and friends and depression prevalence was studied via correspondence method. 9447 attended with 31 cross-sectional.studies, 8113 with 23 spatial studies. Total prevalence of depression founded 28,8% (Mata, et al., 2015).

A research held in Kafkas University Faculty of Medicine, Turkey. In this study the rate of patients diagnosed with depressive disorder was 50,9% (Ya cı, et al., 2014).

Another research made in Turkey with participation of 900 people (65.7% women; 591 people, and 34.3% men; 309 men) who were between the ages 18-68. Research shows that 18.78% of people experiences depression. Major depressive disorder found in 22.5% of women, 11.6% people who are above the age 32,9% people had depressive disorder, 34,3% in low educated group, 34,1% in widow and widowers (Do an, 2010).

According to a research held by Akın and Friends, which was conducted by Ministry of Health in 2005, in a sampling group, which has a population of 831 (7,43%) people who was diagnosed with depression and 10.341 individuals who didn't get depression diagnosis, 79,2%

of them were female while only 20,8% were male. The most depressed age group stated as 35-44 (Akın et al., 2007).

In another research which conducted in Eski ehir by Arslan and Friends, 367 people was diagnosed with major depressive disorder out of 547 people, who got mood disorder diagnosis (37%). A clear correlation stated between gender and mood disorder. 31,9% of the females got MDD while 17,9% of the males got MDD (Arslan, et al., 2009).

In research conducted at Celal Bayar University by Mergen and Friends , which has a sampling group of 279 individuals, 110 people stated with depression. 39 of the 110 was male while 71 of them was female. Total depression prevalence is 39,-4%, 35,5% for males and 64,5% for females (Mergen, et al., 2008).

A research held in the Cyprus Republic by Sokratous and friends, and the prevalence of depression is found 27,9% amongst the 1500 college students. Being a woman, living alone, living in rural areas, families which have lost someone, being divorced, having a family history of depression considered as risk factors. A positive correlation stated between the amount of smoking and amount of drug usage and depression in this research (Sokratous et al., 2014).

3.METHOD

3.1. Sampling

The universe of the study is Turkish-speaking individuals between 18-88 years of age living in Northern Cyprus. Multi-stage stratified (randomised) quota used in the survey and 978 people selected. Selected individuals based and calculated on gender (male/female), age (18-19, 20-29, 30-39, 40,49, 50-65, 65 and above), place of residence (village/city), regional features. 4 December 2011 dated census statistics considered for sampling (Nüfus Sayımı, 2011). With the guidance of the last census, five main regions, which are Nicosia, Famagusta, Kyrenia, Morfou and skele, main characteristics of the population are taken into account. These five central areas of the cities divided into villages and neighbourhoods in the countryside. 16 neighbourhoods, 17 villages, five districts randomised and used in study (Lefke, Güzelyurt, Mehmetçik, skele, Geçitkale).

3.2. Survey Form

3.2.1. Socio-demographic data form

Socio-demographic data form was prepared by the researcher and this form was used to collect profile data and consist of 21 questions. This self-made form, following questions asked to participants: age, gender, marital status, place of birth, where they live, with whom they live, education status, profession, the legal position of their homes, thoughts on uniting with Greek-speaking Cypriots, cigarette/alcohol/substance usage and total monthly income.

3.2.2. Beck Depression Inventory (BDI)

Beck Depression Inventory first introduced in 1961 by Beck, Ward, Mendelson, Mock & Erbaugh, and later in 1971 it revisioned and reproduced in 1978 (Groth-Mamat, 2003). Two forms of BDI can be mentioned; original form introduced in 1961 with 21 articles. Clinician

individually evaluates the current mood of the patients. The other BDI form included 21 articles and developed in 1978. It's suitable for group therapies and self-evaluation type. The internal consistency of work in 1978 showed that two BDI forms were equivalently reliable BDI observes emotional, cognitive and motivational symptoms in depression (Beck & Steer, 1984).

BDI evaluates the emotional, cognitive and motivational symptoms. Each item associated with a behavioural characteristic of the depression. 4-degreed scale with this self-evaluation phrases degree between, 0 (no symptoms) and 3 (symptoms highly observed). Completion of the test takes approximately 15 minutes. Score range is between 0-63 and the cut-off point is 17, which shows clinical depression (Hisli, 1988).

According to Hisli (1988), statistical comparison of Turkish and English forms, showed correlation coefficient as r=.81 and r=.73 (Hisli, 1988).

3.3. Procedure

Research held in April-June 2016 in North Cyprus. Starting points defined randomised in streets for cities, village centres (coffeehouses and village mosques) and directions to the north, south, east and west for villages. Pollsters tried to draw squares with their movement and started with smallest house numbers. One house out of three added to study and turned in the first right to make a square. After the square had completed, a new start point defined to make a new square. With this, pollsters used a standard method and tolerance due to the pollster prevented. Gender and age quotas considered in every house entered. Only one person added to study in every house and it's followed a pattern like one woman, one man in next home, one woman in another home etc. If there is more than one candidate in a home, the one selected whose birthday is nearest. 40 pollsters attended to study after an education. Each pollster applied 25 questionnaires. In this way, the margin of error tried to reduce which may result from the interviewers' application. After detailed information given to the candidate, after they signed

consent form they participated the study. The validity and comprehensiveness of the survey tested with ten patients in the pre-study period. Patients were asked to fill in the BDI *(Attachment-4),*

3.4. Data Analysis

Collected data analysed by computer with Statistical Package for Social Science (SPSS) 23 software package. Each sociodemographic features compared between with and without depression using Chi-Square and risk factors defined by using logistic regression method. 0.05 or lower p values considered statistically meaningful to all these statistical testes. Depression risk factor rate defined (95% confidence interval) by logistic regression rate for every feature of sociodemographic values.

4.RESULTS

Comparison of sociodemographic characteristics of individuals with and without depression. 978 people participated to the study. 453 (46,3%) of them were women and 525 (53,7%) of them were men. 225 (23,0%) of them had depression while 738(75,5%) of them don't. 40 (SD=+l6,27) for the average age of depression while its 39.18 (SD=+l4,66) for without depression. Participants according to their birthplace, 478 (%48,9) for Cyprus, 447 (%45,7) for Turkey, 13 (%1,3) and 40 (%4,1) for others. In marital status, 523 (%53,5) of them married, 46 (%4,7) of them single, 52 (%5,3) in relationship 27 (%2,8) divorced, 52 (%5,3) are widow and 5 (%0,5) of them choosed "others". According to residental data, 256 (%26,2) of them lives in village, 142 (%14,5) of them in town and 579 {%59,3) of them lives in city. According to the education status, 19 (%1,9) of the participans are illiterate while 31 (%3,2) of them literate, 144 (%14,7) of them primary school graduate, J.35 (%13,8) of them secondary school graduates, 274 (%28.0) of them high school graduate and 375 (%38,3) of them are college / university graduates.

Table 1. Distribution of the participants according to presence of depression according to Beck Depression Inventory.

	N	%
With Depression	225	23,4
Without Depression	738	76,6
Total	963	100

Not answered (NA)=l5 (%1,5), N=Frequency, %=percentage

Table 2. Comparison of presence of depression according to gender.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
Female	132	29,7	312	70,3	444	100
Male	93	17,9	426	82,1	519	100
All participants	225	23,4	738	76,6	963	100

X_2=18,642, df=1, p=0,000, NA= 15 (1,5%)

Gender and participants with depression and without depression compared using Chi-square and found a meaningful statistic difference (X_2=18,647, df=1, p=0,000). Women had higher depression prevalance compared to men.

Table 3. Comparison of presence of depression according to age.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
18-29	74	25,1	221	74,9	295	100
30-39	43	18,8	186	81,2	229	100
40-49	42	22,3	146	77,7	188	100
50-59	30	26,1	85	73,9	115	100
60 and more	30	27,0	81	73,0	111	100
All participants	219	23,3	719	76,7	938	100

X_2= 4,599, df= 4, p=0,331 NA=40 (4,1%)

Age average and participants with depression and without depression compared using Chi-square but couldn't found a meaningful statistic difference (X_2 = 4,599, df=4, p=0,331).

Table 4. Comparison of presence of depression according to birth place.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
Cyprus	98	21,0	369	79,0	467	100
Turkey	116	26,2	327	73,8	443	100
Britain	3	23,1	10	76,9	13	100
Other	8	20,0	32	80,0	40	100
All participants	225	23,4	738	76,6	963	100

$X_2=3,699$, df=3, p=0.296, NA=19 (1,9%)

Place of birth and participants with depression and without depression compared using Chi-square but couldn't found a meaningful statistic difference ($X_2=3,699$, df=3, p=0.296)

Table 5. Comparison of presence of depression according to number of years lived in Cyprus.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
0-9	69	30,1	160	69,9	229	100
10-19	23	20,7	88	79,3	111	100
20-29	20	21,3	74	78,7	94	100
30-39	14	22,6	48	77,4	62	100
40-49	10	17,2	48	82,8	58	100
50-59	9	45,0	11	55,0	20	100
60 and more	8	25,8	23	74,2	31	100
All participants	153	25,3	452	74,7	605	100

$X_2=11,215$, df=6, p=0,082, NA=373 (38,1%)

In this study, with and without depression and residency period of people, whose place of birth isn't Cyprüs, compared using Chi-square method but couldn't found a meaningful statistic difference ($X_2=11,215$, df=6, p=0,082).
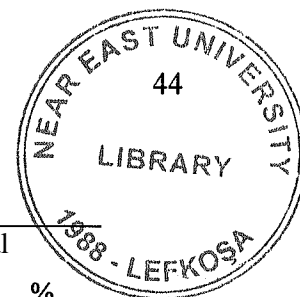
Table 6. Comparison of presence of depression according to marital status.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
Marled	102	19,8	412	80,2	514	100
Engaged	15	33,3	30	66,7	45	100
In Relationship	22	34,4	42	65,6	64	100
Single	54	21,0	203	79,0	257	100
Divorced	7	26,9	19	73,1	26	100
Widow	21	40,4	31	59,6	52	100
Other	4	80,0	1	20,0	5	100
All participants	225	23,4	738	76,6	963	100

$X_2=28,736$, df=6, p=0,000, NA=15 (1,5%)

In this study, marital status and with or without depression compared using Chi-square and found a meaningful statistic difference. ($X_2=28,736$, df=6, p=0,000). Widows had more higher points of depression.

Table 7. Comparison of presence of depression according to having children.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
No Children	103	24,9	310	75,1	413	100
Have Chlidren	122	22,2	428	77,8	550	100
All participants	225	23,4	738	76,6	963	100

$X_2=1,002$, df=1, p=0,317, NA=15(1,5%)

In this study, children distribution and with and without depression distribution compared using Chi-square but couldn't found a meaningful statistic difference ($X_2=1,002$, df=1, p=0,317).

Table 8. Comparison of presence of depression according to number of children.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
1	20	16.3	103	83.7	123	100
2-3	69	19.5	285	80.5	354	100
4 and more	37	42.0	51	58.0	88	100
All participants	126	22.3	439	77.7	565	100

X_2=24.002, df=2 p=0,000, NA=413 (42.2%)

This study used chi square analysis to compare the correlation between depression and number of children and the results were significantly different (X_2=24.002, df=2 p=0,000).

As the number of children increases, there was an increased rate of depression.

Table 9. Comparison of presence of depression according to living place.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
Village	58	23,3	191	76,7	249	100
Town	37	26,1	105	73,9	142	100
City	129	22,6	442	77,4	571	100
All participants	224	23,3	738	76,7	962	100

X_2=0,764, df=2 p=0,682, NA=16 (1,6%)

In this study, individuals with and without depression and the distribution of where they live compared using Chi-square but couldn't found a meaningful statistic difference (X_2=0,764, df=2 p=0,682).

Table 10. Comparison of presence of depression according to employement.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
Employed	96	16,9	472	83,1	568	100
Unemployed	129	32,7	265	67,3	394	100
All participants	225	23,4	737	76,6	962	100

X_2=32,573, df=1, p=0,000 NA=16 (1,6%)

In this study, individuals with and without depression and employment status compared using Chi-square and found a meaningful statistic difference (X_2=32,573, df=1, p=0.000). Employed people showed lower depression rate.

Table 11. Comparison of presence of depression according.to profession.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
Worker	29	19,1	123	80,9	152	100
Student	51	30,0	119	70,0	170	100
Unemployed	9	33,3	18	66,7	27	100
Civil Servant	19	19,6	78	80,4	97	100
Own Business	21	14,3	126	85,7	147	100
Housewife	50	42,4	68	57,6	118	100
Freelance	25	24,5	77	75,5	102	100
Other	21	14,1	128	85,9	149	100
All participants	225	23,4	737	76,6	962	100

X_2=45,782, df=7, p=0,000 NA=16 (1,6%)

In this study, employment of individuals and without depression and employment status compared using Chi-square and found a meaningful statistic difference (X_2=45,782, df=7, p=0,000). Housewifes showed greater depression rate than any other occupations.

Table 12. Comparison of presence of depression according to education level.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
Illiterate	8	44,4	10	55,6	18	100
Literate	14	46,7	16	53,3	30	100
Primaryschool	36	24,8	107	74,8	143	100
Middle School	33	24,8	100	75,2	133	100
High school	51	19,0	218	81,0	269	100
College / University	83	22,4	287	77,6	370	100
All participants	225	23,4	738	76,6	963	100

$X_2= 17,077$, df=5, p=0,004 NA=15 (1,5%)

In this study, education status and with and without depression compared using Chi-square and found a meaningful statistic difference ($X_2= 17,077$, df=5, p=0,004).

Table 13: Comparison of presence of depression according to monthly income.

	With Depression		Without depression		Total	
	N	%	N	%	N	%
No income	26	35,1	48	64,9	74	100
Minimum wage (1700 TL and belove)	76	30,6	172	69,4	248	100
1700-3400 TL	78	21,7	281	78,3	359	100
3400-10.000 TL	34	14,2	205	85,8	239	100
10.000 TL and more	10	25,0	30	75,0	40	100
All participants	224	23,3	736	76,7	960	100

$X_2=24,835$, df=4, p=0,000, NA=18 (1,8%)

In this study, monthly income and with and without depression compared using Chi-square and found a meaningful statistic difference ($X_2=24,835$, df=4, p=0,000). It was found that depression rate drops while monthly income rises.

Table 14. Comparison of presence of depression according to status of home lived in.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
Own resources	75	19,7	305	80,3	380	100
State aid	20	34,S	38	65,S	58	100
On Rent	71	26,7	195	73,3	266	100
Family heritage	53	23,0	177	77,0	230	100
Other	6	21,4	22	78,6	28	100
All participants	225	23,4	737	76,6	962	100

$X_2=8,507$, df=4, p=0,075, NA=16 (1,6%)

In this study, how they owned their house and with or without depression compared using

Chi-square but couldn't found a meaningful statistic difference ($X_2=8,507$, df=4, p=0,075).

Table 15: Comparison of presence of depression according to living location.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
Turkish Property	145	24,S	448	75,S	593	100
Greek Property (Allocated)	SO	25,9	143	74,1	193	100
Greek Property (Equivalent)	28	16,6	141	83,4	169	100
All participants	223	23,4	732	76,6	955	100

$X_2=5,450$, df=2, p=0,066, NA=23 (2,4%)

In this study, status of property and with or without depression compared using Chi-square

but couldn't found a meaningful statistic difference ($X_2=5,450$, df=2, p=0,066).

Table 16. Comparison of presence of depression according to physical illness.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
Have Physical Disease	33	37,1	56	62,9	89	100
Doesn't Have Physical Disease	192	22,0	681	78,0	873	100
All participants	225	23,4	737	76,6	962	100

X_2=10,258, df=1, p=0,001, NA=16 (1,6%)

In this study, physical disease and with or without depression compared using Chi-square and found a meaningful statistic difference (X_2= 10,258, df= 1, p=0,001). People, who don't have any physical disorders, have low rates of depression rate.

Table 17. Comparison of presence of depression according to psychiatric illnesses.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
Have psychiatric disorders	11	33,3	22	66,7	33	100
Dont have psychiatric disorders	214	23,0	715	77,0	929	100
All participants	225	23,4	737	76,6	962	100

X^2=1,886, df=1, p=0,170, NA=16 (1,6%)

In this study, psychiatric disorders and with or without depression compared using Chi-square and couldn't found a meaningful statistic difference (X_2=1,886, df=1, p=0,170)

Table 18. Comparison of presence of depression according to being treated because of a psychiatric illness.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
Yes	22	31,4	48	68,6	70	100
No	202	22,6	690	77,4	892	100
All participants	224	23,3	738	76,7	962	100

X^2=2,803, df=1, p=0,094, NA=16 (1,6%)

In this study, therapy because of a psychiatric disorder and with or without depression compared using Chi-square and couldn't found a meaningful statistic difference (p=0.094).

Table19. Comparison of presence of depression according to whom living with.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
Alone	44	32,8	90	67,2	134	100
Spouse / partner / lover	99	19,2	416	80,8	515	100
Mother / father / brother	39	21,5	142	78,5	181	100
Friend	19	26,4	53	73,6	72	100
Second-degreerelatives	9	75,0	3	25,0	12	100
Other	15	30,6	34	69,4	49	100
All participants	225	23,4	738	76,6	963	100

X^2=31,654, df=5, p=0,000, NA=15 (1,5%)

In this study, who they live with and with or without depression compared using Chi-square and found a meaningful statistic difference (X^2=31,654, df=5, p=0,000). Alone and living with second-degree participants showed higher rate of depression.

Table 20. Comparison of presence of depression according to political beliefs about Cyprus Problem.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
Solution and bi-communal bi-zonal federal state	59	18,8	255	81,2	314	100
Confederal solution of two separate states	36	27,5	95	72,5	131	100
As a continuation of TRNC	39	17,7	181	82,3	220	100
Return to the 1960 Republic of Cyprus	7	23,3	23	76,7	30	100
Combining to Turkey	68	31,5	148	68,5	216	100
Other	15	29,4	36	70,6	51	100
All participants	224	23,3	738	76,7	962	100

X2=17,843, df=5, p=0,003, NA=16 (1,6%)

In this study, thoughts on solution of Cyprus and with or without depression compared using Chi-square and found a meaningful statistic difference (X:2:::::J7,843, df=5, p=0,003). People who wish combining with Turkey showed greater depression rate.

Table 21. Comparison of presence of depression according to alcohol use.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
0	55	24,7	168	75,3	223	100
1-2	13	27,7	34	72,3	47	100
3-5	15	37,5	25	62,5	40	100
6-9	12	29,3	29	70,7	41	100
10-19	18	24,7	55	75,3	73	100
20-39	12	17,9	55	82,1	67	100
40 or more	100	21,2	372	78,8	472	100
All participants	225	23,4	738	76,6	963	100

X2=8,388, df=6, p=0,211, NA=15 (1,5%)

In this study, how many times they drunk alcoholic beverage and with or without depression compared using Chi-square but couldn't found a meaningful statistic difference (X_2=8,388, df=6, p=0,211)

Table 22. Comparison of presence of depression according to smoking.

	With Depression		Without depression		Total	
	N	%	N	%	N	%
0	61	20,8	232	79,2	293	100
1-2	6	24,0	19	76,0	25	100
3-5	8	29,6	19	70,4	27	100
6-9	4	20,0	16	80,0	20	100
10-19	5	17,9	23	82,1	28	100
20-39	15	30,0	35	70,0	50	100
40 or more	126	·24,2	394	75,8	520	100
All participants	225	23,4	738	76,6	963	100

X_2=3,706, df=6, p=0,716, NA=l5 (1,5%)

In this study, how many times they smoke and with or without depression compared using Chi-square but couldn't found a meaningful statistic difference (X_2=3,706, df=6, p=0,716).

Table 23. Comparison of presence of depression according to drug abuse.

	With Depression		Without Depression		Total	
	N	%	N	%	N	%
Yes	173	25,6	503	74,4	676	100
No	52	18,1	235	81,9	287	100
All participants	225	23,4	738	76,6	963	100

X_2=6,284, df=l, p=0,012, NA=l5 (1,5%)

In this study, drug usage and with or without depression compared using Chi-square and found a meaningful statistic difference (X_2=6,284, df=l, p=0,012). Substance users showed greater depression rate.

Tablo 24. Logistic Regression Analsis of Risk Factors.

Demographic Variables	Depression / Non- depression	
	Odds Level	%95CI
Gender (Female / Male)	1.659	(1.314-2.095)**
Age (25 and below / above)	0.971	(0.890-1.060)
Birth (Cyprus / Turkey)	0.801	(0.663 -1.014)
Living status (not with family / with family)	1.656	(1.246 - 2.201)**
Education (High school below / above)	1.472	(1.082 - 2.003)*
Cigarette use (40 times more / less)	0.976	(0.910- 1.046)
Alcohol use (40 timesmore / less)	0.832	(0.661 - 1.048)
Drugs (user / not user)	1.554	(1.099 - 2.198)*
Child (having / don't having)	0.889	(0.707-1.118)
Live in general (urban / rural)	0.970	(0.739-1.273)
Maritial Status (single / married)	1.551	(1.121-2.146)*
Employement Status (unemployed / employed)	1.937	(1.538 - 2.440)**
Monthly Income (belove and above 3400TL)	1.676	(1.243-2.260)**
Pyshcal Disease (having / don't having)	1.686	(1.251-2.271)**
Psychiatric Disorders (having/ don't having)	1.447	(0.679-1.105)
Theraphy due to Psychiatric Disorders	1.388	(0.962-2.003)
Property Status (Greek Property/Turkish Property)	0.881	(0.692-1.123)
Solution in TRNC (willing confederal / federal)	1.638	(1.017-2.638)*

*p ≤ 0.05 ve **p ≤ 0.001 significant level, CI= Confidence Interval.

In the development of depression being a woman, living apart from family, having low levels of education, substance abuse, being a single, unemployment, low income, physical illness and not wanting the Cyprus Problem to be solved are identified as risk factors.

5. DISCUSSION

This study found the current prevalence of depression among people who live in North Cyprus is 23.4%. Epidemiological studies show that some countries have higher depression rates with 29% (Mossie, Kindu, & Negash, 2016). Epidemiological studies in USA show lower depression rates with 5% (Ohayon, 2007). The prevalence level among the world is between 8% and 12% (Andrade, et al., 2003). When we consider the World prevalence, it is clear that TRNC has higher depression prevalence. That fact that TRNC is not a recognized country, recent war history, migration history, previous economic crisis', the uncertainity about Cyprus Problem, high unemployement rates and corrupt public order may seen as the reason for the high depression levels. It has stated in previous researches that war (Naja, et al., 2016), migration (Tuzcu & Bademli, 2014, Aker, et al., 2002; Ozen-et.al., 2001), economic crisis (Breuer & McDermott, 2013; Economou, et al., 2013; Çakıcı, 2010; Buffel et al., 2015), unemployement (Najafpo, and others, 2016, Topuzo lu et al., 2015) can led to depression. Previous researches made in TRNC supports these findings. im ek showed that both societies from North and South of Cyprus experienced depression as well asPTSD because of battle and losing relatives (im ek, 2015). Ergün stated that migration also caused depression compared to the people who did not migrate as a result of the war (Ergün, 2008). Aktolgalı and Çakıcı also stated that the economic crisis and bankruptcy of the banks created intense psychological distress and depression, future concerns and hostality (Aktolgalı & Çakıcı, 2001).Deadlock about Cyprus Problem and future concerns cause depresive thoughts and emotions (Çakıcı, 2010). When we look at the circumstances in the island, we see that depression levels are also high at the South part of the island. In a research made in 2014 among university students in South Cyprus found out that the depression prevalence is 27.9% (Sokratous et al., 2014).

According to the research data, the depression rates in women is higher than men. Researches also suggest that depression is more common in women than men (King & Buchwald, 1982; Kumar et al., 2007; Dogan, 2010 Yelde et al., 2010; Tanjana et al., 2016; Najafipo et al., 2016; Torre et al., 2016; Santos et al., 2016; Kim et al., 2006). However some research is not supporting this finding. Stidies that included people who experienced war in Syria (Naja et al., 2016) and a student group who did not graduate in Sri Lanka (Amarasuri et al., 2015; Aghakh et al., 2011) showed no significant difference between men and women in means of depression rate. The higher rates in depression levels in women in not fully explained. In research carried out so far; it has been reported that depression may be caused by women's hormonal changes (Burt & Stein, 2002), also, postpartum and premenstrual periods can cause to depression (Savran, 1999).

Even thought the difference between age groups were not statistically different, the depression rate in youth and elderly were higher. Studies suggestthat point prevalence in youth(0.19%) and elderly (1.74%) is more common (Liu et al., 2015). The higher rate of depression in youth and elderly can be explained by biological changes. Older people's mental activity is assumed to be limited, which may explain higher rates (Holvast et al., 2012). On the other hand, hormonal changes, search for identity, belonging to a community may explain the higher rates in youth. Even though there were no significant difference between age groups, some studies suggests that as the age increases, the depression level also increases (Do an, 2010).

When the marital status were compared, we saw that married people have lower depression rates then divorced and widowed. Also, single people also have lower levels than people who have relationhips and are engaged. However, Yan's study in China, stated that being married and over 55 of age is a risk factor compared to being divorced or widoved (Küey, 1998; Kayahan et al., 2003; Ball et al., 2010; Yan et al., 2011). Being divorced or widowed is a phonemenon influed by cultural norms. Divorced people usually plan to re-marry, buy only

some of them do. Also, divorce seems like a normal situation for men, whereas for women, it is unacceptable (Jang et al., 2009). All these fmding Show that marital status may have different effects on depression in different cultures.

There has been no significant difference between having children or not having children. As a follow up question, we asked participants the number of children they have. As a result, we saw that as the number of children increases the depression level also increases. Similar results have been found in another studies (Önen et al., 2002; Kayahan et al., 2003). As the number of children increases, the communication between parents decrease (Ça in, 2005). As the number of children increase, the stress and financial bargain on the caretaker also increases, which will explain the incresed rate in depression (Önen et.al., 2002).

When the dispersion of the profession is considered, it is found out that depression levels are higher in housewifes and unemployed. The assumption that being unemployed and not being able to communicate and interact with other people lead people to oneliness also explain the high rates of depression in the people. Some researchers reported of job loss may cause depression (Dooley et al., 1996).

Depression levels are higher in unemployed people compared to the working class. There are research to support higher depression levels in unemployed (Yinokur et al., 1996). Work is the primary factor that provides social security and lack of social security can cause depression which will lead to suicide occasionally. Working also provides social support. Unemployed people faces negative attitude from their environment and as the unemployement duration extends the attitude becomes worse (Yüksel, 2005).

People with low educational level have higher rates of depression than college graduates. Similar results have been demonstrated in other studies (Do an, 2010; Coelho et al., 2013; Tanjana et al., 2016; Cole et al., 2003). High educational levels can provide both social security and it can be effective for people in terms of recognition their depressive scheme (Yüksel,

2005). However, in a study conducted in South Cyprus, it is found that college graduates are more likely to experience depression (Kiliar et al., 2012).

Significant difference were foundwhen incomes were compared. People with lower incomes have significantly higher rates. Similar results were found in previous studies (Özdel et al., 2002; Liu et al., 2015; Tanjanaetal., 2016; Vabl et al., 2016). In developed countries purchases like house and cars are measured. As the numbers of owned cars increase, the possibility of neurotic disorders decrease (Lewis et al., 1998). Income level affects purchasing power in daily life which effects anxiety levels. It is known that people who grew up in poor families are more prone to depression (Einsberg et al., 2007). In undeveloped. countries where there is social inequality, poverty and inequitable income distribution, people.are more likely to develop depression (Ladin et al., 2009).

It is stated that individuals with pyhsical illness have gre~ter .frequency of depression compared to the indivials with no physical illness. As the permanent physical damage block person's movement capacity which leads to social isolation, depressiontreatment is harder with people with permanent physical illness (Oguzhano glu, 2001; Tokgöz et al., 2008; Hidaka, 2012; Cole et al., 2003; Torre et al., 2016).

This findings are also supported by other studies (Cole & Nandini, 2003; Hidaka, 2012). At the same time, living alone in a hotel room is also considered to be a risk factor (Amara Suri et al., 2015).

When political views are considered, people who would like to unite with Turkey, support confederation, and want to form Republic of Cyprus again have significantly higher rates of depression compared to people who are pleased with TRNC and people who believe forming a government with two federal states. Based on these results, we can say that the ongoing Cyprus problem process may disappoint people who want confederation or being united to Turkey. Also, status quo continues because of the ambiguity of the Cyprus problem. This situation may

be explained by the people who have depressive schemes may have a negative structure (Burger, 2006). Also, it can be stated in studies which focus on the relationship between stress and depression, environmental problems can be quite effective in the development of depression (Akba et al., 2005; Santos et al., 2016).

Smoking and alcohol use is not consired as a risk factor in the development of depression. This finding is also supported by the previous research (Risalet et al., 2016). Nevertheless, some studies found that smoking and depression (Özbay et al, 1991;Torre et al., 2016; Mossie et al., 2016), and alcohol use and depression have a direct correlation(Kim and Lee, 2006; Mergen et al., 2008; Santos et al., 2016). This study suggests that smoking and alcohol use is not a primary variable for depression, but they can have be effective in formation of depression. In additon to that, depression rate in other psychoactive substance users. is higher. In the literature, further research also proves the psychoactive substance use leads to depression (Risala et al., 2016; Mossie et al., 2016; Space & Ögel, 2003).

6. CONCLUSION

Depression is important biopyschosocial disorder which is highly observable amongst public and affects individuals health and decisions.

In this research depression prevalence in TRNC examined and potential risk factors analysed. According to the data, women have greater rate of depression than men and people with low level of income, physical illness showed more risk than other groups. Also, living alone, being a single and using psychoactive substances showed meaningful correlation on onset of depression. Depression affects on perception and interpretation in pattern construction progess and affects decision-making progress. It will be good forliterature and country, if future studies emphasize prevalence and risk factors. This research does not include hospitals, prisons and military bases, as it was a home research it was conducted on general population. As the reseach was designed as a self report test, the participants may have reflected themselves differently. It can be usefull for psychologists in TRNC to evaluate and improve mental health programme policy. Clinicians should note the risk factors for depression and also consider the patients cultural traits for a better evaluation process.

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APPENDICES

APPENDIX 1- B LG LEND RME FORMU
KUZEY KIBRIS TÜRKCUMHUR YET NDE MAJÖR DEPRESYONUN Y.A.YGINLIGIVE.R SKF.A.KTÖRLER

Bu çalısmanın alllacı>I<ll:zt!y Kıbrıs Türl<:) Çµ:rıh.uriyetinde Majör Depresyo11un Yaygınlı ı ve Ri.sk. :Fa.kt rleri araştırmaktır. Ça.lı ma.. sorıııcmnda elde edilen veriler do rultusunda KKTC' de depresyon yaygınlı ını bulmayı amaçlanmaktadır.

Bu çalı mada size bir demografik bilgi formu ve. birqi:zi. lçyk sunduk. Demografik bilgi formu sizin ya cinsiyet gibi demografik özellikleriniz hakkırıclajd soruları içermektedir. Ölçekler ise depresyonda gözlemlenen duygusal, bilisse] ye motivasyonel semptomları ölçmektedir.

Daha önce de belirtildi i gibi, ölçeklerde ve görüsmelerde verdi iniz cevaplar kesinlikle gizli kalacaktır. E er çalı mayla ilgili herhangi bir il<:a.yet, gi5ıi.i veya sorunuz varsa bu çalı manın ara tırmacılarından biri olan Psk. Özlem Gökçe ile ileti ime geçmekten lütfen çekinmeyiniz (ozlm-gkce@hotmail.com / 05338868590).

E er bu çalı maya katılmak sizde belirli düzeyde stres yaratmı sa ve bir danı manla konu mak istiyorsanız, iilkemi:zclt! ücretsiz hizmet veren u kurulu lar bulunmaktadır:

E er üniversite ö rencisiyseniz, devam etti iniz üniversitede Psikolojik Danı manlık, Rehberlik ve Ara tırma Merkezine (PDRAM) ba vurabilirsiniz.

E er ö renci de ilseniz, Barı Sinir ve Ruh Hastalıkları Hastanesine ba vurabilirsiniz.

E er ara tırmanın sonuçlarıyla ilgileniyorsanız, ara tırmacıyla ileti ime geçebilirsiniz.

Katıldı ınız için tekrar te ekkür ederim.

Psk. Özlem Gökçe

Psikoloji Bölümü,

Yakın Do u Üniversitesi,

Lefko a.

APPENDIX2-AYD1NLATILMI   ONAM

Bu çalı ma, Yakın Do u.Üniver itçsi FenEdebiyat Fakültesi Psikoloji Bölümü tarafından gerçekle tirilen bir çalı mad.ırt

Bu çalı manın amacı ·~~f2~~ıbrısTürk Cumhuriyetinde rviajör Depresyonun Yaygınlı ı ve Risk Faktörleri ara tırına.ktır. Çalı ma sonucunda elde edilen veriler do rultusunda KKTC'de majör depresyo11yaygı11lı ınıve risk faktörlerini bulmayı amaçlanmaktadır.

Anket tamamen bilimsel amaçlarla düzenlenmi tir. Anket formunda kimlik bilgileriniz yer almayacaktır. Size ait bilgiler kesinlikle gizli tutulacaktır. Çalı madan elde edilen veriler yalnızca istatistik-veri olarak kullanılacaktır. Yanıtlarınızı içten ve do ru olarak vermeniz bu anket sqn11çla.rının toplum için yararlı bir bilgi olarak kullanılmasını sa layacaktır.

Telefon numaranız anketörün denetlemesi ve anketin uygulandı ının belirlenmesi amacıyla istenmektedir.

Yardımınız için çok te ekkür ederim.

Psk. Özlem Gökçe

Yukardaki bilgileri ayrıntılı biçimde tümünü okudum ve anketin uygulanmasını onayladım.

sim:

mza:

Telefon:

APPENDIX 3- ANKET FORMU

Bu anket çalı ması sosyal sorunlarımızı ve alı kanlıklarımızı ara tırmaya yönelik bilimsel bir çalı mamızdır. Kıbrıs genelinde 18-88 ya grubundaki kadın-erkek bireylere uygulanacaktır. Bu çalı mada kesinlikle kimlik bilgileri kullanılmayacaktır. Yalnızca çalı manın istatistik verileri bilimsel olarak akademisyenler tarafından ülkemizdeki sorunların çözümüne yönelik kullanılacaktır.

Katkı sa ladı ınız için te ekkür ederiz.

Bölüm 1: Sosyo-Demografik Bilgi Formu

1.Cinsiyetiniz nedir?

1) Kadın   2) Erkek

2.Kaç ya ındasınız? ....

3. Nerede do dunuz?

1) Kıbrıs   2) Türkiye   3) ngiltere   4) Di er

4.E er Kıbrıs'ta do madı iseniz kaç yıldır Kıbrıs'ta ya ıyorsunuz?

....

5.Medeni durumunuz nedir?

1) Evli   2) Ni anlı-Sözlü   3) li kisi var   4) Bekar

5) Bo anmı   6)Dul   7) Di er

6. Çocu unuz var mı?

1) Yok   2) Var (Kaç tane oldu unu belirtiniz ....)

7. Daha yo unlukla nerede ya adınız?

1) Köy   2) Kasaba   3) ehir

8. Çalı ıyor musunuz?

1) Evet   2) Hayır

9. J\ılesle i:

1) çi   2) Ö renci   3) siz   4) Memur

5) Kendi i i   6) Ev kadını   7) Serbest   8) Di er

10. E itim d.uruJ.11.ıııııız nedir?

1) Qk.ur-yazar de il   2) Okur-yazar   3) lkokul

4) Ortaokul   5) Lise   6) Yüksekokul/üniversite

11. Eve giren aylık gelir ne kadardır?

1) Geliri yok   2) asgari ücret (1700 TL) ve altı   3) 1700- 3400

4) 3400-10.000   5) 10.000 ve üzeri

12. Oturdu unuz evinize nasıl sahip oldunuz?

1) Kendi olanaklarımla   2) Devlet yardımıyla   3} Kirada oturuyorum

4) Aileden miras   4) Di er

13. Oturdu unuz evin konumu nedir?

1) Türk malı   2) Rum malı tahsis   3) Rum malı e de er

14. Herhangi fiziksel bir hastali ınız var mı? (Varise lütfen belirtiniz.)

l)Var...................................   2)Yok

15. Herhangi bir psikiyatrik hastalı ınız var mı?

1) Var…………………………….   2)Yok

16. Herhangi bir psikiyatrik hastalık nedeniyle tedavi gördünüz mü?

1) Evet   2) Hayır

17. Kiminle ya ıyorsunuz?

1) Yalnız   2) E / partner/ sevgili   3) Anne/baba/ karde

4) Arkada   5) kinci dereceden akraba   6) Di er, belirtiniz (………………..)

18. Kıbrıs'ta nasıl bir çözüme varılmasını istiyorsunuz?

1) Çözüm bulunarak iki toplumlu iki bölgeli federal devlet

2) ki ayrı devletli konfederal çözüm

3) KKTC'nin devamı eklinde ayrı cumhuriyet olarak devam etnesi

4) 1960 Kıbrıs Cumhuriyeti'ne dönü

5) Türkiye'ye ba lanma

6) Di er

19. Hayatınız boyunca kaç kez alkollü bir içecek içtiniz?

1) 0   2) 1-2   3) 3-5   4) 6-9   5) 10-19   6) 20-39   7) 40-veya daha fazla

20. Hayatınız boyunca kaç kez sigara içtiniz?

1) 0   2) 1-2   3) 3-5   4) 6-9   5) 10-19   6) 20-39   7) 40-veya daha fazla

21. Hayatınız boyunca herhangi bir uyu turucu madde (uçucu madde, eroin, esrar, bonzai, amfetamin, vb.) denedj iniz oldu mu? E er denediyseniz denedi iniz maddeyi belirtin.

1) Hayır   2) Evet(.....................................)

APPEND1X4':'- BECK DEPRESYON ENVANTER

Bu form son bir (1) **hafta içerisinde** kendinizi nasıl hissetti inizi ara tırmaya yönelik 21

maddeden oluşmaktadır. Her maddenin kar ısındaki dört cevabı dikkatlice okuduktan sonra,

size en çok uyan, yani sizin durumunuzu en iyi anlatanı i aretlemeniz gerekmektedir.

1- 0. Kendimi üzüntülü ve sıkıntılı hissetmiyorum.

  1. Kendimi üzüntülü ve sıkıntılı hissediyorum.

  2. Hep üzüntülü ve sıkıntılıyım. Bundan kurtulamıyorum.

  3. O kadar üzüntülü ve sıkıntılıyım ki artık dayanamıyorum.

2- 0. Gelecek hakkında mutsuz ve karamsar de ilim.

  1. Gelecek hakkında karamsarım.

  2. Gelecekten bekledi im hiçbir ey yok.

  3. Gelece im hakkında umutsuzum ve sanki hiçbir ey düzelmeyecekmi s gibi geliyor.

3- 0. Kendimi ba arısız bir insan olarak görmüyorum.

  1. Çevremdeki birçok ki iden daha çok ba arısızlıklarını olmu gibi hissediyorum.

  2. Geçmi e baktı ımda ba arısızlıklarla dolu oldu unu görüyorum.

  3. Kendimi tümüyle ba arısız biri olarak görüyorum.

4- 0. Birçok eyden eskisi kadar zevk alıyorum.

  1. Eskiden oldu u gibi her eyden ho lanmıyorum.

  2. Artık hiçbir ey bana tam anlamıyla zevk vermiyor.

  3. Her eyden sıkılıyorum.

5- 0. Kendimi herhangi bir ekilde suçlu hissetmiyorum.

  1. Kendimi zaman zaman suçlu hissediyorum.

  2. Ço u zaman kendimi suçlu hissediyorum.

  3. Kendimi her zaman suçlu hissediyorum.

6- 0. Bana cezalandırılmışım gibi gelmiyor.

1. Cezalandırılabileceğimi hissediyorum.

2. Cezalandırılmayı bekliyorum.

3. Cezalandırıldığımı hissediyorum.

7- 0. Kendimden memnunum.

1. Kendi kendimden pek memnun değilim.

2. Kendime çok kızıyorum.

3. Kendimden nefret ediyorum.

8- 0. Başkalarından daha kötü oldu umu sanmıyorum.

1. Zayıf yanların veya hatalarım için kendi kendimi eleştiririm:

2. ~~n.i:11.i:lii:tirmiui:tn~~ dolayı ve her zaman kendimi kabahatli bulurum.

3. Her aksilik kar ısında kendimi hatalı bulurum.

9- 0. Kendimi **öldürmekgibi** dii ü.11celerim yok.

1. Zaman zaman kendimiöldürmeyidü ündü üm olur. Pakatyapnııycrum.

2. Kendimi **öldürmek-isterdim.**

3.Fırsatını bulsam kendimi öldürürdüm.

10- 0. Her zamankinden fazla içimden a lamak gelmiyor.

1. Zaman zaman içinden a lamak geliyor.

2. Ço u zaman a lıyorum.

3. Eskiden a layabilirdim imdi istesem de a layamıyorum.

11- 0. imdi her zaman oldu umdan daha sinirli de ilim.

1. Eskisine kıyasla daha kolay kızıyor ya da sinirleniyorum.

2. imdi hep sinirliyim.

3. Bir zamanlar beni sinirlendiren eyler imdi hiç sinirlendirmiyor.

12- 0. Ba kaları ile görü mek, konu mak iste imi kaybetmedim.

1. Ba kaları ile eskiden daha az konu mak, görü mek istiyorum.

2. Ba kaları ile konu ma ve görü me iste imi kaybettim.

3. Hiç kimseyle konu mak görü mek istemiyorum.

13- 0. Eskiden oldu u gibi kolay karar verebiliyorum.

1. Eskiden oldu u kadar kolay karar veremiyorum.

2. Karar verirken eskisine kıyasla çok güçlük çekiyorum.

3. Artık hiç karar veremiyorum.

14- 0. Aynada kendime baktı ımda de i iklik görmüyorum.

1. Daha ya lanmı ve çirkinle mi im gibi geliyor.

2. Görünü ümün çok de i ti ini ve çirkinle ti imi hissediyorum.

3. Kendimi çok çirkin buluyorum.

15- 0. Eskisi kadar iyi çalı abiliyorum.

1. Bir eyler yapabilmek için gayret göstermem gerekiyor.

2. Herhangi bir eyi yapabilmek için kendimi çok zorlamam gerekiyor.

3. Hiçbir ey yapamıyorum.

16- 0. Her zamanki gibi iyi uyuyabiliyorum.

1. Eskiden oldu u gibi iyi uyuyamıyorum.

2. Her zamankinden 1-2 saat daha erken uyanıyorum ve tekrar uyuyamıyorum.

3. Her zamankinden çok daha erken uyanıyor ve tekrar uyuyamıyorum.

17- 0. Her zamankinden daha çabuk yorulmuyorum.

1. Her zamankinden daha çabuk yoruluyorum.

2. Yaptı ım her ey beni yoruyor.

3. Kendimi hemen hiçbir ey yapamayacak kadar yorgun hissediyorum.

18- 0. tahım her zamanki gibi.

I. tahım her zamanki kadar iyi de il.

2. İştahım çok azaldı.

3. Artık hiç iştahım yok.

19- 0. Son zamanlarda kilo vermedim.

1. İki kilodan fazla kilo verdim.

2. Dört kilodan fazla kilo verdim.

3. Altı kilodan fazla kilo vermeye çalışıyorum.

20- 0. Sağlığım beni fazla endişelendirmiyor.

1. Ağrı, sancı, mide bozuklu u veya kabızlık gibi rahatsızlık:lar beni endi elendiriyor.

2. Sağlığım beni endi elendirdi i için ba ka eyleri dü üllIl1ek zorla ıyor;

3. S°ğ'ı ğ;ırı hakkında o kadar endi eliyim ki ba ka hiçbir ey dii iinemiyorum.

21- 0. Son zamanlarda cinsel konulara olan ilgimde bir de i ınf![ark etmedim.

1. Cinsel konularla eskisinden daha az ilgiliyim.

2. Cinsel konularla imdiçokdaha.._ az ilgiliyim.

3. Cinsel konular. olanilgimitamamen kaybettim.

APPENDIX 5 - CURRICULUM VIATE

1. Name, Surname   : Özlem Gökçe

Contact Information

Address

                        : Çankaya / Ankara

GSM   : 05352639391

E-mail   : ozlm-gkce@hotmail.corr

2. Date of birth   : 18/06/1989

3. Title   : MSc

4. Education Status .. : :tvı:astçrdegree

Degree	l)epı:ırtment	University	Years
University	Psycho logy	Eastern Mediterranean University	2008-2014
Postgraduate	Clinical Psychology	Near East University	2014-2016

Yüksek Lisans Tezi:

Gökçe Ö. (2016). Kuzey Kıbrıs Türk Cumhuriyeti'nde Majör/Depresyonun Yaygınlı ı Ve

Risk Faktörleri, Yüksek Lisans Tezi. Yakın Do u Ünivel'.sitesi. Sosyal Bilimler Enstitüsü

Lefko a, Kıbrıs.

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Toplantı Tarihi : 03.05.2016

Toplantı No :2016--13

ProjeNo. : 13

Yakm Do u Üniversitesi Sosyal Bilimler Fakültesi. Psikolojj\]3:ölürriüö retim üyelerinden Prof. Dr. Mehmet Çakıcı'nın sorumlu ara tırmacısı oldu_u, Y[)IJ,f.2016:-13 proje.numaralı ve *"Kuzey Kıbrıs İ'ürk Cumhuriyetinde Jt/.ajör Depr~syonun ·faJgıtı ı ve Risk Faktörleri"* ba ·fıldıproje önerisi kurulumuzca de erlendirilmi olup, ~til{ql~aj<:)ıygurbulunmu tur.

1- Prof. Dr. Nlehınet Çakıcı   (BAŞKAN)

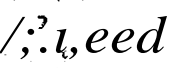2.; Prof. Dr. Mahmut Sava   (ÜYE)

3- T)oç. Dr. Nesil F. Baytın   (ÜYE)

.4- Doç.])r.bjrenç Kanol   (ÜYE)

5- .Yrd.Doç. Özgür Özerdem   (ÜYE)

Katılmadı