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Death anxiety in old individuals and factors affecting depression level related with death

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Abstract

This descriptive, cross-sectional study was designed with the objective to determine the factors affecting the death anxiety and death-related depression in elderly people. This study was carried out with the participation of 185 elderly persons, who applied to a family health center between 5th October and 22nd December 2016, were able to communicate with us and volunteered for the participation. The data for the study was obtained with a questionnaire, which constituted of 21 questions, and with the Death Anxiety and Death-related Depression Scales. Death Anxiety Scale was developed by Templer and adapted by Şenol to the Turkish language. The scale consists of 15 items. Score range of this scale changes between 0 – 15. Higher scores are interpreted as higher death anxiety and a score of 7 or greater is considered as having anxiety. Death Depression Scale was developed by Templer and his colleagues and adapted by Yaparel to the Turkish language. This scale consists of 17 items. The lowest and highest scores in this scale are 0 and 17. It has been interpreted as the following: the higher the score the higher is the death-related depression level. For the evaluation of the data, percentage calculation, one-way ANOVA, T-test and Tukey test were used. 48.9% of the participants were female and 51.1% male; 37.2% were illiterate, 39.4% were housewives, 36.1% were married, 53.9% had a balanced budget, 70.6% had social security insurance, , 73.3% had a chronic disease, 76.1% used regularly medication. Their mean age was 74.4±8.2 years. The mean scores of death anxiety and the death depression scales were 7.3±1.7 and 8.1±1.6 respectively. It was observed that the total score of the death anxiety and death depression scales changed in some elder persons according to the sociodemographic and clinical properties.

Keywords: Death, anxiety, elderliness, depression, fear

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1. Introduction

With aging, certain biological, psychological, physiological impairments emerge, functions show observable deteriorations and difficulties related to daily life activities develop. These physiological and physical changes restrict the daily life activities of the older persons and affect their quality of life negatively (Tajvar et al., 2008). Quality of life is described by WHO as an individual's perception of his/her position in life in the context of culture and value systems in which they live in relation to their goals, expectations, standards and concerns. (The World Health Organization, Quality of Life Group, 1995). Aging is affected by the individual's genetic properties, social environment, psychological condition and lifestyle. Although the aging process differs from individual to individual, cognitive disorders, mobility and balance problems, urinary-fecal incontinence, problems related to chronic diseases and injuries and fractures due to falling are rather common in the elderly population (Discigil, 2009).

Death, which is an unavoidable term and shared by every living being, is the last stage of the individual in respect of psychological and physiological functions. Investigators are almost in consensus that the fear of death is found in every individual (Kızılkaya and Kostu, 2006). Death, as an inseparable part of life, is always at the center of human being's attention. Death anxiety is present from birth to death through whole life and underlies all other fears (Karakus, Ozturk and Tamam, 2012). Death anxiety makes itself apparent in every human being and considered as the base of all the fear we experience. Although death anxiety is considered as a multi-dimensional concept, these dimensions may change according to age, gender, religious beliefs, culture, educational level, marital status, profession, a recent loss of a relative and to the thoughts about death (Softa, Ucukoglu, Karaahmetoglu ve Esen, 2011).

In this phase, as old age is the last part of the developmental stages, every individual faces the limits of the life and the inevitableness of the annihilation. The old age is a period of life, when individuals feel themselves closer to death. Regarding the health care professionals, especially for nurses, it is extremely important that they evaluate the death-related thoughts and concerns of elderly people and determine the appropriate and tailor-made approach (Softa, Ucukoglu, Karaahmetoglu ve Esen, 2011). In this respect, there is a need for studies in order to determine the factors affecting the death anxiety and death-related depression levels in the older community and to demonstrate the differences among countries, regions and cultures depending on the obtained data and information. It is believed that the results obtained from this survey will be useful for the development of appropriate strategies considering the prevention of the death anxiety and death-related depression within the framework of the national and regional action plans.

1.1. Study Objective

The objective of this descriptive and cross-sectional study is to determine the factors affecting the death anxiety and death related depression levels in elderly people, who visited the family health center in Samsun, a city located in the northern part of Turkey. In this study, answers to the following questions were investigated:

- What is the levels of death-related anxiety and depression in older people?
- Which sociodemographic and clinical features are affecting the death-related anxiety and depression in the elderly?

2. Materials and Methods

2.1. The period and location of the study

The study protocol was planned in a descriptive and cross-sectional design and was conducted in a family health center in Samsun, a city in the northern part of Turkey between 5 October and 22 December 2016.

2.2. The population and the sampling of the study

180 older individuals, with whom the study was carried out, were chosen with an improbable sampling method from the persons, who visited the family health center, where the study was planned. Individuals, ages 65 years or above, had no psychological or mental problems, were able capable of verbal communication and willing to participate in the survey were enrolled into the study The dependent variable of the study is the level of death-related anxiety and depression in elderly individuals. The independent variable of the study is the sociodemographic and clinical features of the elderly individuals.

2.3. Data collection tools

The data were obtained with a survey form informatory about the older persons, death anxiety and death depression scales. The survey form included 21 informative questions about the sociodemographic characteristics of the participants (age, gender, education, profession, marital status, socioeconomic level, family type, number of children, social security, living environment), clinical features (perception about own health, presence of a chronic disease, if present type(s) of chronic diseases, ability to perform daily activities, factors limiting the execution of daily activities, need for walking aids, if needed type(s) of walking aids, presence of regular and daily used medications, if used the names of the medications).

2.3.1. Death Anxiety Scale

Death Anxiety Scale was developed by Templer (1970) and adapted by Senol to the Turkish language (1989). The scale consists of 15 items, and arranged as a binary likert scale in a true-false form. Correct answers receive 1 point, wrong answers are not scored. The score range is between 0 and 15 and scores equal to 7 or greater were considered as the presence of anxiety.

2.3.2. Depression Scale on Death

Death Depression Scale was developed by Templer and colleagues and adapted by Yaparel (1998) to the Turkish language. This scale consists of 17 items and its objective is to measure the mood features such as depression, despair, loneliness, dread and sadness. These items (15 true, 2 false), can be answered as "true" or "false". The score range of these scales is 0 and 17 respectively. It has been interpreted as the following: the higher the score in this scale the higher is the death-related depression level.

2.4. Data collection

Questionnaire and scales were first tested with 8 people in order to determine the questions, which are not understood or missing. Following their correction, the draft was finalized. This study conforms to the ethical standards of the Helsinki Declaration. The data was collected with a face-to-face interview method by the investigators after getting the informed consent from each participant. The participants were first informed about the study and thereafter the questionnaire and scales were conducted. The patients were informed, that their participation based totally on their personal decision, names will be not registered and obtained data will be used only for research purposes. The interview was completed in approximately 8-10 minutes with each participant.

2.5. Data evaluation

The statistical analysis of the collected data was done with the package software SPSS v15.0. The normality test of the quantitative data was performed with Shapiro Wilk method. For the evaluation of the data with normal distribution, one-way ANOVA, T-test and Tukey test were used. The results were presented as percentages, mean and standard deviations values. Statistical significance level was accepted as $p<0.05$.

3. Results

180 elderly persons participated in this study. 48.9% of the participants were females and 51.1% males; 37.2% were illiterate, 39.4% were housewives, 36.1% were married, 53.9% had a balanced budget, 70.6% had social security insurance, 73.3% had a chronic disease, 76.1% used regularly medication. Their mean age was 74.4±8.2 years.

We determined that 49.4% of the patients described their health status very well; 73.3% had a chronic disease, the most common diagnoses were coronary artery disease, hypertension, diabetes and respiratory diseases; 76.1% regularly used medication every day; 20% had limited functions regarding the daily activities; 72.2% could not walk; 8.3% had visual impairment; 26.7% used walking aids (walking stick, wheelchair and walker respectively); 12.2% was totally and 12.2% was partially dependent on other people regarding their daily life activities (Table 2).

The mean scores of death anxiety and the death depression scales were 7.3±1.7 and 8.1±1.6 respectively. We observed that the total score of the death anxiety and death depression scale changed according to the sociodemographic and clinical characteristics of the participants. The total score of death anxiety and death depression scales was higher in participants, who had a balanced budget ($F = 4.742$, $p = 0.010$), were living in rural areas ($F = 3.524$, $p = 0.032$) and had an impaired health perception ($F = p = 0$, $p = 6.177$) (Table 3).

4. Discussion

In this study, which was conducted to determine the death-related anxiety and depression levels in elderly persons, we found out that the vast majority of them had moderate anxiety and depressive feelings about death.

Approximately half of the elderly defined their health condition as good, 73.3% had a chronic disease, they were diagnosed with coronary artery disease, hypertension, diabetes and respiratory system diseases respectively and used drugs regularly every day, a quintile of them had limited functions regarding the daily life activities, needed walking aids, used walking stick, wheelchair and walker respectively and that they were totally or partially dependent on others for their daily life activities.

Top, Sarac and Yasar (2010) observed similar results in their study and reported that the elderly people had a moderate perception of their health status; their health status affected their physical activity, half of them had a chronic disease, almost all of them used regularly medication every day and were moderately dependent on other people. In the study conducted by Kasar, Karaman, Sahin, Yıldırım and Aykar (2016) to determine the relationship between older persons' anxiety of death and quality of life, they reported that more than half of them (60.7%) had at least one chronic illness. It is believed that the presence of a chronic disease and partial dependence on others might have an adverse effect on their psychological conditions and predispose them to the death-related anxiety and depression.

The mean scores of death anxiety and the death depression scales were 7.3±1.7 and 8.1±1.6 respectively. In another study, which revealed similar results, the mean scores of the Death Anxiety and Death Depression Scales in the elderly persons were 7.7 ± 3.8 and 9.4 ± 3.9 respectively (Ozturk, 2010). Death Anxiety Scale's average score was 7.73 ± 2.63 in the study of Kasar, Karaman, Sahin, Yıldırım, Aykar (2016); the same score was 7.85 ± 4.45 in the study of Orak, Ugur, Baskoy, Ozcan and Seyis (2015). The average score of death anxiety and death depression scales in elderly differs from study to study, which presumably depends on the sociodemographic and clinical characteristics of the elderly people.

In our study, we observed also that the total score of death anxiety and death depression scales changes depending on the sociodemographic and clinical characteristics of the patients. For example, we determined that the total score of death anxiety and death depression scales was higher in elderly

people, who had a balanced budget, lived in rural areas, had an impaired perception of the health status.

In concordance with our study, it was shown that the death anxiety was not affected by age, gender and presence of a chronic disease [Kasar, Karaman, Sahin, Yıldırım and Aykar (2016)]; by age, gender, marital status and presence of a physical disease [Softa, Ucukoglu, Karaahmetoglu and Esen (2011)]; by gender and age [Arpacı, Avdas, Dogruoz and Sarıdogan (2011)]; by gender, age, number of children, presence of a chronic disease and drug use [Top, Sarac and Yasar (2010)]. On the other hand, Daglı (2010) reported that age, gender and education level affected the death anxiety; elderly females had higher death anxiety than the elderly males; the death anxiety decreased with aging and higher education level and marital status did not affect the death anxiety.

Senol investigated the anxiety and fear levels related to death in elderly people (1989) and reported that the death-related anxiety and fear levels were moderate in elderly people and the death anxiety changed according to the age groups and the highest levels were encountered in ages between 60-64 years. Similarly, Koc conducted a study (2004) on individuals with an age over 60 years and determined that there was a significant correlation between the gender, age, socioeconomic and educational level and religious beliefs and the belief in a life after death. In another study, conducted by Orak, Ugur, Baskoy, Ozcan and Seyis (2015), it was determined that elderly people, who were married, lived in rural areas, received daily care support, had a life-threatening disease in the medical history and had a sudden death in the family, had high levels of death anxiety, but age and gender did not affect the death anxiety levels ($p>0.05$).

In another study conducted by Ozturk (2010) it was determined that although death anxiety was related to education duration, number of children and frequency of death thoughts, the presence of a physical disease did not affect death anxiety. He also reported that the death anxiety levels of people, who had a high school or higher education, was lower than the people, who had a primary school or lower education. Another finding of his study was that the death anxiety levels were higher in nonworkers compared to the workers. He suggested also that death anxiety levels were not affected by gender, age, marital status and physical and psychological disorders. In the same study, death depression scale score was not affected by gender, age, marital status, presence of a previous job, physical or psychiatric disorder; but was affected by education level and death thoughts. The level of death-related depression was higher in people with a high school or higher education compared to the people with a primary school or lower education. The frequency of thoughts about death had also a positive relationship with the death depression scale score. According to the studies investigating the death anxiety and death-related depression levels in elderly people, although the affecting factors presented diversity, it was suggested that these conditions might be influenced by the individual and health characteristics, the presence of the social support systems, cultural characteristics and by the value given to the disease and life.

The meaning of the death concepts is different among adults compared to the children and adolescents. Concepts like culture, belief systems and lifestyle, which are important in the adulthood, have an impact on the attitude to death and on the feelings about life and death. In this respect, it was supposed that directing the elderly people to activities, which let them enjoy the life, increasing their communication with their relatives and friends, arranging social programs, which will connect them to the life could be helpful to decrease the death-related anxieties and to motivate them to live an active old age (Arpacı, Avdas, Dogruoz and Sarıdogan, 2011).

5. Conclusion

In this study, we observed that the vast majority of the elderly people had a moderate death-related anxiety and depressive mood. In the light of the obtained findings, we recommend that the elderly people should be encouraged to express their feelings like death-related fear, anxiety, depression, despair, loneliness, dread and sadness, if necessary psychological support along with guidance and counseling service should be provided. In addition, we recommend that both qualitative

and quantitative research methods should be used together in future studies and advantages of the focus group interview method should be implemented.

Limitations of the Study

- The most important limitation of this study is the lack of long-term observations to evaluate the accuracy of the expressions in the answers given during the face-to-face interviews with the sampling group.

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Table 1. The distribution of the socio-demographic characteristics of the elderly (N = 180)

CHARACTERISTICS		n	%
The average age	7 4.4--± 8.2 years		
	60-69 years	54	30.0
Age Groups	70-79 years	74	41.1
	80-89 years	44	24.4
	90-98 years	8	4.5
Gender	Female	88	48.9
	Male	92	51.1
Education Level	Illiterate	67	37.2
	Literate	46	25.6
	Primary school	43	23.9
	Middle School	11	6.1
	University	13	7.2
Marital status	Married	65	36.1
	Single	17	9.4
	Widowed/divorced	98	54.5
Family structure	Extended family	66	36.7
	Elementary family	114	63.3
Residence	Province	68	37.8
	County	51	28.3
	Village	61	33.9
Socioeconomic status	Income is less than expense	57	31.7
	Income is equal to expense	97	53.9
	Income is higher than expense	26	14.4
Social security	Available	127	70.6
	Not available	53	29.4
The average number of children	3.83.0		

Table 2. The distribution of the clinical characteristics of the elderly (N = 180)

CHARACTERISTICS		n	%
How health status is defined	Good	89	49.4
	Moderate	75	41.7
	Bad	16	8.9
Presence of a chronic disease	Yes	132	73.3
	No	48	26.7
*** If "Yes", which chronic diseases (n = 132)**	Diseases of the cardiovascular system	74	41.1
	Diabetes Mellitus	43	23.9
	Diseases of the musculoskeletal system	20	11.1
	Diseases of the nervous system	31	17.2
	Diseases of the respiratory system	26	14.4
	Diseases of the gastrointestinal system	7	3.9
	Depression	13	7.2
	Glaucoma	2	1.1
	Kidney diseases	8	4.4
	Dermal Diseases	4	2.2
Regular and daily drug usage	Yes	137	76.1
	No	43	23.9
*** If "Yes", which systems drugs are for (n = 137)**	Cardiovascular system drugs	73	40.6
	Musculoskeletal system drugs	17	9.4
	Central nervous system drugs	26	14.4
	Antidiabetics	38	21.1
	Anticoagulants	17	9.4
	Respiratory system drugs	27	15.0
	Analgesics	13	7.2
	Gastrointestinal system drugs	8	4.4
	Antidepressants	12	6.7
	Glaucoma drugs	3	1.7
Presence of limited functionality regarding the daily life activities	Yes	36	20.0
	No	144	80.0
*** If "Yes", which limited functions (n = 36)**	He/she cannot walk	26	72.2
	He/she cannot see	3	8.3
	Other	7	19.4
The ability to execute the daily life activities without assistance.	Independent	136	75.6
	He/she depends on others	22	12.2
	Partially dependent on others	22	12.2
Need for walking tools	Yes	48	26.7
	No	132	73.3
If "Yes",which tools (n = 48)	Walking stick	26	54.2
	Walker	6	12.5
	Wheelchair	13	27.1
	Other	3	6.2

* More than one answer.

Table 3. Distribution of the death-related anxiety and depression scale scores (N = 180)

Distribution of the death anxiety scores	n	%
0-4 points mild	2	1.1
5-9 points moderate	153	85.0
10-14 points severe	23	12.8.
15 and greater points: panic level	2	1.1
Mean of the scale's total score	7.3 ± 1.7	
Cronbach's alpha confidence coefficient	0.68	
Distribution Of Death Depression Scale Scores		
0-7 points not depressed	79	43.9
8-17 points, presence of depressive feelings	101	56.1
Mean of the scale's total score	8.1 ± 1.6	
Cronbach's alpha confidence coefficient	0.72	

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