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THE RELATION BETWEEN DEPRESSION AND FAMILY FUNCTIONS

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We certify that thesis is satisfactory for the award of the Degree of Master of Applied Psychology

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ABSTRACT

THE RELATION BETWEEN DEPRESSION AND FAMILY FUNCTIONS

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The aim of this study is to investigate the relation between depression and family structure among adolescents. Family functions such as problem solving, communication, roles, affective responsiveness, affective involvement, behaviour control and general functions are examined to evaluate family structure.

Research groups are formed from 30 adolescents, diagnosed as Major Depression according to DSM IV criteria, and 52 healthy control subjects. Demographic Information Form, Mc Master Family Assessment Device (FAD), Beck Depression Inventory (BDI), General Health Questionnaire (GSQ28) and Submissive Acts Scale (SAS) are applied to both of the groups. There is no significant difference in the age, sex, social and economical status between the groups.

The results of the study show us that the adolescents with depression show significantly worse family functions such as communication, roles, affective responsiveness, affective involvement, behaviour control and general functions than healthy controls ($p=0.000$-0.034). The subjects diagnosed as 'Major Depression' perceived their parental relations significantly worse than the control group ($p=0.004$).

When we compare the groups according to scores of the scales we applied (FAD, BDI, GSQ28, SAS), experimental group showed a higher unhealthy level. The scores of related subscales correlated significantly, pointing the reliability of the results.

This study shows that Major Depression is related with unhealthy family functioning among adolescents. During psychotherapy of adolescents with depression, we as psychotherapists, must be aware of this effect and give importance to relations of the adolescent with their family.

Keywords: Depression, Adolescence, Family Function.

ÖZET

DEPRESYON VE AİLE İŞLEVLERİ ARASINDAKİ İLİŞKİ

Hazırlayan **Emre Balkan**

Ocak, 2008

Bu çalışmada ergenlerdeki depresyon ve aile yapısı arasındaki ilişkinin incelenmesi amaçlanmıştır. Aile yapısını değerlendirmek amacıyla problem çözme, iletişim, roller, duygusal tepki verebilme, gereken ilgiyi gösterme, davranış kontrolü ve genel fonksiyonlar boyutundaki aile işlevleri incelenmiştir.

Araştırma grupları, DSM IV kriterlerine göre depresyon tanısı almış 30 ergen ve 52 sağlıklı kontrolden oluşmuştur. Her iki gruba da sırasıyla Demografik Bilgi Formu, Aile Değerlendirme Ölçeği (ADÖ), Beck Depresyon Envanteri (BDE), Genel Sağlık Anketi (GSA28) ve Boyun Eğici Davranışlar Ölçeği (BEDO) uygulanmıştır. Depresyon tanısı almış ergenlerle normal kontroller arasında yaş, cinsiyet, sosyal ve ekonomik statüleri açısından anlamlı bir faklılık bulunmamaktadır.

Araştırma sonuçları, depresyon tanısı almış ergenlerde aile işlevleri olan iletişim, roller, duygusal tepki verebilme, gereken ilgiyi gösterme, davranış kontrolü ve genel fonksiyonların sağlıklı kontrollerin aile işlevlerine göre anlamlı derecede olumsuz olduğunu göstermiştir ($p=0.000$-0.034). Depresyon tanısı almış ergenlerin aile ilişkilerini algılamaları kontrol grubuna göre anlamlı olarak daha kötüdür ($p=0.004$).

Uygulanan tüm ölçeklerde (ADÖ, BDE, GSA28, BEDO) deney grubu ölçek puanları açısından kontrol grubuna göre sağlıksızlık yönünde daha yüksek bulunmuştur. Birbiriyle ilişkili olan alt ölçek puanlarının korelasyonu, sonuçların güvenilirliliğini göstermektedir.

Yapılan araştırma ergenlerde Major Depresyon ve sağlıksız aile fonksiyonu arasında ilişki olduğunu göstermektedir. Depresyonlu ergenlerin psikoterapisinde, psikoterapistler olarak, bu etkinin farkında olup ergenlerin aile ilişkilerine önem verilmelidir.

Anahtar Kelimeler: Depresyon, Ergen, Aile İşlevleri.

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ABBREVIATIONS

FAD : McMaster Family Assessment Device

BDI : Beck Depression Inventory

GHQ : General Health Questionnaire

SAS : Submissive Acts Scale

MD : Major Depression

CIU : Cyprus International University

DSM IV : Diagnostic and Statistical Manual of Mental Disorders

SPSS : Statistical Package for the Social Sciences

1. INTRODUCTION

1.1. Definition of Depression

The term depression is used in everyday language to describe a mood state that everyone experiences from time to time; it can be difficult when term is also used to mean an extreme state in which the person may feel entirely hopeless and even suicidal (Wilkinson, Campbell, 1997).

Depression known and lived since a long time ago but recently that psychological problem is increase very fast (Alper, 2001).

Feeling sad and the depression as an illness are very different. Depression is not only affecting feelings and also it is very important medical condition that affects the health, productivity, relations and logical thinking (Quinn, 2002).

1.1.1. The Major Differences between Feeling Sad and Depression

- During feel sad, there are feelings to be enlightened as (crying and hiccough), however for depression, crying is superficial, doesn't have any comfort and the person can not cry easily.
- For feeling sad, emotions and attitudes are so deep and sorrowful. For depression the feelings are silent and uncertain.
- During feel sad, normal behaviours are seen as rare laughs, for depression there is no cheer; subtle and fun decrease gradually.
- The behaviours are normal for feeling sad cases but for depression there is a slow down on behaviours.
- There is no self respect for depression however there is for feeling sad.
- There is isolation during depression, on the contrary closeness are required during feeling sad.

- There is no energy cut for feeling sad. However there is no energy for the ones in depression.
- Feeling sad is a short term period, however depression lasts long and gradually worrying feelings get stronger (Saygılı, 2006).

1.1.2. History of depression

According to different mythologies; the Satan, who is accepted as factor for every evil deed and rebellious to God in all ancient beliefs and in all modern religions, appeared as the only factor for depression in India, 1400-1500 B.C. (Köknel, 1997).

Old Era: The description and understanding of melancholic person temperament date back to Homeros epics. To say in more concrete way, the description of melancholic person temperament in written culture was first observed in Homeros epics (Teber, 2004). Plato (427-342 B.C.) argued that, psychological illnesses were caused by natural and supernatural sources. Celsius, who lived in years 100 A.D., described all the malfunctions on the body and classified melancholia and mania under the head malfunctions in his book "Physician". By that he linked the brain and central nervous system for the first time. Galen (129-199 A.D), pointed as; besides the personality factor, malfunctioning of the brain and secretion also play roles on melancholia and mania (Köknel, 1997).

Middle Era: In middle age, the attitude of melancholic people that could not find a meaning to life, trying to find out the happiness in themselves, lost of trust to God, even disbelief to God, was accepted as a big rebellion and sin (Teber, 2004). In this age, Islam also plays role on describing and classification on psychological disorder. Ibn-I Sina (980-1037 A.D) argued that melancholia was caused by "black bile" in his famous book Canon. Thomas Aquinas (1225-1275 A.D) argued that the Satan only effects perception and thought disorders; however, for slow mental progress, epilepsy, feverish illnesses, mania, melancholic and cloudiness on consciousness are affected by natural reasons (Öztürk, 2001; Köknel, 1997).

New Era: On descriptions and classifications of psychological malfunctions and illnesses the philosophies of ancient Greek, Rome and Islam views gained actuality.

Fennel (1497-1558) classified the malfunctions according to the effects of brain membrane and the loops (Köknel, 1997). In 1586, Timothy Bright published his book "Melancholia" in London and classified the illness in two groups; natural and unnatural. According to him; natural melancholia is caused by "black bile" and unnatural one is caused by malfunctions on "black bile", blood and lymph. And also Hippocrates is depends the reason of melancholia to the "black bile". According to Hippocrates the description of melancholia is: depressed, hopeless, the situation that person lost all his/her courage, worried, writhe with pain, avoid light and people, avoid talking or being questioned, the observance of the abdomen and diaphragm as if swollen and aching of this region when touched. These kinds of people do not want to see scary things or hear bad news. Mostly, the sickness appears in spring. Patients are seen exhausted and they eat little food. Melancholia is mostly associated with epilepsy and epilepsy is mostly seen together with melancholia (Teber, 2004; Köknel, 1997;Öztürk 2001). Paracelsus, in his book "Illnesses Breaking Down the Thought and Logic" described all the psychological illnesses and classified them. Robert Burton (1577-1640) described the various forms of melancholia, in his book "Anatomy of Melancholia" as the types of brain oriented, body oriented and symptoms of hypochondriasis (Köknel, 1997).

Modern Era: Philippe Pinel (1745-1826) from France, after his studies grouped mental disorders into four groups according to their symptoms as mania, melancholic, dementia and mental retardation. According to him, these disorders are resulted because of physical disorders. In 1884, Meynert described his classification by publishing his book "Psychiatry Basic Book". Mania and Melancholia cases are described as resulted from the functional disorders of skull and cloudiness of conscious and delirium disorders are described as resulted from the functional disorders of the areas under the skull (Köknel, 1997).

Modern Opinions: By having place for sensational factors, Bleuler, extended the cover of mania-depressive cases. Freud, in his book "Mourning and Melancholia" 1917, pointed the importance of loosing beloved object on depression while arguing the psycho-dynamics of depression. While he was mentioning the importance of psychological life on depression, on the other hand he was also saying the roles of

chemical-physiologic factors as the reasons of depression (Köknel, 1997). According to Melani Klein, every baby undergoes short or long, less or more depressive position during periods of quitting sucking. Melancholic tendencies appear in cases of failure to overcome this depressive position (Teber, 2004).

1.1.3. Symptoms of Depression

The symptoms of depression may be mild, moderate or severe and continue for at least two weeks.

1.1.3.1. The general aspect and behaviours:

Generally depressive patient's face lines are clear, the lines of forehead are deep, shoulders fall down, face is unhappy and personal care decreases. The behaviours and motions become slowly. The depressive patient especially major types are sometimes very uneasy and have restlessness which increase motions (Öztürk, 2001; Güleç, Köroğlu, 1997).

1.1.3.2. Conversation and Relationships:

The patient's speaking voice is low. It is hard to give answer for the patient. The severe cases may have mutism. It is easy to communicate or to get in touch with mild or moderate level depressive patients. But in severe levels it is hard to get relationship because the symptom of loss of interest toward everything (Öztürk, 2001).

1.1.3.3. Mood Symptoms:

Depression is often characterized by feelings of hopelessness, isolation, sadness and dejection. In addition, there is loss of satisfaction and enjoyment in life. Activities that previously make the people enjoy themselves now seem to be boring, joyless and these activities lose their meanings. The depressive symptoms are generally prominent during the early times of the morning for most of the depressive patients. The most important symptoms are loss of interest or pleasure in all, or almost all activities and anhedonia (Öztürk, 2001; Wilkinson, 1997).

1.1.3.4. Cognitive Symptoms:

The most pronounced cognitive symptoms are negative thoughts. Depressed people often feel hopeless about their situation and future and feel pessimistic about improving things. They tend to feel inadequate, suffer from low self-esteem and are full of self-blame, and sometimes self-loathing (Öztürk, 2001).

1.1.3.5. Thought Trend and Content:

Thoughts are become slowly down. Psychomotor retardation is particularly prominent. It is hard to explain thoughts and also talks very slowly and very low voice. The content of thoughts are formed from usually regret about the past, suffering negative memories and worry about future. The future generally is perceived hopeless and murky. The patient feels guilty. The patient's self esteem become very low (Güleç, 1997; Öztürk 2001).

1.1.3.6. Motivational Symptoms:

Depression has an effect on the ability to "get going" and even to do things that give pleasure. Depressed person see everything as too much effort needed and in extreme conditions even speaking and movements may be slowed down (Wilkinson, 1997).

1.1.3.7. Physical Symptoms

There is loss of appetite in most of the patients. This results with weight loss. Rarely but some patients may have increased appetite weight gain. Most of the patients have sleep disorders. The patients have difficulty to fall asleep, sleep is interrupted or most of mornings they wake up earlier. The patient who has depression with anxiety wakes up early in the morning and feels great distress. The type of seasonal depression shows some symptoms such as eating a lot, weight gain and hypersomnia. The sexual desires decrease (Öztürk, 2001; Wilkinson, 1997).

1.1.4. Diagnostic Criteria for Major Depressive related to DSM IV

A. Five (or more) of the following symptoms have been present during the same 2 week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. fells sad or empty) or observation made by others (e.g. appears tearful) Note: In children and adolescents, can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism)

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation. (DSM IV, 1994).

1.1.5. Types of Depressive Disorder

1.1.5.1. Cyclothymic Disorder

The patients who have cyclothymic disorder can show the symptoms like mild, short-term depressions or mania. Sometimes the changes in mood which does not need clinical treatment, it may be personality disorders. The patient in his/her manic period, feels more lively, increase the motions and social functional activities, also feels more self confident and extrovert. However after a long or short period of time, some kind of attitudes like distress, worrying, calmness, pessimistic, shyness may appear without any good reason. If the patient spends more time with mania than depression he may be more popular, successful in his job and in social life (Öztürk, 2001; Köknel, 1997).

1.1.5.2. Dysthymic Disorder

The symptoms continue for at least for 2 years; besides some mild depressive symptoms, some other symptoms can also be seen like; sleeping disorders, chronic unhappiness, pessimism, exhausted, desire problems, concentration problems, low self-esteem, continuous complains and various somatic distresses. With respect to this, from time to time, some patients may get better for a short period of time while the disorder continuing (Saygılı, 2006; Öztürk, 2001, Köknel 1997).

1.1.5.3. Bipolar II Disorder

This category is characterized by one or more Manic or Mixed Episodes, usually accompanied by Major Depressive Episodes. In contrast to depression, patient in his/her manic period is full of energy and uncontrolable. Also there is an incredible increase in self-esteem and beside of this the patient believes that he/she can achieve everything. The disorder starts with depression, manic episode or mixed episode sometimes have normal periods (Wilkinson, 1997; Akman,2006; Köroğlu 1997).

1.1.5.4. Involutional Depression

Beside of not having several variances with the recognition of depression, in the age turnings depression has heavy distress, morning distress, sleep problems. With respect to these symptoms the patient shows some behavior like walking around with rubbing hands to each other related with confusion and anxiety and the patient is in agitated depression. Furthermore the patient's physical activity and suicidal ideation increased. Usually the symptoms are like that of melancholic depression. This type of depression is seen more often in women and the age range is 40-50 in women and 50-60 in men (Öztürk, 2001).

1.1.5.5. Melancholic Depression

In this type of depression, there is loss of interest to one's surroundings and the patient's non- reacting to the displeasing stimulus. Melancholia is a severe type of depression. The recognition of melancholic depression is very important because this kind of depression needs biological treatment. The main characteristics of melancholic depression are mild stress, major severity of symptoms, serious suicide attempts and tendency to accuse about one's illness (Banu, 2006).

1.1.5.6. Masked Depression

In melancholic depression affect is not so clear, physical and cognitive symptoms are more prominent. Headache, exhaustion, weakness, tiredness, pain in dorsal vertebra, sleeping problems and loosing weight are the complaints of this disorder. Mostly this kind of depression is not recognized for a long period of time and continues without

treatment. In this type of depression, the patient can not aware of their illness. Instead of the patients have physical complaints and more over they mask themselves with smiles in order to hide their illness. Mostly discriminate of the mask depression with respect to the other depression types can not be recognized easily (Akman, 2006; Köknel, 1997; Saygılı, 2006).

1.1.5.7. Atypical Depression

Basically, increased sensational condition is common in atypical depression towards sorrow. However, other symptoms are not enough and sufficient for depression diagnosis. These people show phobic, obsessive, hypochondriac signs, conversion symptoms instead of depression symptoms. Unexpectedly, they show addiction to alcohol, gambling and drugs, tend to get away from their family and work, unexplainably face sexual unsuitability, increased appetite or no appetite and these kinds of deviating symptoms are the causes of the depression in these people. An important property of atypical depression is that they give positive reaction to positive events (Akman, 2006; Köknel, 1997; Öztürk 2001).

1.1.5.8. Reactive Depression

In reactive depression, people show behavioral, affective reactions and disorders in their point of view to the life. This arouses according to the events occurring in life. They mostly feel low and sad; do not enjoy the things that they fancy in doing before. Also, these sensational occasions deviate. While patient feels himself/herself depressive for couple of hours, he/she could feel well afterwards. Generally, they are impatient, grumbling and worried. They tend to blame others for their problems. Spiritual and social changes could increase the occurrence of this type of depression that arouses as people become older (Akman, 2006; Köknel, 1997).

1.1.5.9. Agitated Depression

Agitation is a disorder, which people show severe restlessness and distress. In addition to these symptoms, patients in agitated depression have dramatic view of life, have real

thoughts on committing suicide, mostly have severe delusions, wake up in the midnight and feel sad when they woke up in the morning (Akman, 2006).

1.1.5.10. Psychotic (Delusional) Depression

Delusion, hallucination, thought disorder and serious unsuitable behaviors are the most obvious properties of this kind of depression. Delusions in psychotic depression could be feeling guilty, exaggerated thoughts about being useless, being sinner and showing illnesses that do not actually present in the body. In hallucination, patients blames themselves for various bad actions, hear their name being called or voices that convict them to death, and they see their death relative's views and coffins. Psychotic type of thinking results in usage of more deadly methods (Akman, 2006; Saygılı, 2006).

1.1.5.11. Seasonal Depression

This kind of depression is a repetitive depression arising in every winter. Patients having seasonal depression show atypical symptoms like increased appetite/extra weight, hypersomnia and carbohydrate deficiency. Symptoms in seasonal depression are explained as food selection, putting on weight and changes in basal metabolism (Akman, 2006; Saygılı, 2006)

1.1.5.12. Endogenous Depression

In terms, endogenous depression means that there is no environmental or outer effect that causes disorder and it is related to neurochemical changes. In other words, it defines "biological" depression. In this type of depression, followings are the most important properties: Neurophysiological changes, early wake up in the morning, lose weight, no reaction to events, lose relation, feeling guilty, blame themselves, mood changes during the day, and immobility (Akman, 2006).

1.1.5.13. Postpartum Depression

This category can be applied to the current (or most current) Major Depressive, Manic, or Mixed Episode of Major depressive Disorder if onset is within four weeks after delivery of a child. Many women feel especially guilty about having depressive feelings

at a time when they believe they should be happy. They may be reluctant to discuss their symptoms or their negative feelings toward the children (Saygılı, 2006; Köroğlu, 1998).

1.1.5.14. Depressive Disorder Not Otherwise Specified

Depressive Disorder Not Otherwise Specified category included disorders with depressive features that do not explaining by the criteria for Major Depressive Disorder, Dysthymic Disorder, Adjustment Disorder with Depressed Mood, or Adjustment Disorder with Mixed Anxiety and Depressed Mood (Köroğlu, 1998).

1.1.6. Epidemiology and Prevalence of Depressive Disorder

Depression is the most seen disorder over the other psychiatric disorders. General prevalence is between 9-20% to the depression. It is found that the life time prevalence is %8-12 for man and 20-26% for woman. Investigations revealed that severe depression generally occurs two times more in woman than man. The occurrence of depression is between 35-45 ages in woman and 55 ages in man. Depressions do not show any significant properties according to socio-economic differences (Öztürk, 2001).

According to DSM IV the core symptoms of a depression are the same for children and adolescents, although there are data that suggest that the prominence of characteristic symptoms may change with age. Certain symptoms such as somatic complaints, irritability, and social withdrawal are particularly common in children, whereas psychomotor retardation, hypersomnia, and delusions are less common in prepuberty than in adolescence and adulthood. In elderly adults, cognitive symptoms may be particularly prominent. Major Depressive Disorder (Single or Recurrent) is twice as common in adolescent and adult females as adolescent and adult males. Rates in men and women are highest in the 25 to 44 year old age group, whereas rates are lower for both men and women over age 65 years. On the other hand culture can influence the experience and communication of symptoms of depression. But underdiagnosis or misdiagnosis can be reduced by being alert to ethnic and cultural specificity (Köroğlu, 1998; Öztürk, 2001).

1.1.7. Etiology

1.1.7.1. Biological Effects:

Heredity: Family and heredity studies revealed that primary relatives of patients having affective disorder are at high risk of developing disorders. The risk on primary relatives of patients having recurrent depression to show the depression is three times higher than the risk of general population. Twin studies showed that heredity play an important role at affective disorders. However, how this genetic transfer occurs has not been documented (Öztürk, 2001; Köroğlu, 1998).

Brain Studies: Studies on potential differences in different areas of the brain at depression have increased after recent advances in brain visualization techniques. There has not been any explanation on this issue, but it is believed that scientists got important clues on this subject. According to PET and SPECT analyses, low serotonin activity has been reported on the frontal and sub-cortical areas of the brain at depression (Öztürk, 2001).

Biochemical Effects: As it is understood that drugs have importance on sensational disorders, biochemical investigations have been speeded up. Until now, every aspect of a biochemical disorders have not been explained. According to investigations, disorders in monoamine neurotransmitter especially activity level of noradrenalin and serotonin have been reported in these patients. Noradrenalin activity level increase or decrease in patients undergoing severe depression attack has been proposed. Also, it is proposed that there is a decrease in serotonin activity in depressions (Öztürk, 2001; Alper, 2003).

1.1.7.2. Spiritual – Social Effects

It is known that our senses are very affected by physical and social environmental effects. The importance of spiritual-social effects in sensational disorders can not be despised. A lot of physical or physico-social events such as economical problems, family related boredom, problems and dissatisfaction at work, retirement, losing job, losing loved objects, health problems and humiliation play an important role in emerging real emotional disorders and their continuity. Generally, a life event causes the first

attack. However, the same life event does not trigger this kind of disorder on every person. On the other hand, these effects play an important role in the start of the disorder in biological and spiritual predisposition condition. Losing mother at childhood is known as an important effect on depression. Babyhood or childhood depression in early ages is an important source of predisposition to depressions in the older ages of the person. According to personal properties, people that criticize and do not appreciate themselves, could not cope with stress or show their anger, and perfectionist or pessimistic are more prone to depression. Also, people, who easily lose their self-esteem, have strict superego, have high expectations and addiction in their relationships and therefore most of the times could not get their expectations and thus affected easily, are more prone to depression. However, every person that undergoes depression can not be told to possess any of these properties. Except personal structure, in other causes of depression, these properties should not be ignored (Öztürk, 2001; Akman, 2006). Emotional disorders can be seen in every community, but there could be some differences in symptoms. Blame and commuting a big crime often cause severe depression in Christian communities, while the causes in Turkey and other developing countries are boredom and somatic symptoms (Öztürk, 2001).

1.1.8. Treatment Approaches for Depression

1.1.8.1. Psychoanalytic Approach:

The roles of early loss, self-esteem and dependency have been emphasized by the psychoanalytic approach of depression. In relation to this view, when in childhood for some reason individual's need for care, endorsement and affection would not have been satisfied and a loss in later life, this will re-stimulate the early distress and cause the return of the person to the former original helpless, dependent state (Wilkinson, 1997).

Freud's has mentioned that indication of the psychological depression is nearly similar with the indication of the mourning and he has focused and examines this with comparing in his one of the paper named as "Mourning and Melancholia". The man or woman that mourning he or she loose a real love object. For different kind of people and correlation to the lost object, this mourning can change with by time and severity.

During this time generally they can meet with deeply unhappy feelings, boredom, weep, sleeping disorder, calmness, unwillingness, no enjoyment and feel alone in the world. From several weeks to the several months this feelings of the mourning is slowly decrease and ends. When sometimes remembrance of the lost object this feelings goes up but the normal life cycle is continues (Gürdal, 2000; Öztürk, 2001) .

In the depression, the real love object could be lost or not. By this reason Freud has been point that if there is no any lost real love object there is should be a lost of unconscious imaginary. This means the patient should feel the loss of the lover. This feeling may be or may not be the real. This means the feeling of the losing could be occurred by the effects of the unconscious (Gürdal, 2000).

At depression the patient real or unreal of the feeling of losing may include “I lost my lover, he or she does not love me, I am a bad person” and also may lose self-esteem. But the person who has mourning period does not think these types of feeling. This means they do not lose their self-esteem. The differences between the mourning and depression may found from dynamically from this point. Their relation has ambivalence. This means love and hate feelings are abreast. But the hate is unconscious. For interjected the person’s ego live a love object and includes powerful ambivalence. May be a change on a real condition or real thinking there will be a feeling of lose; the lost feelings are increase for lover or to the object, or maybe really has lost it. The feeling of lost associated with desire and love can stimulate unconsciously grudge and hate. By the reason of the superego hate and grudge emotions directs to the person’s himself/herself (Öztürk, 2001; Gürdal, 2000).

When person directs the hate and grudge to himself self-esteem decrease; person feel worthless, and delinquent. He feels very bad and thinks has to be die. Thus, psychological depression has occurred. Basically for depression respect and grudge, hate aggressive drives should be enforced. This drives by the insensitive superego unchallengeable command directs to persons itself. All the analysis related to ambivalence, aggressive incentive, and to their sources (Öztürk, 2001; Gürdal, 2000).

Edward Bibring, who has an important place on ego psychology, says that to create an ego as calm, amenable, valuable, everybody has aspirations and tries to do some

expectation. All these called as ego's narsisistic aspirations. To be valuable and lovely, to known by everyone; not to be valueless, to be powerful, distingue, trustworthy, not to be feeble, mistrustful, to be good and loveable, not to be aggressive baneful, and unkind. These aspirations, at the beginning could be some defense that enhanced for some impulse, but after those independent egos should be formed that effected from sources. So, after all these they will not have any relations with superego or the power of this relation decreased. The ego has plays a role to save the self-esteem. The ego that does not do its mission will have a conflict by itself. This means that there should not be an id, ego or superego conflict. Let us think that there is a person and his ego's narsisistic aim continues very powerfully but during this time perceives that these are not going to be materialized. For somebody these narsisistic expectations and aims continue very powerfully and an event like retiring, illness, bad feelings, these expectations feelings will formatives at the ego's side. So, ego will have some conflicts. Ego is now feeble and helpless by the reason of the powerful narsisistic aspirations and on the other hand, some feelings for not to be materialize. Self-esteem decreases and this is a depression (Öztürk, 2001).

1.1.8.2. Object-Relations Theory:

According to Melanie Klein, baby learns time by time that the mother he/she hates (frustrated "bad" object) and the mother he/she loves (reinforced "good" object) is one and the same person. Therefore, this normal child develops a consistent ego perception that forms the basics of introverted good object perception. This kind of child do not show tendency to develop severe depression when becomes adult. However, if a child could not unite these two "pieces of objects" (bad and good), he/she will be inclined to develop depression in the latter stages of his/her life. Klein suggested that the child lives without overcoming this "infatile depressive condition (Güleç, 1997).

1.1.8.3. Cognitive Approach:

According to the scientific view of Beck A.T. *et al.*, depression is not an affective disorder but it is a cognitive disorder. Affective disorder is secondary to this. Beck

described how when people become depressed they manifested a negative triad: a negative view of self, world and future (Öztürk, 2001; Wilkinson, 1997).

These negative concepts (schematas according to Beck *et al.*) causes negative judgements, thoughts and attitudes by time. There ara three main components of Beck's cognitive theory of emotional disorders. The first component is presence of negative automatic thoughts. They seem 'immediate' and often 'valid' in the sense that they are often accepted as true by the person without further analysis. The second component is the presence of systematic logical errors in the thinking of depressed individuals. Several categories have been distinguished: arbitrary inference, over-generalization, selective abstraction, magnification, minimization, personalization, when a person attributes bad things to himself despite evidence to the contrary, dichotomous thinking. The third component of the cognitive model is the presence of depressogenic schemata. These general, long-lasting attitudes or assumptions about the world represent the way in which the individual organizes his/her past and current experience, and is suggested to be the system by which incoming information about the world is classified. A schema is a structure for screening, coding, and evaluating impinging stimuli. According to the theory, depressive schemata develop over many years and, although they may not be evident, remain ready to be activated by a combination of stressful circumstances (Öztürk, 2001; Clark, Fairburn, 1997; Savaşır, Soygüt, Kabakcı, 2003).

In every event, the depressive person perceives and thinks the negative sides of the situation. These people think negative and pessimistic scenarios against life events. Therefore, affective disorder emerges after these negative thoughts and concepts (Öztürk, 2001).

1.1.8.4. Behavioral Approach:

In early 1970's, the way in which depressed people seemed to be deficient in reinforcement ,especially social reinforcement, for positive behaviours and in contrast their negative behaviours seemed to be reinforced by attention from others has drawn attention. According to suggestions, depressed people seemed to be on "extinction schedules" for antidepressive behaviours (Wilkinson, 1997).

Seligman explains depression by learned helplessness. After applying electric current on dog, dog is subjected to avoidant condition and if its escape is prevented, dog gives up escape efforts and falls into a sad, calm helplessness condition. This is similar to depression in human being. According to this point of view, depression, from childhood, is the condition of being unable of getting rid of the grieved state and the helplessness situation (Öztürk, 2001).

1.2. Adolescence

Adolescence is a time of change that takes many forms, covering the physical, social and psychological areas and outlines the transition from childhood to adulthood (Calton, Arcelus, 2003).

The word adolescence comes from a Latin word "adolescere" meaning enlargement and to become mature and depending on its structure it states process rather than a condition. Nowadays, it could be defined as the rapid and continuous progress period observed in individuals (Yavuzer, 1998; Temel, Aksoy, 2005).

Aristotles (B.C. 384-322) was the first to scientifically mention about the adolescence period (Şemin, 1992).

Progress and maturation in biological, psychological and social aspects take part in adolescence period and it is the transition period from childhood to adulthood (Yavuzer, 1998).

According to Stanley Hall, who has important investigations on adolescence psychology, adolescence period is between 14-24 ages (Şemin, 1992). In addition to this, UNESCO states adolescence period between 15-25 ages (Yavuzer, 1998).

1.2.1. Physical Development

Physical changes are the starter and regulators of the psychological and social changes that arouse in a period life named as adolescence period and therefore possess a big importance (Şemin, 1992).

Adolescence period forms one of the two fast growing periods in human development. Physical development in this period forms the basis of emotional, social and mental maturity (Yavuzer, 1998).

Sexual characteristics such as growth of hairs in genital region, appearance of moustache and beard hair on the face and change in voice are obvious in male children. Enlargement of breasts, rounding up of hips, appearance genital hairs and start of menstrual cycles are obvious in girls (Yavuz, 1994).

These changes in person result in the rapid enlargement and development of the body. All these changes and the keep up of the person to these changes, brings the person some characteristic qualities (Yavuzer, 1998).

Physical changes observed in adolescence period are followings:

- Enlargement of skeletal system firstly increases than further decreases.
- According to the changes in fat percentage and distribution and development of the skeletal and muscle system, body structure changes.
- Developments in respiration and circulation systems increase person's resistance and strength.
- Reproduction organs, sexual cells and secondary sexual characteristics develop.
- Changes in nervous and endocrine system are observed. Mental functions pregress (Şemin, 1992).

In physical development, the changes of the sexual system through the adolescents both male and female are evident. Androgen and estrogen levels are roughly the same on boys and girls until puberty. At puberty, adrenal and reproductive glands are stimulated by the brain pituitary gland for the hormone production. From puberty onwards, boys have higher level of androgens than girls do, and girls have higher level of estrogen than boys do (Wade, Tarvis, 2005).

Moreover, the major turning point for girls is suggested as the beginning of mensturation, however this is not recalled as a particular significant event in many women. The beginning of adolescent puberty for males is suggested as the first

ejaculation, but this event is often little-remembered (and possibly repressed) (Dacey, Travers, 1999).

1.2.2. Cognitive Development

The youth's increased ability to think abstractly, consideration of the hypothetical as well as real, engagement in more complex and complicated information-processing strategies, consideration of multiple dimensions of a problem at once and reflection on oneself and on complicated problems are the most important cognitive changes during this period of life (Lerner, Easterbrooks, Mistiry, 2003)

The hallmark of Piaget's formal operational stage, which is abstract and hypothetical thinking, is assumed to start during adolescence and to continue through young adulthood. Piaget brings forward that formal operations arises via cooperation with other people. Opinion exchange and discussions start to take an important part in adolescent's life. A cooperation that includes personal views and arguments become necessary along with the start of the adolescence period. Adolescents could test assumptions, become abstract thinking, make generalizations and pass from one event to other using abstract concepts (Lerner, Eastbrooks, Mistiry, 2003; Yavuzer, 1998). They gain skill on thinking ability for future changes. Adolescent could develop thoughts connected to themselves, other people and world. Abstract thinking stage gives opportunity to the adolescent to evaluate probable solutions systematically and instantly to solve a problem (Temel, Aksoy, 2005).

Cognitive development is also influenced by culture and gender. The ideal person is assumed at the end of cognitive development according to Piaget's theory. Piaget accepted that his description of the end point might not be suitable to all cultures because of cultural variation. It would be intellectual snobbism to believe that the formal operations stage is always superior (Dacey, Travers, 1999).

1.2.3. Emotional Development

After a long and stable behavioral period, children suddenly find themselves in an unstable phase “adolescence period”. Adolescence is not a desired part of life and thus it is very hard for the developing child to live in this period (Yavuzer, 1998).

Susman’s research focuses on the relation between hormonal levels in adolescence and emotions such as aggression and depression. There are some consistent connection between specific hormones and feelings of aggression and depression. However, only small proportions of variance in emotion (up to 6%) can be assigned to hormones (Lerner, Easterbrooks, Mistry, 2003).

Some contradictions in adolescent’s emotional life attract attention. Besides the pleasure to be lonely, desire to join a group; looking down on the adult but depending-wanting support from them; despite anxiety and hopelessness, enthusiastic movement towards future could be counted as the evident conflicting feelings in this period. A child that has a successful childhood in the emotional and social interaction with family more easily solves the adolescence period problems. Mostly observed emotional forms in adolescence period are fear, anxiety, anger, frustrations and stress (Yavuzer, 1998; Moshman, 2005).

Adolescence is also a time that many choices are made by individuals and engagement in broad range of behaviours that are likely to affect rest of their lives. Future educational and occupational plans are started to be made in this period (Salkind, 2001).

1.2.4. Personality Development

The ideal time for considering personality and temperament is adolescence period as the transition period between childhood and adulthood (Lerner, Easterbrooks, Mistry, 2003).

The physical changes of adolescence is seen by Sigmund Freud as a reason for conflict.

This conflict prepares the genital stage of mature adult sexuality according to Freud’s view. The libido, which is the energy source that fuels the sex drive, is re-awaken by the physiological changes of puberty. The sexual urges are directed into socially approved channels (Papalia, Olds, 1992).

Erik Erikson believed that the resolve of the conflict of identity versus identity confusion to become a unique adult with an important role in life is the main task of adolescence. Identity is a secure sense of self. Failure to develop self-awareness or cohesive self is identity confusion. Part of the resolution of the identity crisis is to move from being a dependent person to being independent person. Person's identity is formed by the organization of the abilities, needs and desires by ego and helping them to adapt to the demands society (Temel, Aksoy, 2005; Papalia, Sally, 1992; Kaplan, Grebb, Sadock, 1994).

1.2.5. Social Development

Adolescence period is independency period. It is involvement period to the community. Adolescent come off from home and heads to environment. Attention to communal events and politics increases. Heard or loaned opinions are defended; discussed with older people. In this period, adolescent enjoys opinion exchanges and thought discussions (Yörükoğlu,1998; Dönmezer, 2003).

In society adolescent needs to gain respect (prestige) and status. In general measure, social adaptation depends on the satisfaction of these necessities. Adolescence period could be described as social development and adaptation years (Yavuzer, 1998).

In this development period, adolescent's participation to the society and their attribute to take part and keep their situation depends on the gain of certain knowledge, ability and experience. At the end of the adolescence period, adolescents become fully united with their environment, conscious about their own personality and their sense of identity has been developed (Yörükoğlu, 2000).

1.3. Adolescence and Depression

In this stormy period, more spiritual problems are expected to happen. Actually, investigations reveal that during this period 10-15% of adolescents face maladjustment problems (Yörükoğlu, 2000).

Mostly, the reason of this maladjustment can be depression. During adolescence, especially during early periods, depressive symptoms are not always typical. During

early adolescence period, masked symptoms of depression are observed. Depression occuring during late adolescence period mostly resemble adult depression (Akman, 2006).

Since children's and adolescent's life experiences are less than adults and since there is a little comparison possibility, children and adolescents can accept this situation as normal. Furthermore, in relation to this, they generally show their depression by their behaviors, because they can not express their emotional situation in words as good as adults do (Ercan, Turgay, 2004).

1.3.1. Depression Symptoms of Adolescence:

- Feeling unhappy or sad
- Not finding pleasure in doing things that fancy in doing before or not enjoying as if before.
- Often crying for unimportant things or need for crying
- Hopelessness for future.
- Feeling worthless: Often mentioning that noone in the home loves him/her or his/her sibling is more loved than himself/herself
- Feeling guilty: Feeling himself/herself as a cause of all negativity
- Often mentioning death or committing suicide or telling words like "I will run away from here!"
- Attempt committing suicide or presence of other behaviours that will harm self
- Dealing with mother-father until get them angry. Conflicts in relationships with people close to him/her, often arguments and be offended.
- Being tight, uneasy and restless. Often using words "I am bored".
- Complaining about body: Often feeling headache, stomachache or tiredness.
- Changes in apetite: Eating less or more compared to the past. More selective on food compared to the past, to make a fuss on food or make problem on food.

- Sleeping disorders: Sleeping late and hardly waking up in the morning. Changes in sleeping habit; could not sleep alone, troubled sleeping, fear while sleeping or before falling asleep, often telling that he/she sees bad dreams.
- Decrease in self-confidence: Starting every job by telling "I can not do this, I can not manage in doing this"
- Angriness and rage attacks.
- Excessive touchiness
- Decrease in interest on lessons, evident decrease in success.
- Going bad in relations with friends or formation of negative friendships, feeling himself/herself alone.
- Changes in music pleasure: Listening more marginal music (such as while listening to pop music suddenly starting to listening to metal music or while liking folk music tending towards arabesque music).
- Decrease in self-esteem
- Having unreal anxiety such as he/she is not attractive or he/she is not loved by others.
- Having more arguments with his/her father-mother and teachers.
- Avoiding cooperation in family problems.
- Difficulties in concentration
- Acting out like anger, rage attacks, escapes, rebellious and anti-social behaviours.
- Aggressive, thoughtless or increase in risk taking behaviour (Ercan, Turgay, 2004; Quinn, 2002; Saygılı, 2006; Köknel, 1997; Akman, 2006; Yörükoğlu, 2000; Shapiro, 1997; Kulaksızoğlu, 2004; Miller, 2002; Orvin, 1997).

1.3.2. Etiology of Depression during Adolescence

As in most of the psychiatric disorders, appearance of childhood and adolescence period depression could not be connected to a single cause. Causes that could give rise to depression during childhood and adolescence period:

1.3.2.1. Biopsychosocial Model

During adolescence period, changes occurring in physical, social and psychological areas result with the development of the individual to take his/her part as a person between adults. When development is insufficient, psychological problems in adolescence period could come out. According to biopsychosocial model, adolescence depression is explained as a result of biological, psychological, social or environmental effects but each effect may play less or more role in it (Ercan. Turgay, 2004).

1.3.2.2. Heredity

Researches show that the probability to undergo depression of the primary relatives of depressed children, especially mothers, are four (4) times more compared to the normal children's primary relatives. In cases when the mother-father are in depression, the probability of their children to undergo depression increases three times. The psychiatric disorder of mother increases the possibility of the depression of their children; the risk of psychological indisposed of children is three times more when their mothers have a psychiatric disorder. The occurrence of depression at the biological relatives of an adopted and depressed children is eight times more than the adopted but not depressed children. Researches on the twins for childhood depression showed that when one of the identical twins has depression, the occurrence of depression on the other is 60% while this ratio on non-identical twins is 20% (Ercan, Turgay, 2004; Şemin, 1992).

1.3.2.3. Hormonal Factors

Important hormonal change during the adolescence period is the reason why the rate of depression at adolescents is more compared with the children. Hormonal disorders mostly observed during depression are the defects in cortisone and growth hormone secretions. However, while these hormonal disorders are seen at some depressed

adolescents, it is not seen on the others. Therefore it could not be said that hormonal disorders directly cause depression (Ercan, Turgay, 2004; Quinn, 2000; Shapiro, 1997).

1.3.2.4. Psychological factors and problems in the mother-father-adolescent relations

Problems in the mother-father-adolescent relation have an important role in the psychological causes of childhood and adolescence depression. Irregular family structure is one of the important factors. Becoming early or late mother-father, family and environmental factors such as being neglected and living long time as unhappy, insufficient mother-father love, continuously becoming unsuccessful at school and other areas in life, and loss of love relations can form basis of depression (Ercan, Turgay, 2004; Yörükoğlu, 2000 ; Shapiro, 1997).

Also adolescent's perception of the family economic status as low may cause reduced sense of control or mastery over time. Increased emotional distress is associated with low mastery. When family has economic problems, the adolescents are under risk for internalizing the problems (Conger *et. al.,* 1999)

One of the important reasons that could increase the risk of depression occurrence in children is physical or sexual abuse (Ercan, Turgay, 2004; Yörükoğlu, 2000; Shapiro, 1997).

Retrospective studies show that depressed individuals report their parents to be more controlling and rejecting than do non depressed controls (Muris *et. al.*, 2001). According to Kaplan and Sadock, children of divorced and single-parent families are associated with broad range of problems. These problems include low self-esteem, increased risk of child abuse, increased incidence of mental disorders, particularly depressive disorders and antisocial personality disorder as adults, and increased incidence of divorce when they eventually get married. In addition, the death of a parent during childhood or adolescence period is associated with adverse effects like an increase in later emotional problems, particularly susceptibility to divorce or depression (Kaplan, Grebb, Sadock, 1994).

Etiology of depression in adolescents has been connected with several psychological and psychosocial factors. Negative attribution style is an important factor that has received a significant research attention. It is evident that high levels of depression in adolescents are associated with to internal-global-stable attributions for negative events and this is applicable for positive events as well (Muris *et. al.*, 2001).

In addition to these reasons, occasions that decrease the self-esteem of the adolescent such as trouble in the family, divorce, death of mother or father, maternal or paternal depression or existence of other psychiatric disorders in parents also increase the risk of depression (Ercan, Turgay, 2004;Yörükoğlu, 2000)

1.3.2.5. Epidemiology and Prevalence of Depressive Disorder in Adolescence

There are many researches focusing on the frequency of adolescent and childhood depression.

Depression is among the most prevalent mental disorders to afflict adolescent, approximately 20 % experience an episode of major depression during their teens (Smolkowski *et. al.,* 2006).

Epidemiological studies suggest that the prevalence of significant psychiatric disorder among adolescents is around 18-21% (Calton, Arcelus, 2003).

The results obtained from researches revealed that the frequency of depression in children is 1-3%. It is observed that this frequency increases to 3-9% in adolescents. If we look at the gender differences, until adolescence period, depression affects girls and boys the same. However, after twelve years old, the ratio increases for girls. At the age of fourteen, the risk of girls to undergo depression increases approximately two times more than boys (Ercan, Turgay, 2004; Shapiro, 1997; Kulaksızoğlu, 2004).

The life time prevalence of depression in adolescents, which varies between 15-20 %, is comparable with the life time rate in adults and this suggests that the onset of depression in adolescence is frequent (Muris *et. al.*, 2001).

It is observed that adolescents coming from a low socio-economical level family undergo depression more. It is also found out that problems in the family, negative life

experiences, low self-esteem and lack of success at the school increase the risk for depression (Kulaksızoğlu, 2004).

1.3.2.6. Attempt to Commit Suicide in Adolescence

Increased risk of recurrent episodes, other forms of psychopathology, suicidal risk and long term psychosocial impairment are evident in the individuals that experienced clinical depression in adolescence (Georgiades *et. al.*, 2006)

90 % of the individuals committing suicide have a psychiatric disorder. Depression and bipolar disorder are the mostly observed psychiatric disorders related with committing suicide. 15 % of the adolescent having mood disorder commit suicide. It is not a small probability that long time unrecognized and uncured depression drives the individual into committing suicide. Like depression, interaction of factors such as heredity, biological imbalance, adolescent's emotional disorders, violence and trouble in the family, problems in the mother-father-child relation, adolescent facing negative life events could result in committing suicide. Not all of the depressive situation ends with committing suicide but all of the committing suicide events include depression at some point (Ercan, Turgay, 2004; Yörükoğlu, 2000; Quinn, 2002).

Committing suicide significantly increases at adolescence period. New arguments and circumstances appearing at the adolescence period is added to the adolescent's childhood problems. Adolescent's relation with his/her environment breaks down, he/she become lonely and unsupported. Generally, one event, one argument, one shock may break off the adolescent's defences and this gives rise to committing suicide. Adolescents, who have important arguments with his/her family and society and can not find a way to overcome this, may commit suicide. Rigid parental styles or reproach of the parents, an unexpected slap may create negative feelings in some adolescents. When this feeling combines with the complicated feelings of adolescence period, then with an impulsive behavior this gives rise to committing suicide. Presence of unstable and defected relations in the family is an important reason in the adolescent's committing suicide. (Yörükoğlu, 1998; Yörükoğlu, 2000).

Symptoms of committing suicide resemble symptoms of depression. These could be listed as change in school performance, change of friends, keeping away from activities and friends, trouble in the family. Symptoms for an adolescent that is prone to committing suicide are as followings:

- Previously trying to commit suicide
- Experiencing psychological problems in the past
- Alcohol and drug abuse
- Mentioning about death or committing suicide(Shapiro, 1997).

Accidents and committing suicide are the first reasons for the children and adolescent deaths. According to Turkey State Statistic Institute data, committing suicide is mostly seen at the 15-25 years old adolescents (Ercan, Turgay, 2004).

According to the research carried out by Sonuvar and Yörükoğlu (1971) in Turkey on the children and adolescents that commit suicide, these data is found about the children and adolescents' families:

The fathers of 5 of those 30 children were death. One of the fathers and four of the mothers committed suicide. Four of the parents were divorced. Besides the families that remained fatherless, it is determined that there was an obvious parental disagreement and discord in 17 of the remaining 21 families. (Yörükoğlu, 2000)

Every year 4000 adolescents aged between 15-20 commit suicide in USA. This forms 12% of the suicides in the total population.

According to the research in USA carried out by Teicher and Jacobs (1966), it is determined that 72% of the adolescents lose their father or mother because of death or divorce and 58% of the adolescent's father or mother made more than one marriage (Yörükoğlu, 2000).

According to Bronfenbrenner's (1979) social-ecological theories, behavior of family members are influenced by dynamic and mutual relations with the friends, school, work, neighbourhood, and community of the child. Individuals from socially disadvantaged background, which is characterized by low socioeconomic status, limited educational

achievement, low income and poverty, have an increased risk of suicidal behaviour (Ulusoy, Demir, 2005).

1.4. Family

1.4.1. Definition of Family

According to the definition of family given by the Turkish Family Structure Specialization Commission; family is formed of people mostly living together and that have a blood tie, marriage and kinship relationship via other legal ways; a unit that every person's sexual, psychological, social and economical needs are covered and their adaptation and participation to the society is supplied and arranged (Nazlı, 2001).

Family is a social unit that experiences some developmental stages, which could nearly be universal, are lived in. "Family" is described as the smallest social "unit" in society that is formed by the relationship depending on the blood tie between wife, husband, children and siblings (Özgüven, 2001; Gülerce, 1996; Öztürk 2001).

It is the first social system that the child knows and in which he grows, and from it he must gain abilities such as familiarity with the basic roles carried out in the society in which he lives: the roles of parents and child, of boy and girl, of man and woman, of husband and wife, and how these roles impinge upon the broader society and how the roles of others impinge upon the family and its members (Lidz, 1968).

1.4.2. The Functions of Family

Family has three main functions:

1- Answers physical needs of the members

2- Develop autonomy in children

3- Balance and supply development of the personalities of mother and father (Özgüven, 2001, Kulaksızoğlu, 2004).

One of the functions of the family is aid their children. It could be made in two ways:

Nutrition, warmth, and shelter, and protection from danger are the immediate animal needs that the first way family could help; secondly providing the environment in which the children could develop physical, mental and social capacities to the full that will make the children able to deal with physical and social environment effectively when grown up (Bowlyby, 1965).

According to the family system perspective, family is a complex structure that shares a past, has an emotional link and individuals that plan strategies to cover needs of the individual family members and the whole family (Nazlı, 2001).

Subsystems including members of the same generation (as in parent-parent relationships), the same sex (e.g. fathers and sons), or function (parent-child) forms the family system. The key relationships that interact with each other to form a relational subsystem are contained by limits (Pryor, Rogers, 2001; Wade, Tarvis, 2005).

The aspects of system perspective which underlie the model to be presented can be summarized also as follows:

- Relation of parts of the family to each other
- One part of the family can not be understood in isolation from the rest of the system
- Family functioning is more than just the sum of the parts
- A family's structure and organization are important in determining the behaviour of family members.
- Transactional patterns of the family system are involved in shaping the behaviour of family members (Epstein, Bishop, Levin, 1978).

According to Epstein, Bishop and Baldwin (1984), which described the Mc Master of family functioning, there is an assumption that the primary function of the family unit is to supply a setting for the development and maintenance of family members on the social, biological and psychological levels.

Family issues are divided into three task areas; the basic, the developmental, and the hazardous. The basic task area is the most essential of three areas. It is to provide food, money, transportation and shelter. The family issues related to the stages of developmental sequence of the family falls to the developmental task area. How families handle crises resulting from accidents, illness, or loss of income or job is included in the hazardous tasks area. Family functioning, problem solving, communication, roles, affective responsiveness, affective involvement, and behaviour control are the six dimensions of this model. Explanation of these dimensions;

Problem solving: the ability of the family to solve problems at a level that keeps effective family functioning.

Communication: the exchange of information directly and clearly.

Roles: established behavioural patterns for handling family needs, including assignment of tasks appropriately and responsible carrying out the tasks.

Affective Responsiveness: the expression of suitable affect over a range of events.

Affective Involvement: mutual appreciation on concerns and activities

Behavior Control: the maintenance of behavioural standards.

General Functioning: An independent overall of the above, to indicate extensive health/pathology (Zeitlin, 1995; Epitein, Bishop, Levin, 1978; Hinde, Akister, 1995).

In their studies on family essence, Fitzpatrick and Badzinski described family concept as a small social group that is constructed with blood tie and its main function is to feed and socialize the new born children (Gülerce,1996).

Moderate levels of cohesion and flexibility, a balance between closeness and individuality, egalitarian leadership, democratic approaches to discipline forms the overall family system functioning and it uses positive communication skills. Olson (1992) identifies four types of overall family functioning:

a) Balanced families: tend to report moderate levels both cohesion and adaptability,

b) Moderately balanced families: report slightly higher or slightly lower than moderate levels of both cohesion and adaptability,

c) Mid-range families: tend to report a slightly higher or slightly lower than moderate level of either cohesion or adaptability with extreme score on the remaining dimensions,

d) Extreme families: report extremely high or extremely low levels of both cohesion and adaptability (Henry *et. al.,* 2006).

1.4.3. Family Types

1.4.3.1. Extended Family

Extended family is a life style that more than one generation mostly lives under the same roof with close relationship and cooperation. Family members obey this hierarchic system and they live in a division of labour, cooperation and integrity. Since responsibilities related to the life in society is scattered to the whole family members, individual responsibilities decrease, in contrary, responsibility of obeying the rules in family increase and freedom of behaviors is restricted (Özgüven, 2001; Temel, Aksoy, 2005).

In this kind of family, power is more on man and responsibility is on woman.

Family system is set up in the direction of elder's experiences and continues under their control (Aydın, 2003).

Education in extended families, is authoritarian and focuses more on matter and problems. The aim is to make the children dependent on the family. In these families, girl-boy discrimination operates and girls are prevented from benefiting the educational opportunities. This kind of education, which does not depend on children but on pressure, gives rise to a dependent character development in children (Özgüven, 2001).

1.4.3.2. Nuclear Family

Nuclear family is a social unit that is connected with marriage agreement and blood tie. It includes two generations as mother, father and children and the family members are limited in numbers. Continuations of traditional extended family structure in city life

become impossible. Therefore, the family size is diminished and the widespread family type become "nuclear" (Özgüven, 2001; Gülerce, 1996; Temel, Aksoy, 2005).

In nuclear family, people continue their democratic lives under equality, freedom, respect, love and mutual understanding. Responsibilities are shared among all members of the family depending on their age and skills (Aydın, 2003).

As woman's education level increased, mother's rights and activities in family have been increased. Relations have become softer and developed towards equality. The number of children in the family has been decreased and the value given to children has been increased (Yörükoğlu, 1998).

Parallel to the change and development in society, changes in the family structure as well as the function of the family has taken place. In this respect, nuclear family has lost most of the functions of extended family and two social functions are performed. These are; continuation of the race and socialization, and keeping up psychological balance (Özgüven, 2001).

1.4.4. Healthy Family versus Unhealthy Family

Shortly in literature, functional family is described as "healthy" and dysfunctional family as "unhealthy". Nystul gives the functions of the healthy family as follows: gaining the skills of sharing emotions, understanding feelings, accepting individual differences, transmitting relation and love, cooperation, sense of humour, covering the basic needs, solving problems without argument, possessing social values, agreement and taking responsibilities, expressing mutual appreciation, communication, spending free times together, believing in spiritual values, and coping with problems (Özgüven, 2001).

The healthy or effectively functioning family is expected by the Mc Master model of family functioning to cope with every dimension successfully. Healthy families solve their problems easily, communicate directly and clearly, have reasonable and clear roles and accountability, are capable of expressing a full range of feelings, have flexible behaviour control, have empathic involvement in particular interests and activities of individual members. (Zeitlin *et. al.*, 1995).

Five characteristics of family functioning was identified by Jerry M. Lewis and his colleagues as followings:

- Mutual affection and trust in one another and the community
- Respect for individual differences in perception and feelings.
- The ability to communicate
- The ability to accept loss
- Clear-cut boundaries between parents and children (Hyde, 2001).

According to Ackerman (1967), healthy family members could perceive themselves spiritually and could fully express themselves to the others. They could look at the events from different viewpoints. Healthy family members could perceive other people as sympathetic. They are realistic, flexible, and creative and they could reasonably solve their problems.

According to Bowen (1981), members of a healthy family lead their lives according to their aims and values. For this reason, they do not affect others. Differentiated self develops in family members. This happens in a mental process rather than an emotional process.

According to Satır (1981), mature family members respect themselves and they have positive personality perception. They accept all of their bodies, fantasies, functions, thoughts, feelings, behaviours, faults and achievements. Family members can freely express their own ideas, expectations and fears without any worry (Nazlı, 2001).

In healthy family, duties are completed fully and appropriately. Family has three main duties:

a) Family is a legal unit that meets the partners' emotional and sexual needs.

b) Family is a group of people that has common aim, profit, beliefs and rules.

c) Family is the environment where children are fed, looked after and educated

(Yörükoğlu, 1998).

In healthy families, it is known and accepted that every child has his/her unique personality. In healthy family there is unconditional love. There is a healthy communication and dialogue between members of the family especially between mother-father and children. Socialization is firstly obtained in the family environment. For this reason, as a structure, family and relations in the family have an important effect on the children (Özgüven, 2001; Dikeçligil, Çiğdem, 1991).

As healthy families succeed to stay in balance, unhealthy families can not succeed this. While they deal with regular duties, they may not be successful. The general atmosphere in the family is argumentative, irregular and there can be physical and psychological symptoms in family interactions (Nazlı, 2001).

In unhealthy families, no one listens to the other and therefore healthy communication is not established. Relations between individuals depend on the basis of fear and hate. In these families there is conditional love. Conflicting tendencies, misunderstandings, irritabilities and vexations reveal. If a family member expects his/her requests to be understood by everybody without an explanation, then disappointment, reproaches and tension become unavoidable. A selfish member that insists to prioritize his/her needs gives rise to arguments (Yörükoğlu, 1998, Özgüven, 2001).

In discrete families, members have independent and autonomous functions. Family members are loosely connected to each other. There is an insufficient and unhealthy communication in these families, because members do not learn how to communicate in the family. This communication problem causes problem in exchanging feelings in the family. In this kind of families, members are under risk of showing lots of problematic behaviours (Nazlı, 2001; Kulaksızoğlu, 2004; Zeitlin *et. al.*, 1995).

At unhealthy families, it is not known and accepted that every child has his/her own personality; can be different in capacity, ability, natural tendencies and interests. In connection with this, children grown up in unhealthy family environment do not develop normally. When they become adults, they form unhealthy families for their children (Özgüven, 2001). On the other hand dysfunctional relationships have been considered to play an important part in the onset and maintenance of psychiatric disorders, particularly depression (Wilhelm, Boyce, Brownhill, 2000).

1.4.5. Parenting Styles

1.4.5.1. Authoritarian Parents:

Authoritarian parents are demanding, and for them immediate obeying is the most wanted child characteristic. Family environment is stressed and relations are hostile. Children's trust to him/her is removed and this is an attitude that disregards his/her personality. Plenty of criticism, scolding and beating are present. Family members do not show the sign of listening or understanding each other and do not investigate his/her behaviour (Dacey, Travers, 1999; Yörükoğlu, 2000; Aydın, 2003).

1.4.5.2. Authoritative Parents

Authoritative parents respond to their children's wishes and needs. They expect mature behavior and will enforce rule, however they also encourage independence and search potential of their children.

Child is no doubt accepted as an important person in the family and father-mother are sensitive to child's needs. Father and mother having tolerance to their children means they let their children, except some restrictions, able to succeed their wishes as the way they wanted. In this kind of families, there are mutual rights, responsibilities and rules. People are aware of this. Love shown to the child does not make him/her dependent, is moderate and it is an approach that gives chance to the development of balanced personality (Kırkıncıoğlu, 1999; Aydın, 2003; Dacey, Travers, 1999; Cüceloğlu, 1999).

1.4.5.3. Permissive Parents

In this kind of families, children have authority on mother and father and they show little respect to them. Children make almost all of their decisions. Also, in this kind of families depending on the excessive tolerance, children never learn what is true and what is wrong. No limits are drawn to the child and child is never punished (Kırkıncıoğlu, 1999; Aydın, 2003; Dacey, Travers, 1999; Cüceloğlu, 1999).

Generally, according to experimental studies, the most effective parenting involves consistency and reward for good behavior while punishment for unwanted behavior.

However both should occur in a warm and loving environment context (Kaplan, Grebb, Sadock, 1994).

1.5. Adolescence and Family

In family, which is a dynamic system, the interaction between members affects all of the family members; discomfort in one of the members not only affects that person but also affects the whole system (Özgüven, 2001).

There are a lot of factors that positively or negatively affects and directs communication in family. These factors are as active and important as the environment that the person communicates. The values that the person possesses, the differences in temperament and personality structure, economical problems and socio-cultural values are the main causes (Girgin, 2006).

Love and affection are superior as defining features of families across all age groups, and married two- parent households with children are nearly universally accepted. According to adolescents, families do not require legal marriage and encompass a wide range of groupings; however they do not actually accept family members who are not living together and who does not have children (Pryor, Rodgers, 2001).

Parents and adolescents less frequently interact with each other compared with the times in middle childhood. According to some researches, the occurrence of this distance in parent-adolescent relations has great functional value for adolescents. This distancing fosters the individuation of adolescents from their parents, allows them to try more things on their own competences and gives confidence in their abilities (Salkind, 2001).

The need for the realization of how the adolescents are dependent on their family makes them feel a constant tension on them to break away from their families. While keeping parental and family ties, adolescents simultaneously try to establish their own private identity (Papalia, Olds, 1992; Kulaksızoğlu, 2004). While adolescent passes from being childish dependant into free adult condition, socialization period inclines depending mostly on the family structure that the adolescent lives in. (gençlik) Adolescent try to establish a personal identity, become independent from their parents but they stay close

enough to the family structure. They often look themselves through the views of their friends, and any change in appearance, dress code, or behaviour can result in decreased self-esteem (Kaplan, Grebb, Sadock, 1994).

Before adolescents prove themselves or to be obliged to be a perfect adult, they want to be loved and accepted by their parents without any condition. When adolescents are continuously criticized, they tell that they are feeling in difficult condition and adolescents want to be listened and understood by their parents. According to adolescents, parents that show interest and willing to help and support when needed, creates the feeling that they are loved and protected (Özbay, Öztürk, 1992).

When adolescent and parents insist on their own opinions, depression period becomes unbearable to both adolescent and parents. Adolescents despise their father and mother on their thoughts. Generally, they tend to regard their parents as old minded. Adolescents feel that they are superior to their parents. This causes decrease of adolescent's respect to their parents (Çakmaklı, 1999).

During adolescence period the relations of parent-child do change. As physical maturation of adolescence increases, they often look for more independence and autonomy. They may begin to question family roles and rules that could lead to conflicts particularly on dress, appearance, tasks and dating issues (Salkind, 2001).

Nowadays, adolescents tend to be related to only father-mother rather than wide family members like grandmother-grandfather, paternal or maternal aunt, uncle and cousins. In our community, changes in values cause indefiniteness in adolescent's duties and responsibilities and make it difficult to them to adapt these changes. In this situation, "generation conflict" fact appears (Temel, Aksoy, 2005).

When adolescent is at home, arguments and tension in family is further observed. One of the reasons of these difficulties is caused because the parents do not know what their children want and children do not know what their parents want. Generally, youths in their adolescence period are not being understood by their parents and this is also confirmed by the mothers and fathers. Actually, adolescents in fluctuating feelings, in

changing thoughts and actions are not an easily understandable person (Öztürk, 2001; Nazlı, 2001).

The second reason is that adolescent's aggressive, demanding and autonomous requirements come out. This autonomous requirements progress in three areas;

a) Behavioral Autonomy: When adolescent's activities out of home increases, their desire to be more independent increases. When some of these activities are not accepted by the parents, arguments arise.

b) Emotional Autonomy: This means that adolescent's need to decrease or change their strong emotional relation to their parents. New relation forms are developed instead of the decrease or cease of their relation to their family.

c) Value Autonomy: Formation of the person's own value systems starts in adolescence period, but this period in adolescents is defined as they start to take decisions related to their own family and their relations (Nazlı, 2001; Özbay, Öztürk, 1992).

According to some evidence, adolescents who believe their parents are not supplying them enough "space"- parents that fail to loosen their restricting quality and power have tendency to acquire more extreme peer orientations and to look for more opportunities for peer advice (Zanden, 1997).

The association between a range of family problems and child and adolescent psychiatric disorders have long been widely accepted (Tamplin, Goodyer, 2001).

The development of key psychosocial resources could be disrupted by the lack of parental support during childhood. More specially, early parental support is believed to be linked to the development of current supportive social relationships, a sense of personal control and a sense of self-worth. Both mental and physical health outcomes are associated with each of these key psychosocial consequences of early parental support (Shaw *et. al.,* 2004).

Parental support is defined as rearing adolescents through parental behaviours such as general support, encouragement, praise, or physical affection. The well being of

adolescent such as general competence, identity achievement, academic success and self-esteem, family life satisfaction, and career self-efficacy are positively related by parental support. However, parental support is negatively related to alcohol misuse, problems in identity or in peer relationship, diet disorders and depressed affect (Henry *et. al.*, 2006).

Development of depressogenic schemata and attribution styles are significantly theorized to be affected by the insecure attachment to the parents. Child characteristics with poor parent relations could result in a cycle of difficulties with friends that may form a susceptibility factor for depression (Armsten *et.al.*, 1990).

It has been found by the investigation carried out by Cecilia A. Essau that parent attachment was significantly lower among the depressed (pure or comorbid) than among the adolescents without any disorder. Parent alienation was significantly higher in the depressed than the nondisordered adolescents and scores related to parent communication and trust were significantly lower (Essau, 2004; Wilhelm, Boyce, Brownhill, 2000). According to the study carried out by Kaslow, Rehm, & Siegel (1984), self-described depressed children explained their parents as less vacant and less nutriting than nondepressed children did (Kaslow, Rehm, Siegel, 1984).

In psychiatric cases, family studies on child and adolescent have also produced conflicting result on wheter interactions of dysfunctional family vary between depression and other psychiatric diagnoses. According to Friedman, McDermut, Solomon, Ryan, Keitner & Miller, general stressor that is reflected in poor family functioning is thought to be caused by a family member with any psychiatric illness (Tamplin, Goodyer, 2001; Keithner *et. al.,* 1995).

The quality of parent-adolescent relationships is one obvious candidate. According to a research, negative relationships with parents are associated with adolescent depression and aggression. Especially perceived parental rejection is one of the negative relationship factor. Perceived parental rejection is defined as an adolescent's belief that his or her parent is not concerned or interested in him or her as a person. Perceived parental rejection has been demonstrated to be related to adolescent depression (Hale *et. al.,* 2005).

According to Montemayor's foundation, adolescents had three times more conflicts with their mother than their father. Male adolescents had less conflicts than females. Most of the conflicts that females had with their mothers were longer and more intense than they had with their fathers. Also, females had longer and more intense conflicts compared with those reported by males (Fallon, Bowles, 1997).

In the context of family cohesion and adaptability the one of the study concluded that, correlations has shown that low cohesion was associated with depressive symptoms for both parents and adolescents (Prange *et. al.,* 1992). In the investigations on the family functioning it is observed that researches concentrates especially on the adolescence period. According to the investigations, committing suicide in adolescent has been shown to be related to the non-functional family (Nazlı, 2001).

1.6. The Importance of the Study

Depression is an increasing psychiatric disorder in our country, Turkey and throughout the world. Depression is the most prevalent mental disorder among adolescents (Karaveli, 2000). The attention is drawn to the relation between the family functioning and depression in the researches carried out in Turkey and foreign countries. It is determined that the results support the presence of the relation between defects in the family functioning and depression. While the number of researches in Turkey using Family Evaluation Measures is limited, there is not any research carried out in this area in our country (Karaveli, 2000).

During the last years various investigations have been carried out on depression in the world and a lot of results have been obtained. As we look at the recent researches on this area, physical and psychological factors are mentioned as causes of depression. When we look at the physical causes of depression, heredity and hormonal effects attract our attention. In addition to this, environmental factors especially relation of father-mother with adolescent attract attention among the psychological causes.

Interpersonal difficulties and lack of social support play an important role in depressive disorders. Interpersonal stress is an important risk factor in depression, and social

support is an important protective factor (Joiner, Coyne, 2000). Since primary social support of adolescents is given by the family, researches on the relation between adolescence depression and family structure is found in the literature. Taking this reality as a starting point, in the light of the references, we aim to investigate the relation between family structure and depression in adolescents in our country.

1.7. The Purpose and the Problem Statements of the Study

Basic aim in this study is the investigation of the relation between family function and depression in adolescents. The theoretical frame of this study is to take family function and problem areas defined by and related to the Mc Master Family Function Model as a basis. Family function and problem areas are the followings: Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement and Behaviour Control.

Relation between family functions and depression has been mentioned in a lot of researches carried out in Turkey and the world. Family structure and function is directly related with depression. As a result of hormonal and psychological causes, especially together with the adolescent's stormy period, adolescent's risk of depression becomes much more. Therefore we aim to investigate the relation between depression and family function in adolescents.

The problem statements of the research can be summarized as follows:

1. The main hypothesis of this study is to investigate whether defects in family function and relations have an effect on depression among the adolescents or not.
2. As the scores of Beck Depression Inventory (BDI) for the adolescents diagnosed with depression increase, the scores taken from subscales of Mc Master Family Assessment Device (FAD) will also increase at an unhealthy direction.
3. As the scores of Beck Depression Inventory (BDI) of the adolescents diagnosed for depression increase also the scores of Submissive Acts Scale (SAS) also increase.

4. As the scores Beck Depression Inventory (BDI) of the adolescents diagnosed for depression increase the scores of General Health Questionnaire (GHQ28) especially the subscale related to depression will also increase.
5. The scores of the depressive adolescents at four measures (BDI, FAD, GHQ28, and SAS); will be higher compared with the control group.

1.8. Limitations

1. The sample of the study is limited with 82 students who study at universities in TRNC.
2. The students have families with only middle or higher socio-economical status and education.
3. In this study only the perception of the family functions of the adolescents are investigated, the perception of family members can give different points of view.

1.9. Definitions

Major Depression: Disorder that include five (or more) symptoms such as depressed mood, loss of interest, weight loss or gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feeling worthless or guilty, concentration problems, thoughts of death, suicidal ideation or suicide attempt or specific plan for commit suicide that continue for at least two weeks.

Adolescence: It is a time of change that takes many forms, covering the physical, social and psychological areas and outlines the transition from childhood to adulthood.

Family: Family is formed of people mostly living together and that have a blood tie, marriage and kinship relationship via other legal ways; a unit that every person's sexual, psychological, social and economical needs are covered and their adaptation and participation to the society is supplied and arranged.

Family Functioning: The family functioning involves that cover members physical needs, develop autonomy in children, balance and supply development on the personalities of mother and father.

2. METHOD OF THE STUDY

2.1. The Sample of the Study

Experimental group formed from 30 adolescents that fulfill the following criteria and who have applied to the Psychological Counseling and Guidance Service of Cyprus International University and outpatient unit of Barış Psychiatric State Hospital come from Turkey.

- Diagnosed as Major Depression according to DSM IV criteria.
- Scoring 14 or more at Beck Depression Inventory (BDI).
- Not having a significant medical disease.
- Not having alcohol or drug abuse.
- Not receiving drug treatment during the research period.
- Not diagnosed for any psychiatric disorder other than Major Depression.
- 18-24 age group

Control group formed from 52 volunteer first class students of Cyprus International University taking the psychology course, they were from different departments and come from Turkey. Adolescents at control group are designated according to the following criteria.

- Not previously diagnosed for or received any help for a psychiatric disorder.
- Scoring ten (10) or less at Beck Depression Inventory (BDI).
- Not having a significant medical illness.
- Not having alcohol or drug abuse.

2.2. Instruments

In the collection of data in this study: Beck Depression Inventory (BDI), Mc Master Family Assessment Device (FAD), General Health Questionnaire (GHQ28), Submissive Acts Scale (SAS) and Biographic and Demographic Information Form are used.

2.2.1. Beck Depression Inventory (BDI):

BDI measures the emotional, somatic, cognitive and symptoms depending on motivation; it is used mostly at West; not depending on a specific theory and it is formed on the data obtained from clinical observations. First version was created at 1961 and revision was made in 1978 for this tool. It is formed of 21 items. BDI could be applied to the adolescents and adults over 15 years old. There is no time limitation. BDI includes 21 symptom categories:

- Mood
- Pessimism
- Sense of failure
- Dissatisfaction
- Feel of guilty
- Sense of punishment
- Hate to him/herself
- Guilt to him/herself
- Wishing to punish him/herself
- Crying attacks
- Irritability
- Social Introversion
- Instability
- Body image

- Obstacle of working
- Sleeping disorders
- Feeling tired and exhausted
- Loss of appetite
- Weight loss
- Somatic complaints
- Loss of sexual desire

There are four choices at each of the 21 symptom category in the form. It is requested from the person to select the best sentence that describes how he/she felt during the past week including the application day.

* Original Form:

1961 form was developed by A. T. Beck, C. H. Ward, M. Mendelson, J. Mock, and Erbaug.

1978 form was developed by A. T. Beck, A. J. Rush, B. F. Shaw and G. Emery.

Reliability: Test-retest reliability: Miller and Seligman discovered that the reliability coefficient is 0.74 with three months interval.

Two-halves test reliability: Reliability coefficient was found as 0.86 at the Beck's study. Also, it was observed that in various studies at the West various types of reliability coefficient ranges between 0.60-0.87.

Validity: Criterion relation to reliability: It was found out that the correlation coefficient is 0.75 when Hamilton Depression Rating Scale was used as criteria. Also, according to validity studies on students at the West, the validity coefficient was discovered to change between 0.65-0.68 range.

* Turkey Adaptation

Turkey adaptation was made by Buket Tegin (1980).

Reliability: Half Division Reliability: For this student group, the two-half test reliability of the measure was determined as 0.78 and for 30 depressive patients the coefficient was 0.61.

Test-retest reliability: The scale was applied to 40 social science students twice with two week intervals and test-retest reliability coefficient was found out as 0.65.

Validity: Criterion relation to reliability: The relation between the Beck Depression Inventory (BDI) and Cognitive Reactions Scale points was investigated at normal, depressive and schizophrenic people using Pearson's correlation technique. The correlation coefficient between the previously mentioned test groups are 0.20, 0.52 and 0.33 respectively.

The scores obtained from a selected test person from university students between Beck Depression Inventory (BDI) and Depressive Explanation Style Scale found out to have 0.29 Pearson's correlation. The scores obtained from Beck Depression Inventory (BDI), which is applied to neurotic depressions, and Multiphasic Personality Inventory Depression Scale has 0.77 correlation coefficient. According to a research on depressive tests and university students, the correlation coefficient between Beck Depression Inventory (BDI) and Depressive Explanation Style Scale points of depressive tests was found out 0.55 and the same relation was turn out to be 0.26 at university students (Savaşır, Şahin, 1997).

2.2.2. Mc Master Family Assessment Device (FAD)

This is a measure that aims to determine the family functions (structural and organizational quality, and relations and interactions in the family) as healthy/unhealthy. It could be applied to all family members over 12 years old. The measure is formed of 60 items with seven (7) subtests.

- Problem Solving (6 items)
- Communication (9 items)
- Roles (11 items)
- Affective Responsiveness (6 items)

- Affective Involvement (7 items)
- Behaviour Control (9 items)
- General Functioning (9 items) (Hinder, Akister; 1995)

FAD has: (a) adequate test-retest reliability, (b) low correlations with social desirability, (c) moderate correlations with other self-report measure of family functioning and (d) differentiates significantly between clinician – rated healthy and unhealthy families (Miller *et. al.*, 1985).

* Original Form:

The measure has been developed with the cooperation of Brown University Medical Faculty Psychiatry and Human Behaviours Department and Butler Hospital. The measure items of Mc Master Family Functioning Model have been formed depending on the clinical practice on the families. Six of the subtests are sub-measures dealt within the model and problem areas in the family functioning are taken up one by one. The seventh measure was developed by Epstein and Bishop (1983) to generally evaluate whether the family is healthy or not. Items were developed via making operational descriptions of every subtest. As a result of first topic test, measure was reduced to 53 questions; randomly questions were selected from every subtest and this event was continued until every sub-dimension internal consistency was increased to 0.70 Cronbach's Alpha Value.

Afterwards, 7 items were added and the question number was increased to 60 with aiming to increase the validity of the three sub-tests without alternating the correlation of the other subtests.

Reliability: Test-retest Reliability: The measure was applied twice to a group with 45 individuals with an interval of 15 days and the obtained correlation coefficient between the two application results was found between 0.66 (problem solving) and 0.76 (affective responsiveness) values.

Internal consistency: Cronbach's Alpha Values were changed between 0.72 and 0.92 values.

Validity: Construct Validity: Measure was applied to only one individual from each normal families (N=208) and families with psychiatric member (N=98); it was discovered that the subtest point average of normal families were lower than families with psychiatric member. Similar with the expectations, normal families were observed to be healthier.

Criterion relation to reliability: The measure was applied together with Philadelphia Geriatric Morale Scale and Locke Wallance Marital Satisfaction Scale to retired couples around 60 years old and the results were evaluated with regression analysis. A significant relation (r = 0.53) between Locke Wallance Marital Satisfaction Scale and the total points have been revealed. The relation between the points gained from Philadelphia Geriatric Morale Scale and the measure points was determined as 0.47.

In another study, FAD points of family members and the evaluations of an experienced therapist was compared. The FAD mean points of the families that had diagnosed as unhealthy by the therapist, except from the behaviour control subtest, was discovered to be high (unhealthy) and therefore it is concluded that six (6) of the seven (7) subtests are effectively enough to discriminate families with psychiatric disorder from normal families (Öner, 1994).

In a different study, the relation levels between measure and the Circumplex Model of Family Functioning's measure tools FACES II and Family Unit Inventory were determined and only Family Unit Inventory was shown a high correlation with the measure (Miller ***et. al***., 1985).

* Turkey Adaptation:

Turkey adaptation was made by Işıl Bulut (1990).

Reliability: Test-retest Reliability: The measure was twice applied to the staff and students of Hacettepe University Social Care Highschool with three (3) weeks interval; the relations between scores were evaluated using Pearson's correlation. The coefficients were determined as 0.90 for problem solving subtest, 0.84 for communication, 0.82 for roles, 0.78 for affective responsiveness, 0.62 for affective involvement, 0.80 for behaviour control and 0.89 for general functioning.

Internal consistency: Cronbach's Alpha Values, which that were obtained from 67 tests' measure subtests, were 0.80 for problem solving, 0.42 for communication, 0.59 for affective responsiveness, 0.38 for affective involvement, 0.52 for behaviour control and 0.86 for general functioning.

Validity: Construct Validity: The difference between measure point means, which was applied to women in divorce process (N = 25) and one of the couples continuing normal marriage (N = 25), were shown significant results in the range of 0.001 to 0.01 in all of the subtests of the t test. The measure was also applied to family members having a psychiatric illness (N = 190) or not having a psychiatric illness (N = 170) and a significant difference in the range of 0.001 to 0.01 was determined between two groups in every subtest.

Criterion relation to reliability: FAD and Marriage Life Scale (Evlilik Yaşam Ölçeği) was applied to 25 married individuals. The relation with the FAD's general functions subtest were investigated and the Pearson's correlation was found to be significant ($p<0.001$) and at the level of 0.66 (Öner, 1994).

2.2.3. General Health Questionnaire (GHQ28)

This is a measure that is used to search for the symptoms of anxiety and depression apart from psychiatry in the community. It could be applied to healthy tests, first step applicants to the health service, and patient group that has body related illness and does not have psychiatric illness. There are two forms of General Health Questionnaire with 12 and 28 questions. GHQ28 searches for the presence of the recent complaints of every individual and it is graded depending on four (4) Likert type based grade ranging from "less than ever" to "much more than ever". GSQ28 is formed of four (4) sub-measures that each is formed of seven (7) items.

These measures are:

A1-A7 Hypochondriasis

B1-B7 Anxiety and Insomnia

C1-C7 Corruption in Social Functions

D1-D7 Major Depression

Every item points are between 0-3 and overall measure points are obtained by the summation of the items points. In addition, there is a Goldberg type grade system.

In here, every items first two (2) answers receive zero (0) and last two (2) answers receive one (1) point and overall points are calculated by summation of these.

* Original Form:

Goldberg and Williams were developed GHQ12 and GHQ28 was developed by Goldberg and Hillier.

* Turkey Adaptation:

Turkey adaptation was made by Cengiz Kılıç (1996).

Reliability: In reliability studies, Cronbach's Alpha Value was found 0.78 for GHQ12 and 0.84 for GHQ28. Test-retest reliability was obtained r = 0.84 for GHQ12 and r=0.70 for GHQ28. Two-half test reliability correlation coefficient is r=0.81 for GHQ12 and r=0.67 for GHQ28.

Validity: In validity studies, ROC analysis was used and measure validity was obtained. For this purpose, with GHQ type grading GHQ12 definite point was calculated as 1/2 and for GHQ28 4/5 (Köroğlu, Aydemir, 2007; Tezcan, Aslan, 2000).

2.2.4. Submissive Acts Scale (SAS)

When approached to the depression from the view of Social Ranking Theory, the ranking-submissiveness dimension is proposed to explain the dependency better than attachment. It is told that the persons perceiving self at a lower level compared with the people important to self could increase the need for their approval and the need to be close to them. It is defended that depression could be explained as the "insufficiency fears" that could force the individual into a submissive statute. Submissive Acts Scale (SAS) was formed by Gilbert and his friends (1991). However, the basis of the measure depends on the item examples directed to submissive behaviours from the studies of Buss and Craik (1986). It was paid attention that measure items contain only social behaviours, and took care not to give place to sense expressions. SAS is improved in

order to measure the level of the submissive behaviours. In parallel with the "Social Dominance" theory that is pioneered by Price, the high correlations of SAS with depressive symptoms, sociotropic behaviours, the negative comments of individual with self could be accepted as the evidence of the validity of the measure. It measures the submissive social behaviours connected with depression. It is formed of 16 items and could be applied to adolescents and adults. It is asked in every item that how well the mentioned behaviours describe the person. The answers are requested according to the following options: "Not at all describes", "Describes a little", "Fairly describes", "Good describes", "Very good describes"

Items are evaluated according to the five (5) Likert type grade system from 1-5.

* Original Form:

It was improved in 1994 by P. Gilbert and S. Allan.

Reliability: Internal Consistency: Cronbach's Alpha Value was found as 0.89.

Test-retest reliability: This coefficient was found after the second test following 4 months interval as 0.84.

Validity: Criterion relation to reliability: Submissive Acts Scale's correlation was found to be 0.66 with Beck Depression Inventory, 0.65 with Sociotropy Scale, 0.06 with Autonomy Scale, and 0.50 with Social Comparison Scale.

* Turkey Adaptation:

Turkey adaptation was made by Nesrin H. Şahin and Nail Şahin (1992).

Reliability: Internal Consistency: The Cronbach's Alpha Value that is obtained from 540 high school and university students (263 girls, 277 boys) is 0.74.

Validity: Criterion relation to reliability: Submissive Acts Scale's correlation was found to be 0.32 ($p<0.001$) with Beck Depression Inventory, 0.36 ($p<.001$) with Sociotropy Scale, and -0.05 with Autonomy Scale. In another study carried on 627 university students, Brief Symptom Inventory's (BSI) sub-measures and SAS's correlations changes in the range of 0.16-0.42 and the measure could discriminate between the groups prone to or not prone to stress.

Construct Validity: It is observed that measure could discriminate the extreme groups formed according to Beck Depression Inventory (BDI<9 and BDI >17) with a significant p<0.000 level. Moreover, in regression analysis applied to methodize the depression, measured depression was observed to be methodized better by Submissive Acts Scale with Beck Depression Inventory compared with sociotropy, autonomy and shame feelings (Savaşır, Şahin, 1997).

2.2.5. Biographic and Demographic Information Form

This form is prepared by the researcher and it is arranged according to the suitability with the aims of the study. It is formed of 20 questions. Some of these questions are multiple choices and the remaining are open ended. In data analysis, the questions were re-coded by the researcher according to the formed categories. In the Biographic and Demographic Information Form, people are subjected to demographic features related questions (age, sex, which school he/she attends, where he/she lives etc.) and depression and family relations related questions as well.

2.3. Collection of Data

This was applied to the test group during 4 months by the clinicians working at Psychological Counselling and Guidance Service of Cyprus International University and polyclinic of Barış State Psychiatry Hospital to the adolescents diagnosed for depression according to the DSM IV criteria.

Biographic and Demographic Information Form, FAD, BDI, GHQ and SAS were applied to these adolescents respectively. Control group is formed by the volunteer students studying at Cyprus International University, taking the psychology course, they were from different departments and never applied for therapy. All of the previously mentioned measures were also applied to the control group. All of the measures were simultaneously applied to the two groups.

2.4. Data Analysis

All analysis are performed by using the SPSS 15.0 for Windows. The sex distribution, mother's job, father's job, school success, perception of parental relation, suicidal ideation and suicidal attempt data are comparing with Chi-square of the groups. The age, McMaster Family Assessment Device scores, General Health Questionnaire scores, Beck Depression Inventory scores and Submissive Acts Scale scores are compared with Student's t-test. The correlation between income of the families of groups are evaluated by Spearman statistical Analysis. The correlation between McMaster Family Assessment Device (FAD), Beck Depression Inventory (BDI), General Health Questionnaire (GHQ28), Submissive Acts Scale (SAS) scores with each other are calculated by Pearson correlation test.

3. RESULTS

In our study we had 30 students diagnosed as Major Depression according to DSM IV criteria. They had applied either to Psychological Counselling and Guidance Service of Cyprus International University (CIU) or outpatient unit of Barış Psychiatric State Hospital. The control group formed by 52 first class students of CIU taking the psychology course, they were from different departments. They had never experienced Depression and get less than 10 from Beck Depression Inventory.

Our experiment group is formed from 14 male (46.7%) and 16 female (53.3%) students and the control group is formed from 31 male (59.6%) and 21 female (40.4%) students. There is no statistically significant difference between sex distribution of the groups when we compare them with chi-square analysis (p=0,256). (Table 1)

When we compare the age of control and experimental group with Student's t-test, we find no statistical difference (p=0,599).

Table 1: Comparing Gender Differences of Students With Depression and Normal Controls

	Students With Depression		**Control Subjects**	
Sex	**n**	**(%)**	**n**	**(%)**
Male	14	(46.7)	31	(68.9)
Female	16	(53.3)	21	(56.8)
Total	30	(100)	52	(100)

p= 0.256

There is no statistically significant difference between sex distribution of the groups when we compare them with chi-square analysis (p=0,256).

Table 2: Comparing Mothers Job of Students With Depression and Normal Controls

Mother's Job	Students With Depression n	(%)	Control Subjects n	(%)
Civil Servant	8	(26.7)	5	(9.6)
Private Sector	2	(6.7)	3	(5.8)
Own Job	0	(0)	5	(9.6)
Housewife	19	(63.3)	36	(69.2)
Retired	1	(3.3)	3	(5.8)
Total	30	(100)	52	(100)

p=0.151

When we compare the mother's job of depressed and control subjects with chi-square, there is no statistically difference between them (p=0.151).

Table 3: Comparing Father's Job of Students With Depression and Normal Controls

Father's Job	Students With Depression n	(%)	Control Subjects n	(%)
Civil Servant				
Private Sector	13	(43.3)	14	(26.9)
Own Job	7	(23.3)	13	(25.0)
Unemployed	6	(20.0)	16	(30.8)
Retired	0	(0)	5	(9.6)
Military Service	2	(3.3)	2	(1.9)
Dead	1	(6.7)	1	(3.8)
	1	(3.3)	1	(1.9)
Total	30	(100)	52	(100)

p= 0.434

There is no statistically significant difference to the father's job between two groups when we compare them with chi-square analysis (p=0.434).

Table 4: Comparing School Success of Students With Depression and Normal Controls

School Success	Students With Depression n	(%)	Control Subjects n	(%)
Very Good	2	(6.7)	7	(13.5)
Good	9	(30.0)	22	(42.3)
Fair	11	(36.7)	23	(44.2)
Poor	8	(26.7)	0	(0)
Total	30	(100)	52	(100)

p= 001

When we compare the school success of two groups by chi-square, we find that control group report to have significantly better school success (p=0.001).

Table 5: Comparing Perception of Parental Relation of Students With Depression and Normal Controls

Perceived Parental Relation	Students With Depression n	(%)	Control Subjects n	(%)
Poor	10	(33.3)	3	(5.8)
Well	11	(36.7)	29	(55.8)
Very Well	9	(30.0)	20	(38.5)
Total	30	(100)	52	(100)

p= 0.004

When we compare to the two groups by chi-square, we find that the control group report significantly better perception of parental relation (p=0.004).

Table 6: Comparing Suicidal Ideation Scores of Students With Depression and Normal Controls.

Suicidal Ideation	Students With Depression n	(%)	Control Subjects n	(%)
Never Thinking	12	(40.0)	30	(57.7)
Occasionally Thinking	10	(33.3)	20	(38.5)
Sometimes Thinking	5	(16.7)	1	(1.9)
Frequently Thinking	3	(10.0)	1	(1.9)
Total	30	(100)	52	(100)

p= 0.023

When we compare suicidal ideation frequency of the students with depression to the control subjects with chi-square, we find that students with depression have suicidal ideation statistically more often than the control group (p=0.023).

Table 7: Comparing Suicidal Attempt Scores of Students With Depression and Normal Controls.

Suicide Attempt	Students With Depression n	(%)	Control Subjects n	(%)
Never Attempt	19	(63.3)	49	(94.2)
1 Times Attempt	10	(33.3)	3	(5.8)
More than 1 times	1	(3.3)	0	(0)
Total	30	(100)	52	(100)

p= 0.001

When we compare suicide attempt frequency of the students with depression to the control subjects with chi-square, we find that students with depression have attempt suicide statistically more often than the control group (p=0.001).

Table 8: Comparing Mc Master Family Assessment Device (FAD) Scores of Students With Depression and Normal Controls

Family Assesment Device Sub-Scales	Students With Depression	Control Subjects	p
Problem Solving	13.96 ±4.55 (n=27)	12.08±3.70 (n=50)	0.054
Communication	21±6.09 (n=28)	16.24±4.9 (n=50)	0.000**
Roles	24.61±6.21 (n=26)	20.81±4.22 (n=48)	0.003*
Affective Responsiveness	14.28±4.25 (n=28)	11.5±3.78 (n=50)	0.004*
Affective Involvement	14.66±2.68 (n=30)	13.31±2.69 (n=48)	0.034*
Behaviour Control	18.50±4.63 (n=28)	16.12±3.30 (n=49)	0.011*
General Functioning	25.27±8.51 (n=29)	19.48±6.71 (n=50)	0.001**

* p<.05 statistically significant difference

** p<.001 statistically significant difference

When we compare the Mc Master Family Assessment Device (FAD) subscales between the students with depression and control subjects with Student's t-test method, we find that communication subscale, roles subscale, affective responsiveness subscale, affective involvement subscale, behaviour control subscale and general functioning subscales are significantly higher than control subjects (p= 0.000 – 0,034). There is no statistically significant difference between the groups about problem solving subscale score (p=0,054).

Table 9: Comparing General Health Questionnaire (GSQ28) Scores of Students With Depression and Normal Controls

GHQ28 Sub-Scales	Students With Depression	Control Subjects	p
Hypochondriasis	10.06±5.68 (n=30)	7.16±4.80 (n=49)	0.017*
Anxiety and Insomnia	13.53±5.37 (n=30)	9.72±5.86 (n=51)	0.005*
Corruption in Social Functions	11.78±4.49 (n=28)	7.23±4.05 (n=52)	0.000*
Major Depression	10.93±6.07 (n=30)	4.49±4.50 (n=51)	0.000*
GHQ28 Total	46.78±18.08 (n=28)	28.58±16.45 (n=48)	0.000*

* $p<.05$ statistically significant difference

** $p<.001$ statistically significant difference

When we compare the subscale scores of General Health Questionnaire (GSQ28) of both experimental and control group with Student's t-test method, we find that students with depression have significantly higher scores from hyphocondriasis subscale (p=0.017) anxiety and insomnia subscale (p=0.005), corruption in social functioning subscale (p=0.000), major depression subscale (p=0.000) and GHQ28 total score (p=0.000).

Table 10: Comparing Beck Depression Inventory (BDI)and Submissive Acts Scale (SAS) Scores of Students With Depression and Normal Controls

	Students With Depression	Control Subjects	p
Beck Depression Inventory Total	29.06±8.15 (n=29)	13.50±6.10 (n=52)	0.000*
Submissive Acts Scale Total	40.17±13.26 (n=29)	35.72±9.23 (n=50)	0.083

* p<.05 statistically significant difference

** p<.001 statistically significant difference

When we compare the Beck Depression Inventory (BDI) scores of students with depression to control subjects with Student's t-test method, we find students with depression have significantly higher scores (p= 0.000). And we find no statistically significant difference about the scores of the Submissive Acts Scale (SAS) between two groups (p=0.083).

When we investigate the correlation between the age of the students with the scores of the scales with Pearson Correlation Test, we only find mild negative correlation (r=-0.26) between Submissive Acts Scale and age. Age is not a factor that correlated with the score of other scales (p>0.05).

When we investigate the correlation between income of the families and the scores of the scales with Spearman statistical analysis, we find no statistically significant correlation between them (p>0.05).

Table 11: Correlation of FAD Test Scores with BDI,GHQ28 and SAS Test Scores

Scales	FAD Com.	FAD Role	FAD Resp.	FAD Inv.	FAD Beh.	FAD Prob.	FAD Gen.
BDI							
Pearson C.	.456**	.444**	.400**	.459**	.298**	.271*	.420**
Sig.(2-tailed)	.000	.000	.000	.000	.000	.018	.000
GHQ Total							
Pearson C.	.168	.305*	.271*	.376**	.108	.181	.274*
Sig.(2-tailed)	.157	.011	.020	.001	.370	.129	.019
GHQ Hyp.							
Pearson C.	.127	.244*	.154	.312*	.040	.193	.173
Sig.(2-tailed)	.278	.040	.183	.006	.738	.100	.136
GHQ Anx.							
Pearson C.	.106	.176	.089	.284*	-.038	.129	.158
Sig.(2-tailed)	.360	.135	.443	.012	.743	.264	.166
GHQ Soc.							
Pearson C.	.170	.295*	.225*	.261*	.052	.072	.199
Sig.(2-tailed)	.142	.012	.049	.023	.659	.540	.083
GHQ Dep.							
Pearson C.	.282*	.376**	.387**	.427**	.217	.279*	.382**
Sig.(2-tailed)	.013	.001	.001	.000	.060	.015	.001
SAS							
Pearson C.	.209	.188	.115	.201	-.045	-.040	.095
Sig.(2-tailed)	.072	.113	.326	.084	.704	.733	.417

* p<.05 statistically significant difference

** p<.001 statistically significant difference

When we investigate the correlation between Mc Master Family Assessment Device (FAD) and Beck Depression Inventory (BDI), Submissive Acts Scale (SAS) , General Health Questionnaire (GHQ28) of the students with the scores of these scales with Pearson Correlation Test we found these results:

We find mild positive correlation between Beck Depression Inventory (BDI) and Problem Solving (r=0.271) and Behavior Control (r=0.298) subscales of FAD. We find moderate positive correlation between Beck Depression Inventory (BDI) and Communication, Roles, Affective Responsiveness, Affective Involvement, and General Functioning.

When we compare FAD Communication subscale with GHQ subscales, we find mild positive correlation with only GHQ Depression subscale (r= 0.282).

When we compare FAD Role subscale with GHQ subscales, we find mild positive correlation with GHQ Hyphocondriasis (r=0.244), GHQ Corruption in Social Functions (r=0.295) and we find moderate positive correlation with GHQ Depression (r=0.376) and GHQ total (r=0.305).

When we compare FAD Affective Responsiveness subscale with GHQ subscales, we find mild positive correlation with GHQ total (r=0.271), GHQ Corruption in Social Functions (r=0.225) and we find moderate positive correlation with only GHQ Depression (r=0.387).

When we compare FAD Affective Involvement subscale with GHQ subscales, we find mild positive correlation with GHQ Anxiety (r=0.284), GHQ Corruption in Social Functions (r=0.261) and we find moderate positive correlation with GHQ total (r=0.376), GHQ Hyphocondriasis (r=0.312), and GHQ Depression (r=0.427).

When we compare FAD Problem Solving subscale with GHQ subscales, we find mild positive correlation with only GHQ Depression subscale (r=0.274).

When we compare FAD General Functions subscale with GHQ subscales, we find mild positive correlations with GHQ total (r=0.274) and we find moderate positive correlation with GHQ Depression (r=0.382).

When we compare FAD Bahaviour Control subscale with GHQ subscales, we find no statistically significant correlation between them.

When we investigate the correlation between Submissive Acts Scale (SAS) and the Mc Master Family Assesment Device (FAD) test scores there are no statistically significant correlations.

Table 12: Comparing GHQ28 and SAS Test Scores with BDI Test Scores.

Scales	BDI	GHQ	GHQ Hyp.	GHQ Anx.	GHQ Soc.	GHQ Dep.
BDI						
Pearson C.	1	.759**	.605**	.648**	.706**	.728**
Sig.(2-tailed)		.000	.000	.000	.000	.000
SAS						
Pearson C.	.235*	.189	.109	.263*	.204	.107
Sig.(2-tailed)	.038	.109	.350	.020	.075	.351

* p<.05 statistically significant difference

** p<.001 statistically significant difference

We find strong positive correlation between Beck Depression Inventory (BDI) and all of the Subcales of General Health Questionnaire (GHQ28); Hypochondriasis (r=0.605), Anxiety and Insomnia (r=0.648), Corruption in Social Functions (r=0.706), Major Depression (r=0.728) and the total of GSQ28 (r=0.759).

We find mild positive correlation between Beck Depression Inventory (BDI) score and the Submissive Acts Scale (SAS) scores (r=0.235).

We find mild positive correlation between Submissive Acts Scale (SAS) and GHQ Anxiety subscale (r=0.263).

4. DISCUSSION

Depression, one of the most important and fostering psychiatric disorder of our age, is investigated in this study. In this study we aim to investigate the relation between Major Depression and family structure in a group of adolescents diagnosed as Major Depression and compare them with the control group who has never been diagnosed with a psychological disorder. The obtained findings support a correlation between depression and family structure.

As a result of the evaluation of the findings, it is seen that results verify our expectations in a great measure. At this point, I am going to give a short summary of the hypotheses and interpret the obtained findings.

The main hypothesis of the study is to investigate the relation between depression and dysfunctions in family structure. We find that as level of depression increases, the family functions such as problem solving, role, communication, affective involvement, affective responsiveness, behaviour control and general functions will also increase in the direction of unhealthiness.

Keitner G. I. *et al.*(1995) investigated the role of the family in recovery of Major Depression. The authors explore how family functioning relates to Major Depression; they examined changes in family functioning over 1- year course of this illness. 'Mc Master Family Assessment Device' and 'Mc Master Clinical Rating Scale' were applied to 45 inpatients diagnosed with MD and their family members. The result of the study shows that 50% of families with depressed member perceived their own family functioning as unhealthy. Also results were show that there is a clear association between family functioning and recovery from major depression. They find that different aspects of family life have an effect on the depressive disorder and more than one dimension is related with the outcome (Keithner *et. al.*1995).

In our study, similar to Keitner's study we also have determined that adolescents diagnosed for depression show an increase in more than one family function in the unhealthy direction.

According to Hale W. W. *et. al*. (2005) study, negative relationship with the parents is associated with adolescent depression. Especially perceived parental rejection is one of the negative factors. Perceived parental rejection has been demonstrated to be related to adolescent depression (Hale, 2005). In our study we find that adolescents diagnosed for depression shows unhealthy direction lots of the family function. Especially associated with Hale W.W. study we find that depressed adolescents report unhealthiest than controls in communication and affective involvement subscales.

Armsden G. C. *et. al.* (1990) study shows that child characteristics with poor parental relations can result as a susceptibility factor for depression (Armsden, 1990). In addition to this, another study by Essau C. A. (2004) about the relation between family factors and Depressive Disorders in adolescents shows us parent alienation is significantly higher in the depressed than the non disordered adolescents and scores related to parent communication and trust are significantly lower (Essau, 2004). In our study, when we compare to the two groups, we find that the adolescents diagnosed for depression report significantly worse perception of parental relation and communication.

Another research result presented by Unger D. G. *et al.* (2000) explaines a mechanism by which inter-parental conflict may affect depressed mood in a context of the role of family functioning. In this study, they assess two types of interparental conflict: interparental conflict involving arguments about the adolescent, and arguments focused on the parent's behaviour. They applied 'Interparental Conflict Questionnaire' that assess perceived interparental conflict, 'Family Satisfaction Scale' and 'Mc Master Family Assessment Device' that assess perceived family functioning and 'The Centre for Epidemiological Studies Depression Scale' that assess depressed mood. Data is collected three times, with one year intervals. 150 adolescents participated the study, the mean of their age was 15.5 years old. The findings indicate that the role of the family in mediating inter-parental conflicts affect depressed mood. This is more evident for girls than boys (Unger *et. al*, 2000). The results of the study by Unger D. G. *et al.* (2000) also

supports our study and it correlates with our findings on family functions such as communication and problem solving. Adolescents diagnosed for depression show an increasingly unhealthy functioning in these areas. Connected with this, the fact that depressive adolescents fail to maintain a healthy communication in the family is worth to be considered.

Nazlı S. (2001) refers to different researches and concludes that dysfunctional family (like rigid rules, low communication skills, presence of conflicts, undetermined roles) is related with suicide. In respect to this information, we have also found out in our study that adolescents diagnosed for depression attempts more to commit suicide than the control group.

Social-ecological theory assumes that low socioeconomic status, limited educational achievement, low income and poverty increase the depressive symptoms and risk of suicidal behaviour (Ulusoy, Demir, 2005). McMaster Model of Family Functioning, we explains three tasks that are Basic Tasks, Developmental Tasks and Hazardous Tasks. The Hazardous tasks area includes the crises that arise in association with illness, accidents, loss of income, job changes and moves. So these are the cause of unhealtiness on family functioning (Epstein, Bishop, Levin, 1978; Hinde, Akister, 1995; Zeitlin *et. al.*, 1995).s However, in our study we could not find any statistically significant correlation between family income and scale scores that include depression and family functioning. This may be because the range of distribution of socio-economical status and education is narrow at our sample.

The findings of this study can be explained by further researches investigating the previous and current condition of the families of the adolescents and also a research on the family members would be useful. Also, it could be a good research topic to investigate both the adolescent's and family's point of view of the family. Furthermore, in psychological interviews especially in the context of our study, the family functions (problem solving, communication, roles, affective responsiveness, affective involvement, behaviour control and general functioning) of the depressive adolescents should be studied in depth and supported.

As we look at the limits of our study, it was carried out only on university students and they had families with middle or higher socio-economical status. Because of this homogeneity of the subjects, we could not find a difference between the groups. If we could have groups having a large range of characteristics related with depression, probably effect of family socio-economical status could be found. Since our study was carried out on a limited number of people, there could be some problems while generalizing the results to the community.

Moreover, only the perception of the family functions of the depressed adolescents were investigated in this study the perception of other family members could give us a different point of view while explaining the relation between family functions and depression. We have find that family functions are related to depression in adolescents. In connection with this, adolescents in depression may give negative meanings on the family functions.

In addition to this, since the experimental group and control group have relatively equal age and sex properties, this enables us to compare the groups. The scores of BID and GHQ depression subscale correlate strongly and these emphasize the reliability of our results.

This study shows that Major Depression is related with unhealthy family functioning among adolescents. During psychotherapy of adolescents with depression, we as psychotherapists, must be aware of this effect and give importance to relations of the adolescent with their family.

5. CONCLUSION

The present study indicated Major Depression is related with unhealthy family functioning such as communication, roles, affective responsiveness, affective involvement, behavior control and general functioning among adolescents.

In our study is focus on firstly the adolescents that are diagnosed as Major Depression and their family's functions. As related with findings psychotherapists must aware of the family effect and give importance to the relations of adolescents with ther parents during the psychotherapy. Family therapy may be added to individual psychotherapy period.

In addition to this, education can be given to the parents (parenting school) about adolescence and depression as a prevention strategy for depression. The content of the education may cover characteristics of adolescence period, communication skills, problem solving skills, behavior control strategies, explaining and recognizing the roles of the family members and so on.

In this study only the adolescents who attend to university and who have families with middle or higher socio-econmical status and education participated. Low socio-economical status of the family, low education may be some other factors related with depression and to show their relation with depression, a sample having wide range of these characteristics should be formed. Having a large sample of adolescents with different backgrounds may enable to generalize the results to the community. Our study was carried out a limited number of people if the further studies may be apply in wide range of subjects it enables to generalizing the results to the community. Also our study give idea about the view of adolescence on family functions and we suggest that in further studies can be studied point of view of family about family functions.

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APPENDIXES

App. 1. Yönerge

Elinizde bulunan formlar, yüksek lisans tezi sebebiyle yapılan bir araştırma için hazırlanmıştır. Araştırma, aile üyelerinin psikolojik durumlarının tanımlanması ile ilgilidir. Hedefimiz, tek tek kişiler hakkında değerlendirme yapmak değil; bazı genel eğilimleri belirleyebilmektir. Çalışmanın güvenilir olabilmesi için, sorulara vereceğiniz cevapların sizin samimi görüşlerinizi yansıtması çok önemlidir. Soruların doğru veya yanlış cevapları yoktur. Vereceğiniz bilgiler sadece araştırma amaçlı kullanılacaktır. Formlara isim yazmanız gerekmemektedir.

Yardımlarınız ve ayırdığınız zaman için teşekkür ederiz.

App. 2. Beck Depresyon Ölçeği

Aşağıda gruplar halinde bazı cümleler yazılıdır. Her guruptaki cümleleri dikkatle okuyunuz. BUGÜN DAHİL GEÇEN HAFTA içinde kendinizi nasıl hissettiğinizi en iyi anlatan cümleyi seçiniz. Seçtiğiniz cümlenin yanındaki numarayı daire içine alınız. Bir grupta durumunuzu tanımlayan birden fazla cümle varsa, herbirini daire içine alarak işaretleyiniz.

Lütfen seçiminizi yapmadan önce her gruptaki cümlelerin hepsini dikkatle okuyunuz.

A. 0 Kendimi üzüntülü ve sıkıntılı hissetmiyorum.
   1 Kendimi üzütülü ve sıkıntılı hissediyorum.
   2 Hep üzüntülü ve sıkıntılıyım. Bundan kurtulamıyorum.
   3 O kadar üzüntülü ve sıkıntılıyım ki artık dayanamıyorum.

B. 0 Gelecek hakkında umutsuz ve karamsar değilim.
   1 Gelecek hakkında karamsarım.
   2 Gelecekten beklediğim hiçbir şey yok.
   3 Geleceğim hakkında umutsuzum ve sanki hiçbir şey düzelmeyecekmiş gibi geliyor.

C. 0 Kendimi başarız bir insan olarak görmüyorum.
1 Çevremdeki birçok kişiden daha çok başarısızlıklarım olmuş gibi hissediyorum.
2 Geçmişe baktığımda başarısızlıklarla dolu olduğumu görüyorum.
3 Kendimi tümüyle başarısız bir kişi olarak görüyorum.

D. 0 Birçok şeyden eskisi kadar zevk alıyorum.
1 Eskiden olduğu gibi herşeyden hoşlanıyorum.
2 Artık hiçbir şey bana tam anlamıyla zevk vermiyor.
3 Her şeyden sıkılıyorum.

E. 0 Kendimi herhangi bir şekilde suçlu hissetmiyorum.
1 Kendimi zaman zaman suçlu hissediyorum.
2 Çoğu zaman kendimi suçlu hissediyorum.
3 Kendimi her zaman suçlu hissediyorum.

F. 0 Kendimden memnunum.
1 Kendimden pek memnun değilim.
2 Kendime çok kızıyorum.
3 Kendimden nefret ediyorum.

G. 0 Başkalarından daha kötü olduğumu zannetmiyorum.
1 Zayıf yanlarım ya da hatalarım için kendimi eleştiririm.
2 Hatalarımdan dolayı kendimi her zaman suçlu bulurum.
3 Her aksilik karşısında kendimi suçlu bulurum.

H. 0 Kendimi öldürmek gibi düşüncelerim yok.
1 Zaman zaman kendimi öldürmeyi düşündüğüm oluyor fakat yapmıyorum.
2 Kendimi öldürmek isterdim.
3 Fırsatını bulursam kendimi öldürürüm.

I. 0 Her zamankinden fazla ağlamak içimden gelmiyor.
1 Zaman zaman içimden ağlamak geliyor.
2 Çoğu zaman içimden ağlamak geliyor.
3 Eskiden ağlayabilirdim. Şimdi istesem de ağlayamıyorum.

J. 0 Şimdi her zaman olduğumdan daha sinirli değilim.
1 Eskisine kıyasla daha kolay kızıyor ya da sinirleniyorum.
2 Şimdi hep sinirliyim.
3 Bir zamanlar beni sinirlendiren şeyler şimdi hiç sinirlendirmiyor.

K. 0 Başkaları ile görüşmek konuşmak istediğimi kaybetmedim.
1 Başkaları ile eskiden daha az konuşmak, görüşmek istiyorum.
2 Başkaları ile konuşma, görüşme isteğimi kaybettim.
3 Hiç kimseyle konuşmak, görüşmek istemiyorum.

L. 0 Eskiden olduğu kadar kolay karar verebiliyorum.
1 Eskiden olduğu kadar kolay karar veremiyorum.
2 Karar verirken eskisine kıyasla çok güçlük çekiyorum.
3 Artık hiç karar veremiyorum.

M. 0 Aynada kendime baktığımda bir değişiklik görmüyorum.
1 Daha yaşlanmışım ve çirkinleşmişim gibi geliyor.
2 Görünüşümün çok değiştiğini ve daha çirkinleştiğimi hissediyorum.
3 Kendimi çok çirkin buluyorum.

N. 0 Eskisi kadar çalışabiliyorum
1 Birşeyler yapabilmek için gayret göstermek gerekiyor.
2 Herhangi bir şey yapabilmek için kendimi zorlamam gerekiyor
3 Hiçbir şey yapamıyorum.

O. 0 Her zamanki gibi uyuyabiliyorum.
1 Eskiden olduğu gibi uyuyamıyorum.
2 Her zamankinden 1-2 saat daha erken uyanıyorum ve tekrar uyayamıyorum.
3 Her zamankinden daha erken uyanıyorum ve uyuyamıyorum.

P. 0 Her zamankinden daha çabuk yorulmuyorum
1 Her zamankinden daha çabuk yoruluyorum
2 Yaptığım hemen her şey beni yoruyor.
3 Kendimi hiçbir şey yapamayacak kadar yorgun hissediyorum.

R. 0 İştahım her zamanki gibi.
1 İştahım eskisi kadar iyi değil.
2 İştahım çok azaldı.
3 Artık iştahım yok.

S. 0 Son zamanlarda kilo vermedim.
1 İki kilodan fazla verdim.
2 Dört kilodan fazla verdim.
3 Altı kilodan fazla verdim.

T. 0 Sağlığım beni fazla endileşlendirmiyor.
1 Ağrı, sancı, mide bozukluğu gibi rahatsızlıklar beni endişelendiriyor.
2 Sağlığım beni endişelendirdiği için başka şeyleri düşünmek zorlaşıyor.
3 Sağlığım hakkında o kadar endişeleniyorum ki başka bir şey düşünemiyorum.

U. 0 Son zamanlarda cinsel konulara olan ilgimde bir değişme olmadı.
1 Cinsel konularla eskisinden daha az ilgiliyim.
2 Cinsel konularla şimdi çok daha az ilgiyim.
3 Cinsel konulara olan ilgimi tamamen kaybettim.

V. 0 Bana cezalandırılmışım gibi geliyor.
1 Cezalandırılabileceğimi seziyorum.
2 Cezalandırılmayı bekliyorum.
3 Cezalandırılıdığımı biliyorum.

App. 3 . Aile Değerlendirme Ölçeği

Açıklama:

İlişikte aileler hakkında 60 cümle bulunmaktadır. Lütfen her cümleyi dikkatlice okuduktan sonra, sizin ailenize ne derece uyduğuna karar veriniz. Önemli olan, sizin ailenizi nasıl gördüğünüzdür.

Her cümle için dört seçenek söz konusudur.

Aynen katılıyorum	Eğer cümle sizin ailenize tamamen uyuyorsa işaretleyiniz.
Büyük ölçüde katılıyorum	Eğer cümle sizin ailenize çoğunlukla uyuyorsa işaretleyiniz.
Biraz katılıyorum	Eğer cümle sizin ailenize çoğunlukla uymuyorsa işaretleyiniz.
Hiç katılmıyorum	Eğer cümle sizin ailenize hiç uymuyorsa işaretleyiniz.

Her cümlenin yanında dört seçenek için de ayrı yerler ayrılmıştır. Size uyan seçeneğe (x) işareti koyunuz. Her cümle için uzun uzun düşünmeyiniz. Mümkün olduğu kadar çabuk ve samimi cevaplar veriniz. Kararsızlığa düşerseniz, ilk aklınıza gelen doğrultusunda hareket ediniz. Lütfen her cümleyi cevapladığınızdan emin olunuz.

CÜMLELER	Aynen Katılıyorum	Büyük Ölçüde Katılıyorum	Biraz Katılıyorum	Hiç Katılmıyorum
1. Ailece ev dışında program yapmada güçlük çekeriz, çünkü aramızda fikir birliği sağlayamayız.				
2. Günlük hayatımzdaki sorunların (problemlerin)hemen hepsini aile içinde hallederiz.				
3. Evde biri üzgün ise, diğer aile üyeleri bunun nedenini bilir.				
4. Bizim evde, kişiler verilen her görevi düzenli bir şekilde yerine getirmezler.				
5. Evde birinin başı derde girdiğinde, diğerleri de bunu kendilerine fazlasıyla dert ederler.				
6. Bir sıkıntı ve üzüntü ile karşılatığımızda, birbirimize destek oluruz.				
7. Ailemizde acil bir durum olsa şaşırıp kalırız.				
8. Bazen evde ihtiyacımız olan şeylerin bittiğinin farkına varmıyız.				
9. Birbirimize karşı olan sevgi, şefkat gibi duygularımızı açığa vurmaktan kaçınırız.				
10. Gerektiğinde aile üyelerine görevlerini hatırlatır, kendilerine düşen işi yapmalarını sağlarız.				
11. Evde dertlerimizi, üzüntülerimizi biribirimize söylemeyiz.				
12. Sorunlarımızın çözümünde genellikle ailece aldığımız kararları uygularız.				
13. Bizim evdekiler ancak onların hoşuna giden şeyler söylediğinizde sizi dinlerler.				

CÜMLELER	Aynen Katılıyorum	Büyük Ölçüde Katılıyorum	Biraz Katılıyorum	Hiç Katılmıyorum
14. Bizim evde bir kişinin söylediklerinden ne hissettiğini anlamak pek kolay değildir.				
15. Ailemizde eşit bir görev dağılımı yoktur.				
16. Ailemiz üyeleri birbirlerine hoşgörülü davranırlar.				
17. Evde herkes, başına buyruktur.				
18. Bizim evde herkes söylemek istediklerini üstü kapalı değil de doğrudan birbirlerinin yüzüne söyler.				
19. Ailede bazılarımız, duygularımızı belli etmeyiz.				
20. Acil bir durum da ne yapacağımızı biliriz.				
21. Ailecek, korkularımızı ve endişelerimizi birbirimizle tartışmaktan kaçınırız.				
22. Sevgi, şefkat gibi olumlu duygularımızı birbirimize belli etmekte güçlük çekeriz.				
23. Gelirimiz (ücret maaş) ihtiyaçlarımızı karşılamaya yetmiyor.				
24. Ailemiz, bir problemi çözdükten sonra, bu çözümün işe yarayıp yaramadığını tartışır.				
25. Bizim ailede herkes kendini düşünür.				
26. Duygularımızı birbirimize açıkça söyleyebiliriz.				
27. Evimizde banyo ve tuvalet (yüz numara) bir türlü temiz durmaz.				
28. Aile içinde birbimize sevgimizi göstermeyiz.				

CÜMLELER	Aynen Katılıyorum	Büyük Ölçüde Katılıyorum	Biraz Katılıyorum	Hiç Katılmıyorum
29. Evde herkes her istediğini birbirinin yüzüne söyleyebilir.				
30. Ailemizde, herbirimizin belirli görev ve sorumlulukları vardır.				
31. Aile içinde genellikle birbirimizle pek iyi geçinmeyiz.				
32. Ailemizde sert kötü davranışlar ancak belli durumlarda gösterilir.				
33. Ancak hepimizi ilgilendiren bir durum olduğu zaman birbirimizin işine karışırız.				
34. Aile içinde birbirimizle ilgilenmeye pek zaman bulamıyoruz.				
35. Evde genellikle söylediklerimizle söylemek isediklerimiz birbirinden farklıdır.				
36. Aile içinde birbirimize hoşgörülü davranırız.				
37. Evde birbirimize, ancak sonunda kişisel bir yarar sağlayacak- sak ilgi gösteririz.				
38. Ailemizde bir dert varsa, kendi içimizde hallederiz.				
39. Ailemizde sevgi, şefkat gibi güzel duygular ikinci plandadır.				
40. Ev işlerinin kimler tarafından yapılacağını hep birlikte konuşarak kararlaştırırız.				
41. Ailemizde herhangi bir şeye karar vermek her zaman sorun olur.				
42. Bizim evdekiler sadece bir çıkarları olduğu zaman birbirlerine ilgi gösterirler.				

CÜMLELER	Aynen Katılıyorum	Büyük Ölçüde Katılıyorum	Biraz Katılıyorum	Hiç Katılmıyorum
43. Evde birbirimize karşı açık sözlüyüzdür.				
44. Ailemizde hiçbir kural yoktur.				
45. Evde birinden bir şey yapması istendiğinde mutlaka takip edilmesi ve kendisine hatırlatılması gerekir.				
46. Aile içinde herhangi bir sorunun (problemin) nasıl çözüleceği hakkında kolayca karar verebiliriz.				
47. Evde kurallara uyulmadığı zaman ne olacağını bilmeyiz.				
48. Bizim evde aklınıza gelen herşey olabilir.				
49. Sevgi, şefkat gibi olumlu duygularımızı birbirimize ifade edebiliriz.				
50. Ailede her türlü problemin üstesinden gelebiliriz.				
51. Evde birbirimizle pek iyi geçinemeyiz				
52. Sinirlenince birbirmize küseriz.				
53. Ailede bize verilen görevler pek hoşumuza gitmez çünkü genellikle umduğumuz görevler verilmez.				
54. Kötü bir niyetle olmasada evde birbirimizin hayatına çok karışıyoruz.				
55. Ailemizde kişiler herhangi bir tehlike karşısında (yangın, kaza gibi) durumlarda ne yapacaklarını bilirler, çünkü böyle durumlarda ne yapılacağı, aramızda konuşulmuş ve belirlenmiştir.				
56. Aile içinde birbirimize güveniriz.				

CÜMLELER	Aynen Katılıyorum	Büyük Ölçüde Katılıyorum	Biraz Katılıyorum	Hiç Katılmıyorum
57. Ağlamak istediğimizde, birbirimizden çekinmeden rahatlıkla ağlayabiliriz.				
58. İşimize (okulumuza) yetişmekte güçlük çekiyoruz.				
59. Aile içinde birisi hoşlanmadığımız birşey yaptığında ona bunu açıkca söyleriz.				
60. Problemlerimizi çözmek için ailecek çeşitli yollar bulmaya çalışırız.				

App. 4. Genel Sağlık Anketi (GHQ28)

Lütfen bu açıklamayı dikkatle okuyunuz:
Son birkaç hafta içinde herhangi bir tıbbi şikayetinizin olup olmadığını, genel olarak sağlığınızın nasıl olduğunu öğrenmek istiyoruz. Bütün sorunları size en uygun cevabı işaretleyerek cevaplayınız. Geçmişteki değil, yalnız son dönemdeki ve şu andaki şikayetlerinizi sorduğumuzu unutmayınız. <u>Soruların hepsini cevaplamanız çok önemlidir.</u>
Teşekkür ederiz.

SON ZAMANLARDA

A1. Kendinizi çok iyi ve sağlıklı hissediyor musunuz?	Evet, her zamankinden çok	Her zamanki kadar	Her zamankinden kötü	Çok daha kötü
A2. Sizi dinçleştirecek bir ilaca ihtiyaç duyuyormusunuz?	Hayır, hiç duymuyorum	Her zamanki kadar	Her zamankinden çok	Çok fazla
A3. Kendinizi tükenmiş ve dağınık hissediyor musunuz?	Hayır, hiç hissetmiyorum	Her zamanki kadar	Her zamankinden çok	Çok fazla
A4. Kendinizi hasta hissediyor musunuz?	Hayır hiç hissetmiyorum	Her zamanki kadar	Her zamankinden çok	Çok fazla
A5. Başınızda ağrı oluyor mu?	Hayır, hiç olmuyor	Her zamanki kadar	Her zamankinden sık	Çok sık
A6. Başınızda sıkışma veya basınç hissi oluyor mu ?	Hayır hiç olmuyor	Her zamanki kadar	Her zamankinden sık	Çok sık
A7. Sıcak ya da soğuk basması oluyor mu ?	Hayır hiç olmuyor	Her zamanki kadar	Her zamankinden sık	Çok sık
B1. Endişeleriniz nedeniyle uykusuzluk çekiyor musunuz?	Hayır hiç çekmiyorum	Her zamanki kadar	Her zamankinden sık	Çok sık
B2. Uykunuzun bölündüğü oluyor mu?	Hayır hiç olmuyor	Her zamanki kadar	Her zamankinden sık	Çok sık
B3. Kendinizi sürekli gerilim altında hissediyor musunuz?	Hayır hissetmiyorum	Her zamanki kadar	Her zamankinden çok	Çok fazla
B4. Öfkeli ve huysuz oluyor musunuz?	Hayır hiç olmuyorum	Her zamanki kadar	Her zamankinden sık	Çok sık
B5. Nedensiz korkuya veya paniğe katıldığınız oluyor mu ?	Hayır hiç kapılmıyorum	Her zamanki kadar	Her zamankinden sık	Çok sık

B6. Herşeyi üzerinize yüklenmiş gibi hissediyor musunuz?	Hayır hiç hissetmiyorum	Her zamanki kadar	Her zamankinden sık	Çok fazla
B7. Kendinizi sürekli sinirli ve gergin hissediyor musunuz?	Hayır hiç hissetmiyorum	Her zamanki kadar	Her zamankinden çok	Çok fazla
C1. Bir işle meşgul olabiliyor musunuz?	Evet herzamankinden çok	Her zamanki kadar	Herzamankinden az	Çok az
C2. İşlerinizi bitirmeniz daha uzun zaman alıyor mu?	Hayır hiç almıyor	Her zamanki kadar	Her zamankinden çok	Çok uzun
C3. Genel olarak işlerinizi iyi yaptığınızı hissediyor musunuz?	Evet, her zamankinden iyi	Her zamanki kadar	Her zamankinden kötü	Çok kötü
C4. Görevlerinizi yeterince yerine getirebiliyormusunuz?	Evet her zamankinden çok	Her zamanki kadar	Her zamankinden kötü	Çok kötü
C5. İşe yaradığınızı düşünüyormusunuz?	Her zamankinden çok	Her zamanki kadar	Her zamankinden az	Çok az
C6. Herhangi bir konuda fazla zorlanmadan karar verebiliyormusunz?	Evet her zamankinden iyi	Her zamanki kadar	Her zamankinden kötü	Çok kötü
C7. Günlük faaliyetlerden zevk alabiliyor musunuz?	Her zamakinden çok	Her zamaki kadar	Her zamakinden az	Çok az
D1. Kendinizi değersiz biri olarak görüyor musunuz?	Hayır hiç görmüyorum	Her zamanki kadar	Her zamakinden çok	Çok fazla
D2. Yaşamdan hiç umudunuzun kalmadığını hissediyor musunuz?	Hayır hiç hissetmiyorum	Her zamanki kadar	Her zamakinden sık	Çok sık
D3. Hayat yaşamaya değmez diye düşünüyormusunuz ?	Hayır hiç düşünmüyorum	Her zamanki kadar	Her zamakinden çok	Çok fazla
D4. Kendi canınıza kıyabileceğinizi düşündüğünüz oluyor mu?	Kesinlikle hayır	Her zamanki kadar	Aklımdan geçtiği oldu	Çok sık
D5. Sinirlenriniz bozulduğu için hiçbir şey yapamadığınız oluyor mu?	Hiç olmuyor	Her zamanki kadar	Her zamankinden sık	Çok sık
D6. Kendi kendinize "ölsem de kurtulsam" dediğiniz oluyor mu?	Hiç olmuyor	Her zamanki kadar	Her zamankinden sık	Çok sık
D7. Kendinizi öldürme düşüncesi sürekli aklınıza takılıyor mu?	Kesinlikle hayır	Düşünmedim	Aklımdan geçtiği oldu	Çok sık

App. 5. Boyun Eğici Davranışlar Ölçeği

Aşağıda, insanların sosyal ortamlardayken yapatıkları bazı davranışlar ve yaşadıkları bazı duygular verilmiştir. Her cümleyi dikkatle okuyun ve böyle bir davranışın sizin için ne kadar geçerli olduğunu, sizi ne kadar tanımladığını aşağıdaki ölçeği dikkate alarak, o cümlenin yanındaki bölmede işaretleyin.

1.Hiç tanımlamıyor **4. İyi tanımlıyor**

2.Biraz tanımlıyor **5. Çok iyi tanımlıyor**

3.Oldukça iyi tanımlıyor

1. Belirli bir konuda benim hatam olmasa da hatalı olduğum söyleniyorsa tatsızlık çıkmasın diye sesimi çıkarmam	1 2 3 4 5
2. Kendim yapmaktan hoşanmasam da diğer insanlar yapıyor diye bazı davranışları yaparım.	1 2 3 4 5
3. Paramın üstü eksik verilmiş olsa da, sesimi çıkarmadan	1 2 3 4 5
4. Başkalarının beni eleştirmesine ve aşağılamasına izin verir kendimi savunamam	1 2 3 4 5
5. Sevdiğim kişi benden yakınlık istediğinden, o anda içimden	1 2 3 4 5
6. Konuşmaya çalışırken birisi lafımı ağzımdan alıp konuşmayı sürdürse, ben susarım.	1 2 3 4 5
7. Küçük hatalarım yüzünden sürekli özür dilerim.	1 2 3 4 5
8. Annem / babam benim hakkımda hoş olmayan şeyler söylerken, ben sesizce dinlerim.	1 2 3 4 5
9. Arkadaşlarıma kızdığım zaman, bu kızgınlığımı onlara söylemem	1 2 3 4 5

10. Arkadaş toplantılarında konuşmaları yönlendirmeyi başkalarına bırakırım. 1 2 3 4 5

11. İnsanların, benimle konuşurken gözlerimin içine 1 2 3 4 5

12. Herhangi biri benim için küçük bir iyilikte bile bulunsa, içtenlikle ve tekrar tekrar teşekkür ederim. 1 2 3 4 5

13. İnsanlarla göz göze gelmekten kaçınırım. 1 2 3 4 5

14. Arkadaş toplantılarında, konuyu açan kişi hiçbir zaman ben olmam. 1 2 3 4 5

15. İnsanlar ısrarla bana baktıklarında yüzüm kızarır. 1 2 3 4 5

16. Birinin davetini geri çevirirken mutlaka hastalık gibi önemli bir bahane bulmaya çalışırım. 1 2 3 4 5

App. 6. Demografik Bilgi Formu

Aşağıdaki sorularda size uyan seçenekleri lütfen işaretleyin. Boşluk bırakılan yerlere uygun cevapları yazmanız beklenmektedir.

1. Yaşınız:.....

2. Cinsiyetiniz: a) Erkek
   b) Kız

3. Hangi okula devam ediyorsunuz? .....

4. Kaçıncı sınıftasınız? .....

5. Üniversite eğitiminiz için burs alıyormusunuz?
   a) Evet
   b) Hayır

6. KKTC'deyken nerede ikamet ediyorsunuz?
   a) Yurtta
   b) Arkadaşlarla
   c) Ailem ile
   d) Diğer (.....)

7. Türkiye'de nerede yaşıyorsunuz?
   a) Şehir b) Kasaba c)Köy

8. Ailenizin aylık toplam net geliri nedir?
   a) 560 ytl - altı
   b) 560-1000 ytl
   c) 1000-2000 ytl
   d) 2000-4000 ytl
   e) 4000 ytl ve üstü

9. Evde birlikte yaşayan kaç kişisiniz? (Kendiniz dahil)
   a)1 b)2 c)3 d)4 e)5 f).....

10. Annenizin yaşı:.....
    Eğer hayatta değilse öldüğünde siz kaç yaşındaydınız?.....

11. Babanızın yaşı:.....
    Eğer hayatta değilse öldüğünde siz kaç yaşındaydınız?.....

12. Annenizin mesleği nedir?
    a) Kamu kuruluşu
    b) Özel sektör
    c) Kendi özel işi var
    d) Çalışmıyor (ev hanımı)
    e) Diğer (.....)

13. Babanızın mesleği nedir?
    a) Kamu kuruluşu
    b) Özel sektör
    c) Kendi özel işi var
    d) Çalışmıyor
    e) Diğer (.....)

14. Eğer anne ve babanız ayrı ise, ayrıldıklarında siz kaç yaşındaydınız?.....

15. Evlat edinildiniz mi?
    a) Evet b) Hayır

16. Eğer anne ve babanızın yanında büyümediyseniz sizi kim yetiştirdi?.....

17. Okuldaki ders başarınız nasıldır?
    a) Pek iyi b)İyi c)Orta d)Kötü

18. Kendi canınıza kıyabileceğinizi (intihar etme) hiç düşündünüz mü?
    a)Hayır hiç düşünmedim
    b)Aklımdan geçtiği oldu
    c)Arasıra düşünürüm
    d)Sık sık düşünürüm

19. Kendi canınıza kıymaya hiç teşebbüs ettiniz mi?
    a) Hayır hiç etmedim
    b) Evet bir kez teşebbüs ettim
    c) Evet.....kez teşebbüs ettim

20. Anne ve babanızın ilişkisini nasıl algılıyorsunuz?
    a) Kötü b)İyi c)Çok iyi