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ORIGINAL ARTICLE

ASSESSMENT OF THE RELATIONSHIP BETWEEN HOPELESSNESS LEVEL AND DEATH ANXIETY IN GERIATRIC INDIVIDUALS

ABSTRACT

Introduction: This study aimed to examine the relationship between hopelessness and death anxiety among geriatric individuals.

Materials and Method: A cross-sectional study was conducted with individuals aged 65 years and older (N = 220) registered at a community health center in Turkey. Participants completed the Descriptive Characteristics Form and as well as the Death Anxiety Scale and the Beck Hopelessness Scale.

Results: The mean scores for death anxiety and hopelessness were 53.32 ± 13.29 and 9.42 ± 3.86 , respectively. The study revealed that the subdimensions of the Death Anxiety Scale were predominantly positively and weakly correlated with hopelessness and hope components, while motivation loss showed varying levels of negative correlation ($p < 0.05$).

Conclusion: The findings indicate that geriatric individuals experience above-moderate levels of death anxiety and report moderate levels of hopelessness. Furthermore, it was observed that as feelings of hopelessness increased, death anxiety intensified accordingly.

Keywords: Aged; Anxiety; Death; Mental Health.

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INTRODUCTION

Aging is a period in which individuals encounter biological, psychological, and social changes, while simultaneously experiencing an increased awareness of the finitude of life. With the rise in average life expectancy, the number of geriatric individuals has grown, thereby underscoring the importance of mental health issues within this population (1). During this stage, chronic illnesses, changes in social roles, loneliness, increased levels of dependency, and various losses may adversely affect psychological well-being. In particular, hopelessness and death anxiety stand out as prevalent and impactful constructs among older adults, both of which significantly diminish quality of life (2, 3). Hopelessness is characterized by pessimistic expectations about the future and the belief that potential solutions have been exhausted, whereas death anxiety refers to the fear and apprehension arising from an individual's awareness of the inevitability of death (1, 2). In the literature, the co-occurrence of these two constructs in older adults is shown not only to impair psychological well-being but also to exert detrimental effects on physical health, social relationships, and overall quality of life. Indeed, a study conducted in Türkiye demonstrated that higher levels of depression and negative attitudes toward aging increased death anxiety among older individuals, indicating a strong association between depressive symptoms and death anxiety (4).

Similarly, a study conducted with older adults residing in nursing homes reported a significant positive correlation between depression levels and death anxiety. This finding suggests that depressive symptoms may be directly associated with both hopelessness and death anxiety (5). Furthermore, research has shown that death anxiety in older adults is linked to ego integrity, with life satisfaction playing a moderating role in this relationship (6). Beyond their psychological dimensions, hopelessness and death anxiety have also been found to relate to broader health outcomes. Another study

demonstrated that both hopelessness and death anxiety predicted depression, whereas acceptance of one's past served as a protective factor for ego integrity (7). In addition, a hospital-based study conducted in Europe reported that hopelessness is a strong predictor of short-term mortality, with individuals exhibiting symptoms of hopelessness during emergency hospital admission facing a significantly increased risk of death (8).

These findings indicate that hopelessness and death anxiety play a critical role in both the psychological well-being and physical health of geriatric individuals. Therefore, examining the relationship between these two variables is essential for identifying the psychosocial support needs of older adults, protecting their mental health, and developing appropriate interventions. However, research conducted in Türkiye remains limited, and existing studies predominantly focus on the relationship between depression and death anxiety (4, 7). Outpatient older adults differ from hospitalized older adults in terms of health status, level of functional independence, and social engagement. Hospitalized individuals often present with more severe medical conditions and greater physical limitations, which may directly influence their levels of death anxiety and hopelessness. Therefore, findings derived from inpatient populations cannot be directly generalized to community-dwelling outpatient older adults. Examining outpatient individuals enables a more accurate evaluation of death anxiety and hopelessness among older adults with relatively stable health conditions and may contribute to the development of early, community-based psychosocial interventions. Yet, investigating the direct association between hopelessness and death anxiety is crucial for understanding the psychological needs of older adults and designing suitable psychosocial interventions. Nursing—particularly psychiatric nursing—holds a pivotal role in supporting emotional well-being, facilitating the early identification of hopelessness and death

anxiety, and implementing holistic care approaches for older adults (9). Existing literature examining the relationship between hopelessness and death anxiety has predominantly focused on hospitalized patients, nursing home residents, or clinical populations, which often include individuals with more severe physical or psychiatric conditions. This limits the generalizability of findings to community-dwelling older adults receiving outpatient care. In this context, the present study, conducted among geriatric individuals attending a community healthcare center, provides an important contribution by evaluating this relationship in a community-based outpatient population. This approach enables a more accurate understanding of the psychosocial needs of older adults living in the community and offers valuable evidence for preventive mental health services, early identification, and community-based psychosocial interventions. In this context, generating scientific evidence to address the gap in the literature is of considerable importance. The primary aim of this study is to examine the direct association between hopelessness and death anxiety among older adults attending a community health center. In this context, the study goes beyond merely assessing the statistical relationship between two psychometric measures and seeks to contribute to a deeper understanding of the psychological vulnerabilities of older individuals. The findings are expected to contribute to strengthening the mental health of older adults, improving their quality of life, and informing gerontological and psychiatric nursing practices, as well as guiding clinical initiatives and mental health policies.

Research Question:

1. What are the hopelessness levels of geriatric individuals?
2. What are the death anxiety levels of geriatric individuals?
3. Is there a significant relationship between hopelessness and death anxiety?

MATERIALS AND METHOD

Design

The study used a descriptive cross-sectional fashion and looked at 220 people aged 65 and up who were registered at a Community Healthcare center in Elaziğ between November 2024 and August 2025.

Sample and Participants

In the main hypotheses of the study, it was planned to investigate the relationships between the measured variables. In this research, since the population size was known, the sample size was calculated at a 95% confidence level. The population size was determined as 500, and the prevalence rate of the targeted sample profile within the population was assumed to be 0.50. When the significance level was set at $\alpha = 0.05$, the z test statistic was 1.96. Based on these parameters, the minimum required sample size was calculated as 217. With the effort of the researcher, the study was completed with a total of 220 older adults. A computer-assisted simple random sampling method was used to determine the participants included in the research.

Inclusion Criteria

- Being open to communication and collaboration
- Volunteering to participate in the study

Exclusion Criteria

- Having a communication problem
- Having a psychiatric disease

Data Collection Tools

The Descriptive Characteristics Form, Thorson–Powell Death Anxiety Scale, Beck Hopelessness Scale were employed to collect the data.

Descriptive Characteristics Form

The form had 11 questions prepared by the researcher by scanning the literature, Age, gender, marital



status, educational status, income level, employment status, presence of chronic illness, with whom they live, perspective on the future, frequency of death-related thoughts, and level of life satisfaction.

Thorson–Powell Death Anxiety Scale

The Thorson and Powell (1992) scale is a 25-item instrument structured in a five-point Likert format. The scale consists of 17 positively worded and 8 negatively worded items, and comprises four subdimensions: uncertainty related to death, fear of suffering, the dying process, and decay and deterioration. The internal consistency coefficient of the original form was reported as 0.85 (10). The initial Turkish adaptation of the scale was conducted by Karaca (2000), who reported a test–retest reliability of 0.90. In a subsequent adaptation, Karaca and Yıldız (2001) found the internal consistency coefficient to be 0.84. In the present study, the Turkish version adapted by Karaca and Yıldız (2001) was used, and the items were scored on a five-point Likert scale ranging from “0 = Strongly Disagree” to “4 = Strongly Agree” (11). The reliability analysis conducted in this study yielded an internal consistency coefficient of 0.85.

Beck Hopelessness Scale

The Beck Hopelessness Scale was developed by Beck and colleagues in 1974 and consists of 20 items answered in a true–false format. (12). The scale includes 11 true statements and 9 false statements, and responses consistent with the scoring key are assigned 1 point, while inconsistent responses are scored as 0. The total score ranges from 0 to 20, with higher scores indicating greater levels of hopelessness. The scale comprises three subdimensions: feelings about the future, loss of motivation, and future expectations. The Turkish adaptation of the scale was conducted by Seber et al.1993, who reported a test–retest reliability coefficient of 0.72 and an internal consistency

coefficient of 0.86. (13) In the present study, the Turkish version adapted by Seber et al. was used, and the internal consistency coefficient obtained was 0.82.

Data Collection

Researcher collected data in a Community Healthcare Center in Elazığ using the face-to-face interview method in a room. The researcher read data collection tools to participants and filled in according to the answers received, which took 20–25 min.

Data Analysis

The data were analyzed using the SPSS 25 statistical software package. The internal consistency of the scales was assessed using Cronbach’s alpha coefficients. Normality was examined through skewness–kurtosis values within the +3/–3 range. The data were presented using percentages, frequencies, mean scores, and standard deviations. For normally distributed measurements, the Independent Samples t-Test was used to compare the mean scores of two independent groups, while the One-Way ANOVA test was used to compare the mean scores of three or more independent groups. For non-normally distributed measurements, the Mann–Whitney U Test was used for comparisons between two independent groups, and the Kruskal–Wallis Test was used for comparisons involving three or more independent groups. To determine relational inferences, Pearson correlation analysis was used for normally distributed data, whereas Spearman correlation analysis was applied to non-normally distributed data. Effect sizes were reported using partial eta squared and Cohen’s d values.

Ethical Aspects of the Study

Health Sciences Non-Interventional Clinical Research Ethics Committee of Inonu University approved the study (15-10-2024, 2024/6499).

RESULTS

The study found that 59.1% of the older adults were between 65 and 69 years of age, 69.5% were male, 74.1% were married, and 61.8% had completed primary education. Moreover, 69.1% reported a moderate level of income, 51.8% were employed, 82.7% had at least one chronic disease, and 52.8% were living with their spouse. In addition, 59.1% stated that they had a hopeful outlook toward

the future, 46.4% reported thinking about death occasionally, and 42.7% indicated low levels of life satisfaction (Table 1).

It was determined that the mean scores of older adults were 12.65 ± 4.15 for the "Deprivation and Helplessness" subscale, 19.63 ± 7.73 for the "Uncertainty of the Afterlife" subscale, 8.39 ± 2.78 for the "Decay and Deterioration" subscale, and 12.65 ± 4.85 for the "Death Process and Suffering"

Table 1. Distribution of Older Adults According to Sociodemographic Characteristics (n= 220)

Characteristics	Variables	N	%
Age	65-69	130	59.1
	70 and above	90	40.9
Gender	Male	153	69.5
	Female	67	30.5
Marital status	Married	163	74.1
	Single	57	25.9
Educational status	Primary education	136	61.8
	Secondary education	62	28.2
	Bachelor's degree and above	22	10.0
Income level	Poor	43	19.5
	Average	152	69.1
	Good	25	11.4
Employment status	Employed	114	51.8
	Unemployed	106	48.2
Chronic illness status	Present	182	82.7
	Absent	38	17.3
Living arrangements	Alone	72	32.7
	With spouse	128	58.2
	With spouse and children	20	9.1
Outlook on the future	Hopeful	130	59.1
	Hopeless	90	40.9
Frequency of thoughts of death	Frequently	73	33.2
	Occasionally	102	46.4
	Never	45	20.5
Level of satisfaction with life	None	26	11.8
	Low	94	42.7
	Moderate	87	39.5
	High	13	5.9



Table 2. Mean Scores and Minimum–Maximum Values of the Scale and Its Subscales

Scale and Subscales Names	$\bar{x} \pm SD$	Min-Max
Deprivation and Helplessness	12.65±4.15	2-25
Uncertainty of the Afterlife	19.63±7.73	4-58
Decay and Deterioration	8.39±2.78	0-15
Death Process and Suffering	12.65±4.85	6-49
Thorson–Powell Death Anxiety Scale	53.32±13.29	29-130
Feelings and Expectations About the Future	2.27±1.95	0-22
Loss of Motivation	4.12±2.06	0-8
Hope	3.04±2.10	0-9
Beck Hopelessness Scale	9.42±3.86	1-28

subscale. The mean total score of the Thorson–Powell Death Anxiety Scale among older adults was found to be 53.32 ± 13.29 .

It was further identified that the mean score for the “Feelings and Expectations About the Future” subscale was 2.27 ± 1.95 , the mean score for the “Loss of Motivation” subscale was 4.12 ± 2.06 , and the mean score for the “Hope” subscale was 3.04 ± 2.10 . The mean total score of the Beck Hopelessness Scale among older adults was determined to be 9.42 ± 3.86 (Table 2).

It was observed that older adults aged 60–65 had higher mean scores on the Thorson–Powell Death Anxiety Scale compared to those aged 70 and above ($p < 0.05$). Individuals with a pessimistic outlook toward the future had higher mean Thorson–Powell Death Anxiety Scale scores than those with an optimistic outlook ($p < 0.05$).

No statistically significant differences were found between the mean Thorson–Powell Death Anxiety Scale scores and variables such as gender, marital status, educational level, income level, employment status, presence of chronic illness, cohabitation status, frequency of death-related thoughts, and level of life satisfaction ($p > 0.05$) (Table 3).

It was observed that single individuals had higher mean Beck Hopelessness Scale scores compared to married individuals ($p < 0.05$). Those who reported

having death-related thoughts occasionally had lower mean Beck Hopelessness Scale scores than those who reported having no such thoughts ($p < 0.05$) (Table 3).

No statistically significant differences were found between the mean Beck Hopelessness Scale scores and variables such as age, gender, educational level, income level, employment status, presence of chronic illness, cohabitation status, future outlook, and level of life satisfaction ($p > 0.05$) (Table 3).

It was determined that the ‘Deprivation and Helplessness’ subdimension of the Death Anxiety Scale showed a positive and weak correlation with the ‘Feelings and Expectations About the Future’ and ‘Hope’ subdimensions, as well as with the total score of the Beck Hopelessness Scale ($p < 0.05$). The ‘Uncertainty After Death’ subdimension was found to have a negative and moderate correlation with the ‘Loss of Motivation’ subdimension ($p < 0.05$). Additionally, the ‘Uncertainty After Death’ subdimension demonstrated a positive and weak correlation with the ‘Hope’ subdimension ($p < 0.05$). The ‘Decay and Deterioration’ subdimension was observed to be positively and weakly correlated with the ‘Loss of Motivation’ subdimension ($p < 0.05$) (Table 4) (Figure 1).

It was determined that the ‘Death Process and Suffering’ subdimension showed a positive

Table 3. Comparison of Scale Scores According to Sociodemographic Characteristics of the Elderly (n=220)

Characteristics	Variables	Thorson–Powell Death Anxiety Scale		Beck Hopelessness Scale	
		$\bar{x}\pm SD$		$\bar{x}\pm SD$	
Age	65-60	54.68±12.38	U=4659.50 p=0.010	9.42±3.70	t=-0.022
	70 and above	51.34±14.34		9.43±4.10	p=0.983 d=0.003
Gender	Male	53.27±13.16	U=5100.00 p=0.953	9.49±3.76	t=0.423
	Female	53.43±13.67		9.25±4.10	p=0.673 d=0.062
Marital status	Married	53.64±13.71	U=4543.50 p=0.805	9.08±3.92	t=-2.217 p=0.028 d=0.341
	Single	52.40±12.07		10.39±3.54	
Educational status	Primary education	54.09±12.97	KW=1.460 p=0.482	9.02±3.52	F=1.926
	Secondary education	51.94±11.74		10.08±4.60	p=0.148
	Bachelor's degree level and above	52.45±18.67		10.05±3.39	$\eta^2=0.018$
Income level	Poor	53.40±13.81	KW=3.513 p=0.173	9.16±3.73	F=0.340
	Average	53.98±13.33		9.40±3.89	p=0.712
	Good	49.16±11.76		9.96±3.96	$\eta^2=0.003$
Employment status	Employed	53.21±13.68	U=6001.50 p=0.932	9.47±3.63	t=0.214
	Unemployed	53.43±12.92		9.36±4.10	p=0.831 d=0.029
Chronic illness status	Present	53.00±12.47	U=3441.00 p=0.962	9.36±3.99	t=-0.463
	Absent	54.84±16.79		9.68±3.18	p=0.644 d=0.083
Living arrangements	Alone	51.83±11.28	KW=4.011 p=0.135	9.38±4.13	F=0.052
	With spouse	54.68±14.35		9.48±3.78	p=0.949
	With spouse and children	49.95±12.25		9.20±3.50	$\eta^2=0.001$
Outlook on the future	Hopeful	51.55±11.38	U=4929.00 p=0.047	9.43±3.66	t=0.029
	Hopeless	55.88±15.35		9.41±4.14	p=0.977 d=0.004
Frequency of thoughts of death	Frequently	53.68±12.36	KW=0.069 p=0.792	9.60±3.68	F=4.150 p=0.017 $\eta^2=0.037$ 2-3
	Occasionally	53.77±14.99		8.73±3.52	
	Never	51.69±10.46		10.67±4.54	
Level of satisfaction with life	None	56.92±18.74	KW=4.235 p=0.235	10.69±3.58	F=1.214
	Low	54.60±12.66		9.29±4.08	p=0.306
	Moderate	51.06±11.87		9.12±3.65	$\eta^2=0.017$
	High	52.00±12.63		9.85±3.93	



and weak correlation with the 'Feelings and Expectations About the Future' and 'Hope' subdimensions, as well as with the total score of the Beck Hopelessness Scale ($p < 0.05$). The 'Death Process and Suffering' subdimension was also found to have a negative and weak correlation with the 'Loss of Motivation' subdimension ($p < 0.05$). The

Thorson–Powell Death Anxiety Scale demonstrated a positive and weak correlation with the 'Feelings and Expectations About the Future' and 'Hope' subdimensions ($p < 0.05$). Additionally, the Thorson–Powell Death Anxiety Scale showed a negative and weak correlation with the 'Loss of Motivation' subdimension ($p < 0.05$) (Table 4) (Figure 1).

Table 4. Mean Scale Scores of Older Adults and Correlation Analysis Results Regarding Mean Scores (N = 220)

		Feelings and Expectations About the Future	Loss of Motivation	Hope	Beck Hopelessness Scale
Deprivation and Helplessness	r	0.197^y	-0.001 ^x	0.294^x	0.233^x
	p	0.003	0.988	0.001	0.001
Uncertainty of the Afterlife	r	0.048 ^y	-0.378^x	0.227^x	-0.091 ^x
	p	0.483	0.001	0.001	0.181
Decay and Deterioration	r	-0.051 ^y	0.236^x	-0.116 ^x	0.058 ^x
	p	0.447	0.001	0.085	0.393
Death Process and Suffering	r	0.211^y	-0.182^y	0.287^y	0.162^y
	p	0.002	0.007	0.001	0.016
Thorson Powell Death Anxiety Scale	r	0.155^y	-0.257^y	0.288^y	0.095 ^y
	p	0.022	0.001	0.001	0.161

x= Pearson correlation analysis, y=Spearman rho correlation analysis

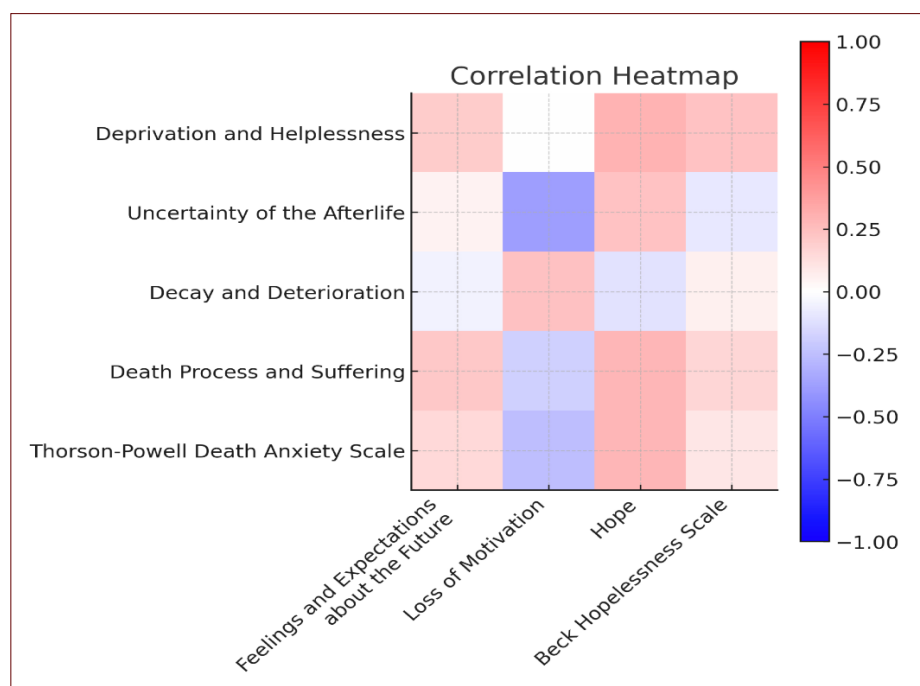


Figure 1. Corelation Heatmap

DISCUSSION

In this study, the mean total score of older adults on the Thorson–Powell Death Anxiety Scale was found to be 53.32 ± 13.29 , indicating that death anxiety is above a moderate level. The decline in physical capacity specific to old age, the increase in chronic illnesses, and changes in social roles are identified in the current literature as key determinants of death anxiety (14). Recent studies have demonstrated that loneliness, negative attitudes toward aging, and higher levels of depression significantly increase death anxiety among older adults (4, 5). In this context, the mean score obtained in our study being consistent with the literature supports the notion that cognitive and emotional processes related to death are distinctly active in older individuals (2, 5). The findings indicate that reducing death anxiety requires strengthening older adults' coping strategies regarding the concept of death by expanding their social support networks, as well as implementing psychosocial support programs and death-related awareness initiatives. The fact that death anxiety among older adults remains above a moderate level can be explained by the interaction of biological, psychological, and social factors inherent to the aging process. The rising prevalence of physical health problems and chronic illnesses may elevate anxiety levels by causing individuals to confront the reality of death more directly. Moreover, social isolation factors—such as changes in social roles associated with aging, a reduction in close social contacts, and increasing loneliness—can intensify fears and anxieties related to death (14). Psychologically, confronting the inevitability of death, uncertainty about the future, and the awareness that life will eventually come to an end may trigger existential concerns in older adults, thereby contributing to increased levels of death anxiety (9, 15). For these reasons, the presence of moderate or high levels of death anxiety among older adults is considered a multidimensional phenomenon that emerges not only from physiological factors but also from the influence of psychosocial processes.

In our study, the mean total score of the Beck Hopelessness Scale among older adults was found to be 9.42 ± 3.86 , which is consistent with the moderate level of hopelessness described in the literature. International research indicates that hopelessness is an important factor negatively affecting psychological health and quality of life in the older population (2, 16). In particular, hopelessness in older adults has been associated with pessimistic future expectations, loss of motivation, and depressive symptoms. Furthermore, a lack of social support and the presence of chronic illnesses may also contribute to increased levels of hopelessness (17). In this context, the findings highlight the importance of interventions targeting hopelessness in older adults and support the necessity of developing psychosocial support programs. The underlying reasons for the observation of moderate levels of hopelessness among older individuals stem from multiple biopsychosocial factors associated with the aging process. Increasing physical health problems and the prevalence of chronic diseases may reduce quality of life, leading individuals to develop pessimistic expectations about the future (18). In addition, the narrowing of social networks, the loss of family members, and increasing social isolation in later life are significant factors that contribute to heightened feelings of hopelessness. Psychologically, role loss experienced during old age and the heightened awareness of approaching the end of life may intensify feelings of helplessness and reduce motivation (19). In this context, the presence of moderate levels of hopelessness among older adults can be viewed not only as a reflection of their health status but also as an outcome of insufficient social support and challenges in psychological adaptation.

In the present study, death anxiety levels were found to be higher among older adults who had a hopeless outlook toward the future compared to those who were hopeful, which is consistent with findings in the literature. Indeed, studies



demonstrating that individuals with higher levels of depression and hopelessness also experience increased death anxiety support the systematic emergence of this relationship across different populations (4, 20). However, the findings of the present study demonstrate that hopelessness is associated with death anxiety independently of depression. This suggests that hopelessness may function as an early cognitive risk indicator even in the absence of clinically significant depressive symptoms. Hopelessness is recognized as a critical psychological construct associated with adverse clinical outcomes in older adults and has been identified as one of the strongest predictors of suicide risk, particularly among older men. In this context, the independent association between hopelessness and death anxiety observed in the present study further underscores the clinical relevance of hopelessness beyond depressive symptomatology. This finding highlights the importance of routinely assessing hopelessness in geriatric care, as it may facilitate the early identification of psychologically vulnerable individuals and support the implementation of targeted psychosocial interventions aimed at reducing death-related distress and improving psychological well-being. Therefore, evaluating hopelessness as a distinct construct may facilitate the early identification of older adults at risk and support the implementation of targeted psychosocial interventions aimed at strengthening positive future expectations, enhancing coping capacities, and reducing death-related anxiety. In this respect, the present study contributes to the literature by demonstrating that hopelessness is not merely a reflection of depressive symptoms, but rather an independent and clinically meaningful factor associated with death anxiety among community-dwelling older adults. The emergence of this result may be explained by the lack of positive future expectations among hopeless individuals, psychosocial vulnerabilities, and a weakened sense of life meaning, all of which

may contribute to heightened death anxiety. Furthermore, the higher levels of hopelessness observed among single individuals compared with married individuals may be attributed to the protective effects of marriage, such as increased social support, a sense of belonging, and emotional security, which collectively help mitigate hopelessness. Marriage enhances individuals' psychological resilience by providing a sense of meaning and future orientation in life (21). On the other hand, the finding that individuals with thoughts of death exhibited lower hopelessness scores suggests that psychological processes other than hopelessness—such as anxiety or fear—may be more prominent in this group (6). This situation may also be influenced by variables such as individuals' cognitive or emotional defense mechanisms, levels of awareness, or belief systems that shape how they confront thoughts of death (5).

In our study, the predominantly positive and weak correlations observed between the Death Anxiety Scale subdimensions and the components of hopelessness and hope, as well as the varying degrees of negative correlations with loss of motivation, are largely consistent with the general findings in the literature. Although previous research frequently reports a positive association between death anxiety and hopelessness or depression (4, 15), the inverse relationship found with loss of motivation suggests that death anxiety is not always a destructive psychological process; rather, in some individuals, it may be associated with existential awareness and an enhanced motivation to hold onto life (3). Furthermore, various studies emphasize that social support, belief systems, and individual coping mechanisms influence the direction and strength of the relationship between death anxiety and hopelessness (14, 22). In this regard, the psychological effects of death anxiety can be considered multidimensional and complex, with the dynamics among hope, motivation, and hopelessness shaped by individual differences.

The findings of our study highlight that death anxiety may serve both risk-related and potentially protective functions, underscoring the importance of examining subdimensions and individual psychosocial factors in greater detail in future research on hopelessness.

CONCLUSION

The findings of this study indicate that older adults attending a community health center experience above-moderate levels of death anxiety and moderate levels of hopelessness, and that increases in hopelessness are associated with corresponding increases in death anxiety. The predominantly positive, albeit weak, associations between the subdimensions of the Death Anxiety Scale and the components of hope and hopelessness suggest that the emotional dimension of death anxiety is closely linked to cognitive appraisal processes and future-oriented expectations. In contrast, the negative associations observed between loss of motivation and certain subdimensions of death anxiety indicate that motivational processes may play a differential role in shaping how older individuals perceive and experience death-related concerns. These findings highlight that death anxiety in later life should be understood as a multidimensional psychological construct influenced not only by emotional responses but also by cognitive and motivational factors. Furthermore, demonstrating this association in a community-based outpatient population underscores that psychological vulnerabilities such as hopelessness and death anxiety are not limited to hospitalized or clinically diagnosed individuals, but are also relevant among older adults living in the community. In this respect, the present study contributes to the literature by situating hopelessness as an important psychological factor associated with death anxiety within a community health context and by emphasizing the importance of assessing cognitive vulnerability factors in aging populations. Based on these findings, it

is recommended that hopelessness, hope, and motivational levels be systematically assessed in geriatric and psychiatric nursing practice. In addition, integrating psychoeducation, hope-enhancement interventions, life-review therapies, and social support-based approaches into care programs may help strengthen psychological resilience and reduce existential distress among older adults. Furthermore, incorporating routine screening for hopelessness and death anxiety into community-based elderly health services may facilitate the early identification of at-risk individuals and support the implementation of timely preventive psychosocial interventions. In conclusion, this study demonstrates that hopelessness is significantly associated with death anxiety among community-dwelling older adults and underscores the importance of incorporating the assessment of cognitive vulnerability factors into geriatric mental health care. These findings highlight the need for comprehensive, preventive, and community-based psychosocial approaches to support psychological well-being and improve overall quality of life in aging populations.

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