Doi: 10.4274/Npa.Y5785

Coping Strategies and Family Functionality in Youths with or Without Suicide Attempts

İntihar Girişimi Olan ve Olmayan Gençlerin Başa Çıkma Tutumları ve Aile İşlevselliği Açısından Değerlendirilmesi

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ABSTRACT

Objectives: Youths' ineffective strategies for coping with stress, which are not geared towards generating solutions, and lack of familial social support may easily lead to suicide attempts. In this study, the coping strategies employed by suicidal youths and the functionality of the family are investigated.

Method: Coping Strategies Inventory (COPE), the Family Assessment Device (FAD), the State-Trait Anxiety Inventory (STAI-1, STAI-2) and the Beck Depression Inventory (BDI) were administered to a total of 60 suicidal and non-suicidal youths at Ataturk University, Medical School.

Results: A statistically significant difference was observed between suicidal and non-suicidal youths regarding the coping strategies of positive reinterpretation and growth, mental disengagement, the use of instrumental social support, active coping, and humor ($p<0.05$). Based on the FAD, statistically significant difference between the two groups was found in problem solving, communication and general functioning ($p< 0.05$).

Conclusion: It has been found that suicidal youths use effective coping mechanisms less frequently than the healthy controls and they experience communication problems and problem-solving difficulties within the family. Understanding the factors that lead the youths to attempt suicide will help to provide prevention of adolescent suicide. *(Archives of Neuropsychiatry 2011; 48: 195-200)*

Key words: Coping strategies, family functionality, suicide, adolescent

ÖZET

Amaç: İntihar davranışı çocuk ve gencin stresle baş etme tutumlarının etkisiz ve çözüme yönelik olmaması, ailenin çocuk ve gence yeterli sosyal desteği göstererememesi nedeniyle düşünceden kolayca eyleme geçebilmektedir. Bu çalışmada intihar girişimi olan çocuk ve gençlerin kullandığı başa çıkma tutumları ve aile işlevsellikleri araştırılmıştır.

Yöntem: Atatürk Üniversitesi Tıp Fakültesi Psikiyatri Kliniğine, intihar girişimi sonrası başvuran 30 gençle, kontrol grubu olarak 30 sağlıklı genç bu çalışmaya dahil edilmiştir. Çalışmaya katılanların tümüne Başa Çıkma Tutumlarını Değerlendirme Ölçeği (BÇTDÖ), Aile Değerlendirme Ölçeği (ADÖ), Beck Depresyon Ölçeği (BDÖ), Durumluk ve Sürekli Kaygı Envanteri (DSKE-I,II) uygulanmıştır.

Bulgular: Pozitif yeniden yorumlama ve gelişme, zihinsel boş verme, yararlı sosyal destek kullanımı, aktif baş etme, şakaya vurma başa çıkma tutumları intihar girişimi olan ve olmayan gençler arasında istatistiksel olarak anlamlı düzeyde farklı bulunmuştur ($p<0.05$). Aile işlevselliği ile ilgili problem çözme, iletişim ve genel işlevler ölçek puanları iki grup arasında istatistiksel olarak anlamlı düzeyde farklı bulunmuştur ($p<0.05$).

Sonuç: İntihar girişiminde bulunan gençler özellikle problem çözümüne yönelik olan pozitif yeniden yorumlama ve gelişme, aktif baş etme, şakaya vurma başa çıkma tutumlarını daha az kullanmaktadırlar. Aile içinde iletişim ve problem çözme ile ilgili sorunlar yaşamakta ve genel aile işlevselliklerinde bozukluk bulunmaktadır. İntihar girişiminde bulunan çocuk ve gençlerin, intihara sürükleyen nedenlerin araştırılması hala sorun olan intihar davranışından çocuk ve gençleri korumaya yönelik önlemler geliştirmemize yardımcı olacaktır. *(Nöropsikiyatri Arşivi 2011; 48: 195-200)*

Anahtar kelimeler: Başa çıkma tutumları, aile işlevselliği, intihar, genç

Introduction

Suicidal ideation and suicide attempts are important psychiatric symptoms whose pathogenesis involves psychiatric disorders, genetic factors, stressful life events, problems in social adjustment, and socio-cultural factors. The concept of suicidal behavior in youths includes thoughts about causing intentional self-injury or death (suicidal ideas) and acts that cause intentional self-injury (suicide attempt) or death (suicide) (1).

Adolescence is the period between childhood and adulthood when the individual is confronted by a series of developmental hurdles and challenges. Young people with suicidal thoughts or attempts have been exposed to greater amounts of stressful life events than youths who have no suicidal behavior (1).

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Archives of Neuropsychiatry 2011; 48: 195-200
Nöropsikiyatri Arşivi 2011; 48: 195-200

Coping mechanisms can imply a range of behaviours which are akin to adaptation, mastery, defense or realistic problem solving. The young needs to cope in school, home, peer groups, the juvenile justice system, the workplace, etc. Regardless of the location, all sections of the population have matters that concern and worry them. Increasing number of young people has concerns that may be both overwhelming and disabling. In some circumstances, the problems faced by youths may lead to severe depression and suicide. Youths choose suicide because they cannot cope with the problems at a time when they are vulnerable to increasing pressures and uncertainties. However, not all worries are so overwhelming that they lead to suicide attempt. Nevertheless, how young people cope with their concerns can provide clues for suicide prevention and life style enhancement (2)

The coping strategies used to minimize or completely eliminate stress vary depending on factors such as age, gender, culture, and disorders that they may have, and they are specific to each individual (3). Coping strategies are generally categorized into two groups as problem-solving strategies and emotion-focused strategies. Problem-solving coping involves attempts to do something constructive about the stressful conditions that are harming, threatening or challenging an individual. Emotion-focused coping involves efforts to regulate emotions experienced because of the stressful event (4). Studies on coping strategies used by adolescent suicide attempters generally reveal that they may use less adaptive strategies. This group of youths tended to use the strategies to manage their emotional reactions rather than solve the problem that led to the suicidal ideation (5).

High rates of family problems, substance abuse by family members and mother's suicidal attempt have been reported among young people with a history of a suicidal attempt (1). In earlier studies performed in different environments and societies, it was found that the weakening or breaking up of family ties is among the most important factors affecting the prevalence of suicide among youths. It has also been reported that the families of youths displaying suicidal behavior are less supportive and have more conflicting and hostile attitudes (6).

The aim of the study was to evaluate the effect of coping strategies and the family functionality in youths regarding suicidal behavior and also to examine the relationship between coping strategies and general family functionality among youths with and without suicide attempt.

Method

A total of 60 youths aged 14-22 years were included in the study. 30 of the participants had attempted suicide and the other 30 had no suicide attempts. The study group consisted of all youths who were admitted to Emergency Department of Research Hospital for suicide attempts in a 6-month period. The matched control group comprised randomly selected healthy students from a public school and vocational college. The participants were interviewed by the researcher according to the DSM-IV-TR and those with no previous suicide attempt and an active or severe chronic psychiatric disorder were selected. All participants were provided with information regarding the aim and nature of the study, and informed consent was obtained from all of them.

The data regarding the socio-demographic features of the participants were collected by means of a form prepared by the researchers. All subjects were administered the Coping Strategies Inventory (COPE), the Family Assessment Device (FAD), the State-Trait Anxiety Inventory (STAI-1, STAI-2) and the Beck Depression Inventory (BDI).

Coping Strategies Inventory (COPE)

COPE is a self-rating inventory composed of 60 items answered on a 4-point Likert type scale (1=never; 2=seldom; 3=sometimes; 4=usually). The inventory consists of 15 subscales. Each sub-scale includes four items. The 15 sub-scales that represent distinct coping strategies are as follows:

1) Positive reframing; 2) Mental disengagement; 3) Focusing on and venting of emotions; 4) Use of instrumental social support; 5) Active coping; 6) Denial; 7) Religious coping; 8) Humor; 9) Behavioral disengagement; 10) Restraint; 11) Use of emotional social support; 12) Substance use; 13) Acceptance; 14) Suppression of competing activities; 15) Planning. Each of these subscales gives information about a different coping strategy. The minimum and maximum score that can be obtained from each subscale is 4 and 16, respectively. The higher the score, the more the individual is using the coping strategy (7).

Family Assessment Device (FAD)

The FAD was developed by Epstein (8). The FAD is an instrument developed to determine the areas in which the family can and cannot fulfill its functions. FAD was obtained with the clinical implementation of the McMaster Model of Family Functioning on families. The FAD consists of seven sub-scales, which are the sub-dimensions of the McMaster Model. Six of these sub-scales deal with each problem area concerning the family functioning separately, and each contains 60 questions focusing on general functioning. FAD, which can be administered to all family members over 12 years of age, consists of seven subscales: Problem Solving (PS), Communication (CO), Roles (RO), Affective Responsiveness (AR), Affective Involvement (AI), Behavioral Control (BC), and General Functioning (GF). The maximum score that can be obtained from the scale is 4. A high score indicates malfunction. That is, if any of the dimensions in the scale scores an average of 2.0 or above, it means it is not functioning in a healthy way. The instrument was adapted to the Turkish culture with validity studies by Bulut (9).

Beck Depression Inventory (BDI):

It is a 21-item self-rating, 4-point Likert type inventory developed by Beck (10). When the test is scored, a value of 0 to 3 is assigned for each answer and, the total score that can be received ranges between 0 and 63 (11). In the Turkish adaptation study conducted with university students, a cut-off score of 17 was reported to correctly differentiate 90% of depression cases (12) and was used among youths (13).

State-Trait Anxiety Inventory (STAI):

STAI is a self-rating questionnaire measuring state and trait anxiety. It has 40 questions and two subscales. The first one assesses the state of anxiety that an individual feels at a particular point in time, a transitional emotional state. The second one assesses trait anxiety - how an individual feels most of the time and is a measure of relatively stable individual differences in anxiety across people. The questionnaire has been well validated in youths and adults (14,15).

The inventory was translated into Turkish upon the completion of the validity and reliability studies in 1975. The total score that can be obtained from both inventories ranges between 20 and 80. The STAI is not designed to categorize the levels of distress, but to place distress on a continuum from none to severe; a higher score indicating greater anxiety. Hence, there are no cut-off scores for clinically significant levels of anxiety (16).

In this study, SPSS-15.0 statistical package program was used for the statistical analyses. The categorical variables were presented in percentages, and the continuous variables were presented as mean ± standard deviation. In the analyses where the groups were compared, chi-square was used for discrete variables, and t-tests were used for continuous variables. Also, the Pearson's correlation was performed. $p<0.05$ was considered as statistically significant for all values.

Results

Thirty youths with suicide attempts and 30 youths without suicide attempts having similar socio-demographic features were included in the study. The age range of the youths was 14-22 years, with a mean age of 17.6±2.3years. Of the youths with suicide attempts, 83.3% were female and 16.7% were male; 33.3% were primary-school pupils, 53.3% were high-school students and 13.3% were university students. As regards their school performance, 13.3% had low school performance, while 46.7% had average, and 40% had high school performance. The frequency of family history of psychiatric disorder and the presence of a psychiatric disorder in adolescent was significantly higher in the study group with suicidal attempt (p=0.000, p=0.009). In the control group, of the youths who had psychiatric disorder, one had stuttering and the other had enuresis nocturna in the past (Table 1).

Table 1. The sociodemographic characteristics of the youths

Sociodemographic characteristics		Suicide attempters (n=30)		Control (n=30)			
		n	%	n	%	X^2	p
Gender:	Female	25	83.3	24	80		
	Male	5	16.7	6	20	0.551	0.74
Age:	14-18 years	20	66.7	20	66.7		
	>18 years	10	33.3	10	33.3	0.77	0.96
Education:	Secondary	10	33.3	4	13.3		
	High School	16	53.3	22	73.3	2.690	0.26
	University	4	13.3	4	13.3		
School Performance:	Poor	4	13.3	2	6.7		
	Average	14	46.7	16	53.3		0.29
	Good	12	40.0	12	40.0	2.447	
Settlement:	City Centre	24	80.0	25	83.3		
	Rural	6	20.0	5	16.7	0.682	0.41
M/F status of Employment:							
	employed	1/27	3.3/90.0	6/30	20.0/100	4.737/-	0.30/-
	unemployed	29/3	96.7/10.0	24/0	80.0/0		
Number of siblings:	1	1	3.3	2	6.7		
	2	6	20.0	4	13.3	3.807	0.28
	3	5	16.7	9	30.0		
	4 or more	18	60.0	15	50.0		
Birth Order:	1st child	10	33.3	12	40.0		
	2nd child	7	23.3	2	6.7	1.846	0.60
	3rd child	7	23.3	6	20.0		
	4th or later child	6	20.0	10	33.3		
M/F Age:	21-40 years	12/5	40.0/17.9	9/5	30.0/16.7	3.123/0.123	0.77/0.940
	41-60 years	18/23	60.0/75.0	21/23	70.0/76.7		
	>60 years	0/2	0/7.1	0/2	0/6.7		
M/F Education Status:	Illiterate	4/0	13.3/0	5/0	15.2/0.0	3.041/3875	0.219/0.275
	Primary	19/15	63.4/50.0	19/16	56.7/48.5		
	High School	7/11	23.3/36.7	9/13	27.3/39.4		
	University	0/4	0/13.3	0/4	0/12.2		
Family Structure:	Nuclear family	24 80.0		24	80.0	0.34	0.85
	Extended family	6	20.0	6	20.0		
History of PD:	Yes	18	60.0	2*	6.7		
	No	12	40.0	28	93.3	21.100	0.000*
History of PD in the Family:	Yes	11	36.7	3	10.0	6.914	0.009*
	No	19	63.3	27	90.0		

M/F: Mother/Father, PD: Psychiatric Disorder, * Having stuttering or enuresis nocturna in the past, $p<0.05$

The characteristics of patients with suicide attempts are presented in Table 2. In terms of suicide attempts, it was found that 73.3% were impulsive, while 26.7% were pre-planned. Ninety-three percent of the participants attempted suicide by ingesting medicine or poison (mouse poison, etc.) and two participants had used incisory materials or firearms. In terms of the number of suicide attempts by each participant, 53.3 % of the participants reported it as their first attempt, 46.7 % as their 2nd or more attempts (Table 2).

The differences between the control group and the group with suicide attempts in terms of COPE subscale scores for positive reframing, mental disengagement, use of instrumental social support, active coping, and humor were statistically significant (p<0.05). In addition, the differences between the control group and the group with suicide attempts in terms of FAD subscale scores of problem solving, communication, and general functioning related to family functioning were statistically significant (p<0.05). When the control subjects and those with suicide attempts were compared in terms of BDI scores, the depression scores were significantly higher in the group with suicide attempts (p<0.05) (Table 3).

We found a negative correlation between COPE 1,6,7,8,10,11,12 subcale scores and FAD general functioning score (r=-0.471 p=0.000, r=-0.319 p=0.013, r=-0.262 p=0.043, r=-0.442 p=0.000, r=-0.400 p=0.002, r=-0.350 p=0.006, r=-0.282 p=0.029). And we also found a positive correlation between BDI score and FAD general functioning (r= 0.335, p= 0.009).

We were unable to find a correlation between characteristics and methods of suicide attempt (p<0.05). A positive correlation was found only between the number of suicide attempt and the COPE 12, the roles, affective responsiveness, general functioning subscales of FAD (r=0.581 p=0.003, r=0.551 p=0.002, r=0.496 p=0.005, r= 0.464 p=0.010).

Table 2. Characteristics of Suicide Attempts

		Group attempting suicide (n=30)	
		Number	Percentage
Characteristic of SA:	Impulsive/spontaneous	22	73.3
	Planned	8	26.7
Method of suicide:	medicine-poison	28	93.3
	incisory instruments/firearms	2	6.7
Number of SA:	once	16	53.3
	twice	8	26.7
	three times or more	6	20.0

SA: Suicidal Attempt

Discussion

In this study, the mean age of the participants was 17.6±2.3 years. All sociodemographic findings (age, gender, family properties, etc.) were similar between the study and control groups. According to TurkStat, Turkey's Statistical Yearbook

Table 3. The comparison of COPE and FAD scores of those with and without a suicide attempt

	Suicide attempters (n=30)		Control (n=30)		
	Mean	SD	Mean	SD	p
COPE 1 Positive reframing	11.1	2.9	13.0	2.2	.007*
COPE 2 Mental disengagement	9.3	2.5	10. 7	2.6	.048*
COPE 3 Focusing on and venting of emotions	11.6	3.0	11.1	2.9	.514
COPE 4 Use of instrumental social support	9.3	3.4	11.5	3.4	.011*
COPE 5 Active coping	9.4	3.3	12.3	2.8	.001*
COPE 6 Denial	6.9	3.1	8.5	3.3	.058
COPE 7 Religious coping	12.7	2.9	14.1	2.9	.078
COPE 8 Humor	5.8	2.5	8.8	3.7	.001*
COPE 9 Behavioral disengagement	8.6	2.9	7.8	3.1	.347
COPE 10 Restraint	9.5	2.4	9.8	2.6	.683
COPE 11 Use of emotional social support	10.5	2.9	11.5	2.9	.187
COPE 12 Substance use	6.4	3.5	6.5	4.2	.947
COPE 13 Acceptance	9.9	2.8	9.9	2.9	1.000
COPE 14 Suppression of competing activities	10.4	2.5	10.4	2.1	.911
COPE 15 Planning	10.9	3.2	11.4	2.6	.508
FAD Solving problems	2.8	0.72	2.1	0.6	.000*
FAD Communication	2.5	0.5	2.1	0.5	.010*
FAD Roles	2.3	0.6	2.1	0.4	.292
FAD Affective Responsiveness	2.4	0.70	2.4	0.6	.796
FAD Affective Involvement	2.3	0.5	2.4	0.3	.626
FAD Behavior control	2.2	0.4	2.1	0.4	.089
FAD General functioning	2.3	0.7	1.9	0.6	.015*
BDI	24.5	9.3	16.5	11.3	.004*
STAI-1	47.4	7.4	48.5	7.4	.555
STAI-2	48.0	4.8	47.7	6.5	.874

COPE: Coping strategies, FAD: Family assessment device, BDI: Beck Depression Inventory, STAI-1/2: State-Trait Inventory, SD: Standard Deviation, * p<0.05

2008, most of the suicide attempts were seen between the ages of 15 and 24 (17). The cases in this study were also youths between 14 and 22 years of age.

The frequency of family history of psychiatric disorder and the presence of a psychiatric disorder were higher in youths with suicide attempt than in the control group. These findings were similar to the earlier studies where parental psychopathology has been found to be associated with adolescent suicidal behaviour (18). Of youths who completed suicide, more than 90% suffered from an associated psychiatric disorder at the time of their death. The most prevalent psychiatric conditions were depressive disorders, substance abuse, early emotional deprivation and other childhood experiences that made a predisposition to both depression and behaviour problems, as well as a temperamental predisposition to violent or impulsive behaviour (18).

In our study, females (83.3%) having suicide attempt were significantly more than males (16.7%). This finding was similar to that in most countries; males have a higher reported rate of completed suicide, whereas females have a higher rate of attempted suicide (19).

In terms of suicide attempts; 26.7% were pre-planned, 93% of the participants attempted suicide by ingesting medicine or poison (mouse poison, etc.). 46.7% of the participants had attempted suicide for the 2nd time or more. Andrews and Lewinsohn (20) studied 1710 high-school students at baseline and 1 year later. Those who attempted suicide before baseline, compared with nonattempters, were substantially more likely to attempt suicide again. We can say that in this study, one half of the youths that have attempted suicide are at risk for attempting suicide again.

In this study, it was found that the youths who have attempted suicide used less frequently the adaptive/problem-solving coping strategies, which are positive reframing, mental disengagement, and use of instrumental social support, active coping and humor. The inability of the child or adolescent to effectively use problem-focused coping strategies such as positive reframing, active coping, and humor shows that he/she cannot easily overcome the stress-causing situations (3). Mental disengagement and the use of instrumental social support are emotion-focused coping strategies (3) and they are beneficial in enabling the individual to abstain from the stress-causing incident. Thus, in this study, the youths that had a suicide attempt were not able to decrease their emotional stress. In a study (21), it was found that while those who had a higher tendency to experience stress resorted to emotion-focused coping strategies, those who had a positive attitude and were contented with life applied problem-focused coping skills more often. If the coping strategies used against stress do not appropriately eliminate stress, and as long as the stress continues, the negative impacts of desperation and stress will sustain. The method of coping especially with stress-causing situations actually determines the risk of attempting suicide to a certain extent. The effective use of coping strategies to solve problems will enable the child or adolescent to abstain from the stress-causing situation and, thus, from attempting suicide.

In this study, the statistically significant results showed that youths who have attempted suicide use instrumental social support less than those without the suicide attempts. Thus, not being able to use social support in times of stress and trying to cope with stress on his/her own without producing a solution may lead the child or adolescent to attempt suicide. In a study (22), adolescent suicide attempters were compared with both distressed and nondistressed nonsuicidal youths in terms of problems reported and coping strategies utilized. It was found that suicide attempters used social withdrawal, problem solving, and emotional regulation more than did nondistressed controls, but not more frequently than distressed controls. Also in a study (23), Eskin found that youths who preferred to establish relationships with others to cope with loneliness were more successful in refraining from suicide. While individuals cope with their own problems, they often resort to emotionally dominant coping methods. However, their peers' coping strategies for the same problem is generally problem-focused. In coping with their own problems, individuals feel desperate and hopeless, whereas they can solve their problems by simply talking with their family members or friends. After receiving information on suicide prevention, youths are more controlled when they face the problems of their peers, and they suggest appropriate solutions such as receiving professional assistance if their peers have depression or a suicidal thought. Approximately half of those who have a suicidal tendency reveal their suicidal thought first to their close friends. It was found that after receiving information on suicide prevention, youths taught their peers more appropriate coping strategies and played a major role in preventing their peers from committing suicide (24). We can say that the risk of suicide is lower if youths having suicidal thoughts or intent are seeking help or social support and adequate social support is presented in their surroundings.

In our study, we were unable to find a difference between genders and the type of suicide in the subscales of COPE and FAD. Edwards and Holden (25) reported in their study that females who had attempted suicide used emotion-focused coping strategies more frequently (25).

A positive correlation was found between the number of suicide attempt and substance use in roles, affective responsiveness, and general functioning of the family assessment device. We emphasize that the family functionality was important for reducing the number of suicide. A positive correlation was also found between the number of suicide attempt and substance use in COPE 12 (substance use). A high prevalence of comorbidity with substance abuse disorders has been found in adolescent suicide victims (18). Hawton and colleagues (26) reviewed 8 studies, of which 7 showed a significant association between cigarette smoking and suicidal phenomena, which is important as cigarette smoking is often the gateway to drug use in youth (26).

Problem solving, communication and general functioning related to family functionality in FAD were impaired in those with suicide attempts when compared with the control group in this study. In other words, youths with a suicide attempt were having problems in terms of problem-solving, communication and general functional abilities within the family. In a study (22), adolescent suicide attempters were compared with both distressed and nondistressed nonsuicidal youths. All of the groups reported most frequently occurring four problems, which are school, parents, friends, or boyfriend/girlfriend issues. The suicide attempters and distressed controls reported problems with parents more frequently than did nondistressed controls.

In this study, 80% of the children or youths with a suicide attempt had a BDI score greater than 17. In the literature, depressive complaints were found to be associated with ineffective coping strategies. It was also shown that rather than strategies of adaptation or active coping strategies, there was a significant association between the use of coping strategies for decreasing emotional tension and the emergence and maintenance of psychopathological symptoms (27,28).

A positive correlation between BDI score and FAD general functioning was found, depression was detected in suicidal youths, and the general family functionality was also impaired. (29) Similar to the findings of our study, in a study where depressive and normal individuals who attempted and did not attempt suicide were compared in terms of family functionality, the subtest scores of problem solving, communication, general functioning as well as affective responsiveness were found to be significantly higher for those with suicidal attempt.

In our study, 66.7% of the participants were aged between 14 and 18 years. Parent-child conflict is a more common precipitant for children under 16 years of age, who cite arguments with parents as the precipitating factor in more than one-half of cases. Positive family relationships have been found to be protective and family conflicts have been found to be a risk factor for suicidal behaviour (6,18). We can say that youths who have attempted suicide have parents who were unable to guide them in coping with emotions and thoughts causing stress and, therefore, these young people have used ineffective coping strategies.

Family relationships and mental health are important to cope with stress in youths. In youth suicidal cases, parents have difficulty guiding their children to solve the problems and the impairment of communication between the parent and the youths as well as the youth's depression may present as a risk factor for suicide attempt. In youths, family functionality and mental health for adaptive/problem-solving coping strategies is essential and provides a protection from suicide.

Conclusion

As with all research, this study also has limitations. As with all researches, this study also has limitations. First, further studies are needed to compare the coping strategies between youths with and without psychiatric disorders in terms of suicide attempts. Second, this study evaluated suicide attempts only for social and behavioral dimensions, but it is known that suicidal attempts have also genetic, neurobiological risk factors. Third, this study was conducted in a particular facility, so these results may not be generalizable to the whole population.

In conclusion, investigating the coping strategies applied by youths with suicidal behavior and the role of the family in suicide attempts will help the mental health professionals to provide comprehensive evaluation. Understanding the maladaptive coping strategies that lead to suicide attempt, training youths and families about suicide and using education models whereby positive thinking skills are taught would be beneficial in increasing the adaptive coping skills, which then will prevent adolescent suicide.

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