NEAR EAST UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SCIENCES
APPLIED (CLINICAL) PSYCHOLOGY MASTER PROGRAM

MASTER THESIS

THE RELATIONSHIP OF SUICIDE PROBABILITY TO PROBLEM SOLVING SKILLS, SOCIAL SUPPORT AND SELF ESTEEM IN ADOLESCENCE PERIOD

NİLGÜN KAYA

20062564

SUPERVISOR

ASSOC. PROF. DR. EBRU TANSEL ÇAKICI

NICOSIA

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The Relationship of Suicide Probability to Problem Solving Skills, Social Support and Self Esteem in Adolescence Period by: Nilgün Kaya

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

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ÖZET

Ergenlikte Problem Çözme Becerisi, Sosyal Destek ve Benlik Saygısının İntihar Olasılığı ile İlişkisi

Nilgün Kaya

Mart, 2014

İntihar sıklığının arttığı günümüzde ergenlik döneminde gençlere intiharı düşündüren sebeplerin ve risklerin neler olduğunu belirlemek, özellikle okul ortamında risk altındaki ergenlerin zamanında fark edilebilmesinde son derece önemlidir. İntihar sürecindeki risk faktörlerini belirlemek amacıyla yapılan bu araştırmada ergenlik dönemindeki gencin problem çözme becerileri, benlik saygısı ve algıladığı sosyal desteğin intihar olasılığı üzerindeki etkisi incelenmiştir.

Çalışmanın örneklemi Lefkoşa ve Girne Bölgesindeki 5 devlet okulunun 10. ve 11. sınıflarında öğrenim gören 15-20 yaş arası 260 öğrenciden oluşmuştur. Öğrencilere Sosyo-Demografik Bilgi Formu, İntihar Olasılığı Ölçeği, Problem Çözme Envanteri, Algılanan Sosyal Destek Ölçeği ve Benlik Saygısı Ölçeği uygulanmıştır. Sonuçlar SPSS programında değerlendirilmiştir.

Çalışmadan elde edilen sonuçlara göre problem çözme becerileri düşük olan çevresinden algıladığı sosyal desteği az olan ve benlik saygısı düşük olan ergenlerin intihar etme olasılıkları yüksek bulunmuştur. Ayrıca sosyal desteği az olan ergenlerin problem çözme becerilerini de yetersiz algıladıkları görülmüş ve benlik saygılarının da düşük olduğu saptanmıştır. Ergenlerin intihar olasılıkları, algıladıkları sosyal destek düzeyleri ve benlik saygıları cinsiyetlerine göre farklılık göstermezken sadece kız öğrencilerin problem çözme becerileri erkek öğrencilere göre yüksek bulunmuştur. Çalışmada KKTC ve TC uyruklu öğrenciler arasında intihar olasılığı, problem çözme becerisi, algılanan sosyal destek ve benlik saygısı değişkenleri açısından fark bulunmamıştır. Ayrıca ergenlerde sigara ve alkol kullanım sıklığı arttıkça intihar olasılıkları da artmaktadır.

Sonuç olarak intihar riski taşıyan ergenlerin belirlenmesi, sosyal destek sistemlerinin artırılması, problem çözme becerileri ve benlik saygılarının sosyal beceri eğitimleri verilerek güçlendirilmesi intiharın önlenmesinde önem taşımaktadır.

Anahtar Sözcükler: ergenlik, intihar olasılığı, sosyal destek, benlik saygısı

ABSTRACT

The Relationship of Suicide Probability to Problem Solving Skills, Social Support and Self Esteem in Adolescence Period

Prepared by Nilgün Kaya

March, 2014

Nowadays, frequency of suicide incidences show a significant increase. Determining reasons and risk factors that motivate an adolescent to think about suicide, especially recognition of adolescents under the risk at right on time has a crucial value. This study which was conducted in order to determine risk factors in suicide process aimed to examine the influence of adolescent's problem solving skills, self-esteem and perceived social support on suicide probability.

Sample of this study consisted of 260 10th and 11th grade students between 15 and 20 years who attended to 5 public schools in Nicosia and Kyrenia districts. Those students were asked to fullfill inventories of Sociodemographic Information Questionairre, Suicide Probability Scale, Problem Solving Inventory, Perceived Social Support Scale and Self Esteem Scale. Data collected via those inventories were evaluated by using SPSS.

Findings indicate that adolescents with lower levels of problem solving skills, perceived social support and self esteem had higher suicide probability. Moreover, it was observed that adolescents who had lower social support perceived their problem solving skills as inadequate and tended to have lower levels of self-esteem. Whereas suicide probability, perceived social support level and self-esteem did not differ according to sex, females found to have better problem solving skills. This study did not reveal any difference between citizens of Turkey and citizens of TRNC in terms of suicide probability, problem solving skills, perceived social support and self-esteem. Moreover, it was found that frequent smoking and alcohol among adolescents increased suicide probability.

In conclusion, precautions such as determination of adolescents under suicide risk, empowerment of social support systems, providing problem solving skills training and empowerment of self-esteem by providing social skills training have crucial value for suicide prevention.

Key Words: Adolescence, Suicide Probability, Social Support, Self-Esteem

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Lefkoşa **Nilgün Kaya**

March 2014

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ABBREVIATIONS

TRNC **:**Turkish Republic of Northern Cyprus

WHO **:** World Health Organization

CDC : Centers for Disease Control and Prevention

TDK : Turkish Language Institution

DİE : State Institute of Statistics

SPSS **:** Statistical Package for the Social Sciences

SPS : Suicide Probability Scale

PSI : Problem Solving Inventory

MSPSS : Multidimensional Scale of Perceived Social Support

RSES : Rosenberg Self Esteem Scale

1. INTRODUCTION

Suicide incidence has been seen to have various prevalence rates during the history of mankind. Suicide behaviour has increased in many countries recently and nowadays it is accepted as a universal problem. Suicide behaviour that generally appears in the form of one's thoughts, actions or attempts to kill one's self shows significant prevalence in youth.

Suicide is accepted as the today's most important health problem by WHO (World Health Organization). While suicide rate was calculated as 3.3 in one thousandth in the year of 1970 for TRNC, it increased to 5.3 in one thousandth in the year of 1971. This rate followed an instable route and finally reached to 22.6 in one thousandth at the year of 1990. WHO put 62 countries in hierarchical order according to suicide rates between 1980-1986, and TRNC was placed in top ten countries (Yağlı,1992).

In Turkey, the suicide rate between the years of 1990 and 2001 increased to 3.77 in one hundred thousandth from 2.42 in one hundred thousandth and between 29.7% - 36% of all suicides were committed by youngsters between the ages of 15-24 years old (DİE, 2001).

In a multicentric study conducted in Turkey by the support of WHO, suicide rate mean average between the years of 1998 and 2002 was determined as 46.89 in one thousandth. This rate is lower when compared with European countries. However suicide rate increased 93.56% in those 4 years ((Devrimci-Özgüven ve Sayıl 2003).

Suicide is an incidence which is observed in a large population extended from "normal" individuals reacting stressful life events to the patients with severe mental diseases and it is also observed that there is an obvious increase in suicide frequency in adolescence. Adolescence is a complex period in which individual undergoes into a series of biological, social and emotional changes. Individuals try to adapt themselves into changes specific to adolescence period which involve a transition process from childhood to adolescence and they also cope with life problems at the

same time. In this context, some adolescents successfully cope with stress factors while others fail and choose suicide as a solution method. At this point, risk factors motivate adolescents to suicide show a large variation. This study which aimed to determine the influence of content of sociocultural and sociodemographic characteristics, self-esteem, social support and problem solving skills, emphasized preventive strategies that should be taken in school context.

Determining of risk factors which motivate a person to commit suicide who experience process of biopsychosocial changes in adolescence period, recognizing adolescents under risk and intervening those adolescents appropriately will contribute to develop preventive strategies. This study emphasizes risk factors related with suicide such as problem solving skills, perceived social support and self-esteem.

This research aims to examine the influence of problem solving skills, self-esteem and perceived social support of youngsters on suicide probability at adolescence. Hypothesis of this research claims that youngsters who have inadequate problem solving skills, self-esteem and social support would tend to have higher probability of suicide commitment. This study aims to provide contributions to the suicide literature by identifying reasons that make individual to terminate his life at early ages and determining preventive strategies in order to predict possible suicide attempts. It is important and necessary to understand the content of adolescence and developmental phases experienced by adolescents in order to identify reasons and motives behind the suicide commitments at young ages.

1.1 Adolescence

All human beings maintain their whole life in a process of change and development. The most important changes emerge in the adolescence period. The adolescence period forms the key point of the transition process from childhood to adulthood and has a very important place in the human life span.

During the history of humankind, many researchers identified adolescence period as a stormy and stressful period (Yörükoğlu, 2004; Kulaksızoğlu, 2013;Yavuzer, 2005). Adolescence may be defined as a period that includes series of obvious physical, sexual, mental and emotional changes as well as problems accompanied

with those changes. . Youth is the period which has a larger age range that includes adolescence as well (Kulaksızoğlu, 2013). Basic characteristics of this period may be summarized as emotional irritability, relationships that either maintained or broken up easily, impressionability, exceeding personality boundaries, excelling in society, attracting attention (Yavuzer, 2005). It is very hard to determine definite age limits for this period. Ages between 15 and 25 is accepted as the adolescence period by UNESCO. WHO determined age range between 10-19 as 'adolescence', 15-24 is the 'youth period' and they define people between 10-24 years old as 'young people'. According to research conducted by TÜBA (Turkey Science Academy) the age range of adolescents was found to be between 12.7 and 21.6 for females, 13.7 and 23.1 for males (Çuhadaroğlu et.al., 2004). Introduction to puberty is influenced by various factors such as local climate, genetic structure, socioeconomic conditions and individual differences.

Adolescence involves a rapid change and reconstruction process. Those rapid changes are not only limited to bodily growth, changes in sexual organs and impulsive exacerbation. They also involve rapid changes and reconstruction in psychic structure. Namely, those developmental changes appear in the form of bodily, psychological, social and cognitive characteristics.

The most distinctive characteristics of adolescence period are biological and hormonal changes. Development of secondary sexual characteristics is known as one of the most significant change in physical changes. Changes in physical appearance, impulsive exacerbation, and increase of the concerns about sexual identity motivate youngsters to acquire a gender role. By this way adolescents identify their gender roles and the gender identity formation process becomes complete (Çuhadaroğlu, 1996).

In adolescence period, parent's treat individuals as a child or adult according to different situations. Those inconsistent attitudes may make adolescent indecisive about how to react in various situations. Individual may experience identity confusion as a result of failure to adapt to emotional, sexual and bodily changes. Some adolescents experience this process easily whereas others experience serious symptoms. Near the end of this period adolescent's self concept becomes clearer, conflicts become less intense, sexual identity becomes integrated and purposes

appear. If adults exhibit an appreciative and warm hearted approach towards adolescents instead of harsh and authoritarian approaches, it would be helpful for young one at the identity development process. (Yörükoğlu, 2004; Kulaksızoğlu, 2013).

A significant change in social relationships is another important aspect of adolescence period. Friendship bonds become more important than parental relationships. Adolescents feel the need to be involved in a peer group. Peer groups support the adolescent by providing them opportunity for identity formation, empowering self-esteem and individual activity.

In adolescence period, the value system becomes permanent. This period is also characterized by biological, sociological and psychological conflicts and imbalances. Attitudes of the adults family members should be in a pattern that enables to maintain a balance between adolescent's rights and responsibilities. Evaluation of adolescent by the point of view that refers the circumstances of the parent's own generation, excessive pressure and domestic stress are the factors that motivate adolescents to behavioural and adjustment disorders such as elope or wagging school. Breaking the rules, suicide attempts, emotional irritability and restlessness are the behaviours that occur frequently in this period (Yavuzer, 2005; Eskin, 2003).

1.2 Suicide

Suicedere is a Latin word that was formed by the combination of two words means "sui" which means "I" and "cedere" which means "to kill". This portmanteau word, which means "killing one's self" was transferred into the English language as "suicide**"**. Word of suicide is made up by mixture of two Latin Suicedere is a Latin word that was formed by the combination of two words means "sui" which means "I" and "cedere" which means "to kill". (Volant, 2005). Nowadays, self-destruction is also used as a synonym for suicide in literature.

It is very hard to make an absolute and comprehensive definition of the term suicide. Suicide is a very complicated and subjective concept. Because killing one's self is an action which is a combination of unknown motivations, complicated psychological conditions, changing conditions can be very hard to handle. Up until now, various definitions which mention different aspects of suicide were made by suicidologists,

philologists and philosophers. Although none of them could handle the issue in all its dimensions, some of those definitions received more acceptance than others and are used more prevalently than others.

Durkheim (1992) defined suicide as a fact *applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result.*

Turkish Language Institute has defined suicide, under the influence of a persons psychological and social causes ending their life. In modern Turkish language, "öz-kıyım" is the word that corresponds the term of suicide (TDK, 2013).

CDC (Centers for Disease Control and Prevention) defined suicide as a behaviour as something that is self-directed and deliberately results in injury to oneself such as mutilation, suffocation or empoisoning which has evidence, whether implicit or explicit, of suicidal intent (Jamison, 2004).

Suisidologysts generally evaluate suicide incidence as behaviour. Suicide behavior is different than suicide attempt since it began with thoughts and resulted in death. Suicide attempt is a voluntary act characterized by self-mutilation which is not resulted in death (Çekirge, 1996). Unlike suicide behaviour, suicide attempt is not a voluntary strive for death. It is a sign of strive for giving alert or providing help and concern from others (Volant, 2005). People with suicide attempt history are always under risk for committing suicide.

1.3 Classification of Suicidal Behavior

Experts who accepted the term of suicide as a behaviour or process formed some kind of classifications in order to define this behaviour with all of its dimensions and limitations.

1.3.1 Suicide Types Defined by Durkheim

According to French sociologist Durkheim, suicide should be regarded as a social incidence. Factors involved in this incidence are the trends which are in a specific society and create suicidal impulses. Durkheim assumed that the number of suicide incidences in a certain period determine the moral structure of that period. Durkheim emphasized terms of social integration and organization while identifying suicide. He

identifies every kind of suicide behaviours with social integrity and social organization level. People kill themselves easily when they became over integrated with or over isolated from society. Durkheim proposed that suicide frequency would increase due to decrease of social integration level and he classified suicide types under 4 main titles (Durkheim,1992; Volant,2005; Eskin,1997)

1.3.1.1 Egoistic Suicides

This type of suicide occurs due to lack of social integration. Namely, it emerges when social ties become weakened and individual feels himself alone. As the emotional bonds that attach individual to a social group become weaks and sense of being depended to specific group decreases, individual feels loneliness. Life becomes meaningless if the individual fails to respond the need of being a part of society. Main reason for higher egoistic suicide rates is "incurable weariness and depression consisting of sadness". For instance, Protestant countries tend to have higher suicide rates when compared with Catholic ones. This situation is attributed to higher integrative characteristic of Catholicism than Protestantism.

1.3.1.2 Altruistic Suicides

Durkheim assumes altruistic suicide as the second suicide type. This type of suicide occurs when individuals and the group are too close and intimate. Person who kills himself aims to perform a social duty. Society puts pressure on an individual and forces to commit suicide. Main factor that increases the risk of committing altruistic suicide is the religious belief that promises a reward after that. "Harakiri" in Japan and "suttee" in India can be given as examples for altruistic suicide.

1.3.1.3 Anomic Suicide

Occurs when the society fails to control individual sufficiently. Main reasons of those suicides are the changes in life style occurred as a result of social depression and collapse of social values. Durkheim who claimed that financial crisis would lead to suicide explained main reason for this as the changes in social structure, not poverty or prosperity. It is not important that whether the change was positive or negative. The most important issue is the collapse of individual's life style due to social changes. The main reason of suicide is this anomic situation.

1.3.1.4 Fatalistic Suicide

This type of suicide is due to overregulation in society. Under the overregulation of a society, when a servant of slave commits suicide, when a barren woman commits suicide, it is an example of fatalistic suicide.

1.3.2 Suicide Types Defined by Beachler

Beachler classified 4 different types of suicide (Volant, 2005; Eskin,1997).

1.3.2.1.Escape Suicide

Person aims to escape from a problem or situation that is perceived as unsolvable. For instance a person who commits suicide aims to avoid sorrow, loss, disease, agedness or failure. There are three subtypes;

a. **"Escape"** suicides are regarded to be committed to avoid an unbearable pain

b. **"Mourning"** suicides are generally committed just after the loss of a loved one

c. **"Punishment"** suicides are committed as a result of a mistake or failure of the individual

1.3.2.2 Aggressive Suicide

This type occurs as a result of feelings about other people. There are 4 subtypes;

a. Revenge suicides are committed for taking revenge from someone

b. In murder suicides, individual aims to kill someone else by killing himself

c. Blackmail suicides aim to threat someone

d. Alarm suicides convey meanings of a call for help to the social environment

1.3.2.3 Devotion Suicide

There are two subtypes;

a. Someone aims to increase his self-worth by devoting himself to someone or something and then commits victimization suicide.

b. Suicides committed for sublimating oneself.

1.3.2.4 Game Suicides

Death incidences occur as result of risky behaviours. There are two subtypes;

a. A person may commit a "constitutional testing" suicide in order to demonstrate his strength.

b. A "Game" suicide is committed by risking one's own life.

1.3.3 Suicide Types Defined by Shneidman

Shneidman classified suicide types aetiologically. Suicides resulted with death are classified under three main titles (Volant,2005; Eskin,1997)

1.3.3.1 Egoistic Suicides

These are psychological suicides. They may either find their source in dysfunctional cognitive characteristics or psychic processes.

1.3.3.2 Dual Suicide

Disappointments, anger, limitations, and dissatisfied needs can motivate someone to terminate his life.

1.3.3.3 Isolation Suicides

These are the suicides that occur as a result of loneliness. An individual isolates himself from his peers, generation and perhaps from all social circumstances.

1.4 Frequency of Suicide

1.4.1 Worldwide Frequency of Suicide

Many countries consider the suicide incidence as a universal health problem that threatens human life. Studies conducted in various countries indicate a serious increase in suicide rates. It was reported that annually 163.000 people in Europe and 873.000 in the whole world die because of suicide (WHO, 2005). WHO reported suicide as the 8th largest cause of death. The Frequency of suicide in societies is around 10-20 in one hundred thousandth. However this rate varies between 10 and 40 in one hundred thousandth in some countries (Batıgün, 2005).

During the past six decades, according to the WHO Japan, Hungary, and Lithuania have topped the list of world countries by suicide rate, but if the current trends

continue South Korea will overtake all others in a few years. The heart of the problem of suicide mortality has shifted from Western Europe to Eastern Europe and now seems to be shifting to Asia. China and India are the biggest contributors to the absolute number of suicides in the world (Varnik, 2012).

Rate of suicide generally tends to be higher in developed countries and Eastern Europe when compared with less developed ones. However, lack of sufficient registration systems in developing countries prevents the collection of sufficient information about the cross-cultural epidemiology of suicide (Sayar, 2002).

Lithuania has the highest rate with 31.6 in one hundred thousandth. Southern Korea follows it with 31.2 in one hundred thousandth. Guyana has the third highest with 26.4 in one hundred thousandth (WHO, 2011).

Another region which has prevalent suicidal behaviour is Northern America. Studies indicated prevalent suicidal behaviour despite high prosperity levels in this region. Official statistic records indicate that, every year approximately 30.000 people terminate their own lives. Suicide for 10-19 years old was found at 4.5 in one hundred thousandth in the year of 2009. In USA, suicidal behaviour is at the 10th row among the other most common death types for adult ages, while it was found as the 3rd most common death type for the age rank between 10-24 (CDC, 2012).

The top 25 countries with highest suicide rates are given as following in the table below.

Table 1. Annual suicide rate of countries per 100.000 people

Row	Country	Male	Female	Total	Year
1	Lithuania	54.6	11.6	31.6	2011
2	South Korea	41.4	21.0	31.2	2010
3	Guyana	39.0	13.4	26.4	2006
4	Kazakistan	43.0	9.4	25.6	2008
5	Belorussia			25.3	2010
6	Hungary	37.4	8.5	21.7	2009
7	Japan	33.5	14.6	23.8	2011
8	Latvia	33.8	4.0	17.5	2009
9	China			22.23	2011
10	Slovenia	29.3	3.0	17.2	2010

11	Sri Lanka			21.6	1996
12	Russia			21.4	2011
13	Ukraine	37.8	7.0	21.2	2009
14	Serbia-Montenegro	28.4	11.1	19.5	2006
15	Estonia	20.6	7.3	18.1	2008
16	Switzerland	15.7	6.5	11.1	2007
17	Croatia	24.3	6.6	14.7	2009
18	Belgium	26.5	9.3	17.6	2009
19	Finland	25.7	8.1	16.8	2010
20	Moldovia	30.1	5.6	17.4	2008
21	France	23.5	7.5	15.0	2009
22	Uruguay	26.0	6.3	15.8	2004
23	Southern Africa	25.3	5.6	15.4	2005
24	Austuria	20.9	5.7	12.8	2009
25	Poland	28.0	3.8	15.4	2010

(World Health Organization, 2011)

1.4.2 Suicide Frequency in Turkey

Until 1974, statistical records on suicide incidences were published in the form of brief information as parts of annual forensic reports. State Institute of Statistics (DIE) has been publishing statistical records of suicide incidences in independent reports since 1974 (Okman, 1997). In Turkey, the suicide rate between the years of 1990 and 2001 increased to 3.77 in one hundred thousandth from 2.42 in one hundred thousandth and between 29.7% - 36% of all suicides were committed by youngsters between the ages of 15-24 years old (DİE, 2001).

According to the data provided by DIE, suicide rate increased 100% between the years of 1974 and 1998. Moreover, rough suicide rate was calculated as 3.62 in one hundred thousandth for the year of 2011. A 4 year follow up study was conducted in Mamak district of Ankara between 1998 and 2001 and its results indicated the rate for suicide as 57.9 in one hundred thousandth at the end of first year and then it was found as 112.1 in one hundred thousandth for the fourth and last year (Sayıl, Devrimci-Özgüven, 2002).

Between the years of 1991 and 1997 significant increases were observed in all geographic regions of Turkey, except Aegean Region. Southeast Anatolia which had

the highest increase became the region with 167%. In a study conducted by Batman Bar it was found that 135 suicide attempts and commitments occurred between the years of 1999 and 2000. 42 suicide cases resulted in death and 93 cases remained at the process of suicide attempt (Halis, 2002).

Most of the studies about suicide in Turkey are known as regional studies. However a study conducted by the cooperation of Ankara University Psychiatric Crisis Centre and WHO presents the most comprehensive data about suicide commitments in Turkey. Despite the fact that there are no precise statistical records about suicide attempts in our country yet, a study conducted in Ankara in the year of 1990 reported suicide attempts rate as 107 in one hundred thousandth (Palabıyıkoğlu, 1992, Sayıl, 2000).

Aysev chose 30 children among 7582 children who applied to child psychiatry clinic of Ankara University between the years of 1981 and 1991 and included them into a study in order to investigate suicide attempts. Variables such as age, sex, birth order, type of suicide were compared in terms of life events which lead to suicide. The age range for females was determined as 9-14. It was determined that suicide attempt incident increased among girls with the emergence puberty and suicide attempt was found as more frequent among first children. Family relationship problems were found as a more frequent life event among the people who have suicide tendency or attempt. Families of these children found to have lower socioeconomic status and high levels of parental conflict, divorce, paternal alcohol use. These children were found to have depressive symptoms like introversion, excessive tearfulness, desire for loneliness, insomnia; behavioural problems like elope or wagging, stealing money, telling lies, vandalizing; and additional symptoms like fainting, headache and enuresis (Aysev, 1994).

There are no significant changes in the amount of suicides according to different years. However findings indicate there have been an increased number of suicides since 2002, but if this result was evaluated regarding population increase it is not possible to find a significant difference between previous years.

Table 2. Suicide levels between 2002-2011

Years	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Suicide Amounts	2301	2705	2707	2703	2829	2793	2816	2898	2933	2677

(TUIK, 2012)

Suicide rates between the years of 2007-2011 are given in Table 2. As seen on the table there is no consistent decrease and increase between each year.

Table 3: Crude Suicide Rates Between 2007-2011

Years	2007	2008	2009	2010	2011
Crude Suicide Rate	3.98	3.96	4.02	4.02	3.62

(TUİK, 2012)

If statistical records between the years of 2002 and 2011 are to be investigated by age it can be seen that people between 15 and 34 years old constitute almost a half of suicide incidences occurred between those years. Moreover, other results indicate that suicide takes place by individuals below 15 years old constituted 3-4% of whole suicide incidences and it can be clearly seen that these suicides rates tended to decrease after the age of 35. However suicide rates for the age group over 75 showed a significant increase and this increase is consistent with historical point of view (DIE, 2011).

The most common three reasons behind the suicides occurred between 2002-2011 were found as “Illness”, “family incompatibility” and “economic problems”. “Emotional, relationship and not marrying the person they wanted” follows those three reasons. However, the concept of illness given as a reason is not clear yet. It still remains unclear if it includes psychological illnesses and there was no clear discrimination made between acute and chronic illnesses. Another remarkable point is the excessive intensity of suicide level among people from young and middle age groups and males (DIE, 2011).

Findings indicate that “Hanging” was the most common suicide method for the suicides occurred between the years of 2002-2011. Past studies indicated lowest suicide rates for the people who had higher education level. (DİE, 2011).

A study was conducted in Nevşehir city centre in order to determine prevalence of suicide attempt and related family factors with it. Sample consisted of 359 high school students. Results indicated that 20.5% had suicide thoughts and 6% had suicide attempt in the past. In addition to this, family functions of students who reported suicide thoughts or attempts were determined as unhealthy (Şimşek, Karataş, 2011).

When the suicide rates in 2011 are compared according to regions, DİE reported that the Central Eastern Anatolian region (Malatya, Elazığ, Bingöl, Tunceli, Van, Muş, Bitlis, Hakkari) had the highest suicide rate with 4.70 in one hundred thousandth. The Eastern Black Sea region (Trabzon, Ordu, Giresun, Rize, Artvin, Gümüşhane) had the lowest suicide rate with 2.66 in one hundred thousandth.

1.4.3 Suicide in TRNC

A study aimed at the documentation of suicide attempts and dead incidences resulted by suicide was conducted in TRNC (Turkish Republic of Northern Cyprus) through the investigation of police and hospital records between the years of 1970 and 1990. Suicide attempt rates increased to 22.6 in one hundred thousandth in 1990 the same rates that were found as 3.3 in one hundred thousandth in 1970. TRNC was placed in the top 10 countries with high suicide rates in a study conducted by WHO among 62 countries. The distribution of suicide rates according to gender in TRNC showed consistency with other literature. Consistent with previous studies, suicide attempt rate in TRNC was found higher for females. However suicide attempts that resulted in death were found to be more prevalent among males and it was also found that males used more violent and fatal suicide methods than females (Yağlı et al., 1990).

When participants of this study were classified according to the age level, the highest suicide rates were found as 14 and 24 years old and aged over 55 for males and ages between 25 and 34 years old for females (Yağlı et al., 1990).

A study investigated files of 43 people over 17 years old, who was hospitalized due to suicide attempt between the years of 1988 and 1992 in order to investigate suicide

attempts that require hospitalization. The most common suicide method was determined as taking drugs or chemical substances and it was also reported that people living in rural areas used drinking pesticides method more frequently. It was found that disruption in interpersonal relations formed a big majority reasons responsible for suicide attempts (Şahin, Özkan, 1992).

Mass media of TRNC reported that in the year of 2012 between January and September, 14 people between 19-54 years old committed suicide by using different methods and it was also reported that 9 people attempted suicide. Methods used in those suicide attempts and commitments were declared as drinking insecticide or pesticide, by hanging, using firearms and taking pills (Haberkktc, 2012).

1.5 Theoritical Approaches

1.5.1 Biological Approaches

Several explanations were given about the biological aspects of suicide. Some parts of these emphasized on genetics whereas others pointed out changes in endocrine system. Endocronilogical approach assumes that biochemical changes is the main factor that motivates someone to commit suicide.

The risk of suicide is higher for people who had a first-degree family relative who committed suicide before. Studies conducted with both adolescents and adults also supported this argument. A series of studies indicated a relationship between lower serotonin levels and depression. It was reported that a person might be suicidal as a result of unhappiness and hopelessness feeling brought by depression due to a decrease in serotonin level (Eskin, 2003).

Yüksel (2001) found a meaningful relationship between lower levels of BOS 5-HIAA (5-hydrosyndolaestic acid: solvent product of serotonin which influence happiness and other related feeling in the brain) and agression, criminal acts, hostility, irritability.

Many studies indicated that suicide behaviour might have a genetic basis. However, there are also weak arguments of this approach. For instance, despite the genetic transfer some people who have family relatives committed suicide do not attempt or commit suicide. Biological factors are not sufficient for explaining and

understanding suicide behaviour as it has a multi-dimensional characteristic and they do not involve explanations at a behavioural and social level.

1.5.2 Sociological Approaches

French sociologist Emile conducted a comprehensive study about suicide by using statistical data and sociological explanations and ne published his book Le Suicide in 1887. Durkheim proposed that individuals needed to be regulated and controlled by society and he added that circumstances related with satisfying those needs should be in harmony with those needs. Individuals perceive themselves as a part of society by means of roles occupied in society, activities participated other emotional factors. Durkheim called this process as "Social integration". The term of social regulation is defined as the regulation of individual's desires that are sourced by individual's irrationality and every individual need this. Durkheim showed that suicide which appears as an individualistic incidence was actually sourced by disorganization and fluctuation in individual's interaction with society. It was found that people who had attached to society more than the people who failed to identify themselves with a group had lower suicide frequency. In his book, Durkheim mentioned that weakened attachment with the society identified with social group and alienation to social group was a main factor in suicide cases (Durkheim,1992)

1.5.3 Psychological Approaches

1.5.3.1 Psychodynamic Approach

Psychoanalytic theory assumes that suicide finds its source in feelings of anger towards oneself. Because of this, suicides have comparisons with murder. According to Freud's psychoanalytic theory, the individual reflects his anger onto someone else by committing a murder. In suicide, the individual reflects his anger onto himself(Eskin, 1997)

1.5.3.2 Social Learning Theory

Lester (1987) who revised social learning approach in relation to suicide claimed that suicide was a partially learned behaviour that operated against the stressful life conditions. The role and significance of social learning and imitation at the beginning of a suicide act can be seen clearly when we take a look at the background of a

suicide. For example, Europe was invaded by a suicide outbreak which is known as "Werther's syndrome" when German novelist Goethe published his novel "Werther's Sorrows". Eventually, European countries forbidden to publish this book in order to prevent spreading suicide commitments. This fact proves the effect of social learning on the emergence of suicide (Atay & Kerimoğlu, 2003).

1.5.3.3 Hopelessness Theory

Cognitive theory assumes that hopelessness that is defined as having negative expectations about the future is the most important factor that triggers and retains depression. The relationship between the depression and suicide behaviour is the starting point of this theory. If a person loses self-trust and power to cope with problems, he becomes isolated and attempts to find a solution by himself. About 75-80% percent of suicide cases emerge sourced by depression that accompanied with excessively pessimistic feelings. Thus, a person who commits suicide evaluates terminating his life as an only solution way to fix his inevitable and unsolvable situation (Geçtan, 2003; Eskin, 1997).

1.5.3.4 Escape Theory

According to Baumeister's escape theory, motivations about escape from the self, sourced by aversive self-awareness play a key role in suicide. A person tries to get rid of sorrow and unhappiness by escaping. The escape theory combines motivational factors with cognitive factors and proposes 6 phases in order to explain the process that leads to suicide (Geçtan, 2003; Eskin, 1997).

1- The person becomes aware that his or her current successes/acquisitions were not at their desired level.

2- The person attributes responsibility on himself for the personal acquisitions that remained below expectancies and blames himself for this. And the person convinces himself to accept his own personal inadequacy as a reason for this failure. Also the person's self-worth level decreases due to those accusations.

3- The individual experiences a state of self-awareness in a high level and focuses his attention on himself.

4- Aversive self-awareness is experienced by the individual and induces aversive or negative mood states such as depression and anxiety.

5- The individual experiences a cognitive destruction by the effect of the negative mood state. Cognitive destruction leads to hopelessness. An individual who commits suicide evaluates the situation that he lives in as a dilemma or unsolvable situation and chooses death in order to get rid of it as soon as possible.

6- It was declared that cognitive destruction 4 outcomes that leads to the individual killing himself.

   A- **Vanishing of internal preventions:** A big majority of people have internal restrictions or preventions against killing themselves. People who commit suicide remove those internal preventions by making them less effective.

   B- **Passivity:** People who are going to commit suicide see themselves as a sacrifice that is passive and unable to produce solution for the problem that they faced with.

   C- **Absence of Feeling:** Those people exhibit an artificial feeling of absence by repressing powerful negative feelings they have experienced.

   D- **Irrational Cognitions:** The individual becomes more prone to have irrational attitudes/dysfunctional attitudes and cognitive rigidity as a result of cognitive destruction.

Escape theory takes its place among the most comprehensive psychological theories that have been proposed recently. Because it explains the process that leads to suicide in a staggered order which progress step by step. Neglect of sociocultural variables can be shown as a defect for this theory.

1.6 Factors Related With Suicide

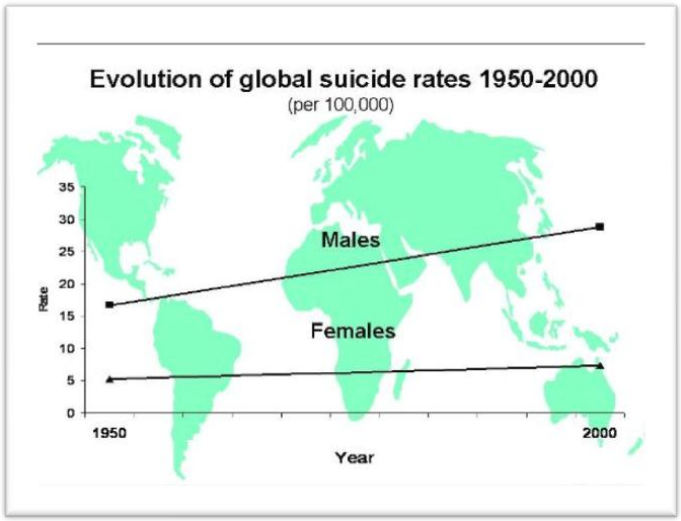
1.6.1 Sociodemographical Factors

1.6.1.1 Suicide and Gender

The distribution of suicide behaviour frequencies according to gender shows statistically meaningful differences in both Turkey and other countries (DSÖ, 2011; TUİK, 2011). Suicide behaviour is more prevalent in men than women. However, suicide thoughts and attempts are more prevalent among women than men

It can be seen from this information that men from all age groups committed suicide more than women. WHO reported higher suicide rates for males in all countries except China. Suicide attempt rate in USA was found to be 2 or 3 times more for men than women. On the other hand, rate of suicide attempt that resulted in death was found to be 4 times more amongst American men (Anderson, 1995).

Graph 1: Changes in suicide rates between the years of 1950-2000 according to gender



(World Health Organization, 2002)

TUİK (2008) reported the amount of completed male suicides were almost 2 times more than completed female suicides It was also reported that men formed approximately 60% of the whole suicide population between the years of 1987 and 1995 (Okman, 1997).

Batman'da 2000 yılında gerçekleşen intiharların büyük çoğunluğu genç yaştaki bekar ve evli bayanlarda görülmüştür. Literatürle çelişen tamamlanmış kadın intiharlarının yüksek olmasının sebeplerini Halis, "Batman'da Kadınlar Ölüyor" adlı kitabında toplumun geleneksel yapısı, kadının her türlü özgürlükten yoksunluğu, yaşam tarzı ve aile ilişkilerinden kaynaklandığını vurgulamıştır (Halis, 2002).

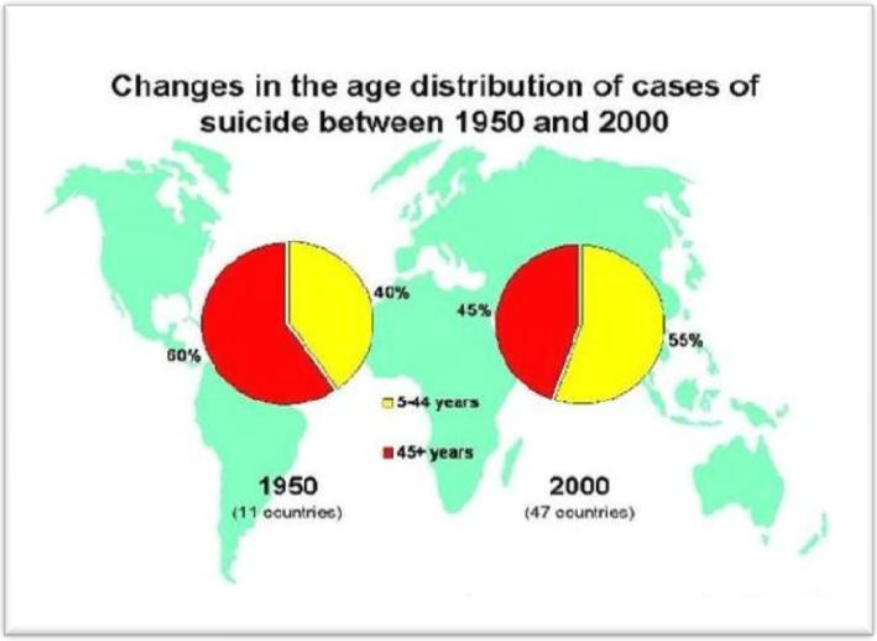
Sayar et. al. studied with adolescents who attempted suicide by taking overdose pills in order to investigate psychological factors that influence suicide intention and mortality of suicide attempt. 33 adolescent patients hospitalized in emergency unit due to taking overdose medicine included into this research. Data analysis indicated that females formed a big majority of adolescents who attempted to suicide and pointed out high mortality for their suicide attempts. A relationship between suicide intention and hopelessness was also determined (Sayar et al., 2000).

Ankara and Kırıkkale, in order to determine suicide risk of high school and college students. When high school and college students were evaluated according to the gender, it was found that male students got higher scores than female students. Hopelessness subscale was found to be having highest average score among other subscales. Findings obtained by this study indicate that high school and college students formed risk group in terms of suicide (Ceyhun, Ceyhun, 2003).

1.6.1.2 Suicide and Age

According to 2009 data of CDC, suicide rates were determined as 4.3 in one hundred thousand for the age group between 10 and 14, 7.75 in one hundred thousand for adolescents between 15-19 and 12.5 for the young adults between 20 and 24 years old. Global data indicates that suicide risk increases with age. Although it was observed that adolescent suicide rates had been increasing for 20 years, late adulthood is still known as the period that has the highest suicide rate.

Graph 2. Suicide rate changes according to the age groups in the years between 1950-2000



(World Health Organization, 2002)

When the distribution of suicides classified according to the age group, the highest suicide rates were found in the ages 15 and 54. Suicide rates in total indicate that the number of people who kill themselves increases by age.

WHO European Regional Office started a follow up study in 1988 in order to investigate the suicide rates in Europe. Participants from Ankara were also included into the sample as a part of this study. A group of patients who had attempted suicide before were taken into a follow up interview. The rate of recurring suicide attempts and possible factors that might be related with those attempts were investigated in this sample. Results indicated higher suicide attempt prevalence for young adults and women. It was also found that suicide attempts convey an intention of expressing hopelessness and seeking for help from others. People who reattempted suicide were found to have more frequent suicidal thoughts than others. History of previous suicide attempt and hard life events were found to be serious risk factors for suicide (Paracıkoğlu, Sayıl, Özgüven, 2004).

1.6.1.3 Suicide and Marital Status

DIE reported that 875(48.2%) of 1815 people who committed suicide were married, 769 (42.4%) of those people had never been married, 92 (5.1%) experienced partner loss loss due to death, and 79 (4.3%) was divorced. In the year of 2002 marital status

of the people who committed suicide were listed as 50% married, 36% had never married and 5.9% divorced. When the marital status of the people distributed according to sex, it was observed that majority of males who committed suicide were married and majority of females committed suicide had never married (TUİK, 1996, 2012)

Özen reviewed marital status of the people who committed suicide between the years of 1926 and 1993 in his book named as "suicide". In conclusion, he found that suicide risk of young men who lived alone was lower than married ones and men at older ages who lived alone had higher risk for suicide. Single people have more risk for suicide than married ones. Married people have lower suicide probability since married since they took responsibility of other family members. In other words, it can be said that responsibility diminished suicide probability (Özen,1997).

1.6.2 Psychological Risk Factors

Suicide behaviour is a multi-dimensional issue and its risk factors show an extended distribution. Certain risk factors can be listed as psychiatric disorders, being exposed to abuse in childhood, suicide attempt history in family, hopelessness, alcohol and substance abuse, accessibility to suicide tools, lower self esteem, loneliness, cognitive distortions, inadequacies in problem solving and coping skills and lack of social support (Ersoy, 2008; Jamison,2004; Eskin,2003,Özgüven, 12; Şevik ve ark. 2012). This study emphasized on relationship of suicide with problem solving skills. So many studies had been conducted ever to determine risk factors in suicide behaviours.

A study was conducted with a sample consisted of 114 people between the years of 2002 and 2005 in order to determine risk factors related with suicide. The most frequent suicide method was found as taking overdose pills with 81.6% (n=93). It was determined that 37.7% had previous suicide attempt, 8.8% had suicide attempt in family, 15.8% had suicide attempt in their intimate environment. Major depression was found as the most frequent psychiatric disorder for the people who attempted to suicide (Deveci, Aydemir,Mızrak, 2006).

Sayar and Bozkır investigated risk factors for adolescent suicide attempts with a sample consisted of 60 adolescents who were hospitalized because of suicide attempt during the first 4 months of 2002 in Trabzon. They concluded that suicide intention

was determined by variables such as leaving a suicide note, sleep problems, living in the city centre. In addition to this, they also reported that suicide intention was determined by intensity of depression and mortality was determined by the intensity of suicide ideation and intention (Sayar, Bozkır, 2004).

Batıgün investigated possible differences of factors according to gender that predict suicide risk such as interpersonal relationship styles, reasons for retaining their life, loneliness and hopelessness on a sample consisted of 1003 people between 18 and 60 years old who were from Ankara, İzmir and Mersin provinces. Loneliness, hopelessness and dependence to life were found as common predictors for both males and females. Lack of nourishing style and social support was found as predictors of suicide risk for women and frustrating communication style and education was found as predictors of suicide risk for males (Batıgün, 2008).

Gürkan and Dirik (2009) studied on 385 students in order to determine factors related with suicide thoughts and behaviours. It was reported that female students had more reasons for maintaining their lives than male students. Desperation, dependence to life, suicide plan and attempt, seeking for optimistic/social support, coping, suicide thoughts, satisfaction about health condition were found as factors related with repeatability of suicide.

A study conducted in 2005 aimed to determine opinions of senior students in high school in the context of self-mutilation and suicide thoughts. A survey study conducted with 726 senior students in high schools indicated existence of a powerful and meaningful relationship between suicide perception of youngster and factors like sex, parental child care style, stigmatize family relationships, substance addiction, self-mutilation, gender identity, belief. When sex and youngster's respect for individuals who attempted to suicide compared, it was found that males had less tendency than females (56.9%). Investigation of the relationship between being stigmatized by parent and youngster's suicide perception revealed that youngsters who were stigmatized by their parents had an increased tendency to accept suicide as a normal behaviour (27%). Investigation of the relationship between coherence of adolescent's parents and adolescent's suicide perception revealed that children of parents with incompatibility had an increased tendency to accept suicide as a normal behaviour (18.5%). Investigation of the relationship between experiencing discipline

problems and youngster's suicide perception revealed that youngsters experienced discipline problems at school had an increased tendency to accept suicide as a normal behaviour (46.3%). It was also reported that youngsters who did not believe in god were more tended to accept suicide as a normal behaviour (%22) (Ulusoy, Demir, Baran, 2005).

Haran and Aydın, conducted a study on a sample consisted of 160 participants. They investigated the relationship of depression, hopelessness, social acceptance, self-monitoring with suicide ideas by comparing normal participants and those in crisis and they also evaluated whether which one of those variables was the most powerful predictor of suicide. Findings indicated that suicide ideas of normal individuals were related with hopelessness. Namely, it was thought that depression was the basic variable that determines suicide ideas of normal individuals (Haran, Aydın, 1995).

1.7 Problem Solving and Suicide

Bingham defines the problem as the obstacle that blocks a person's existing powers that prepared for achieving a goal. Being encountered with obstacles at the process of trying to reach a goal is the indicator of having a problem. Problem solving is a process of defeating difficulties that experienced while trying to achieve a goal (Bingham, 1998). Individual has to make a decision about the most reasonable solution way and how to act in the process of problem solving. This skill, which is acquired in developmental stages significantly, effects individual's social adjustment and daily functioning success.

People who have inadequate problem solving skills fail to create alternative solutions when they encountered with a problem or situation. Eventually, they walk in the trap of hopelessness. As the hopelessness level increases people become more disposed to depression. Thus, they attempt to terminate their lives. Perceiving a problem as unsolvable is very important factors that trigger suicide (Eskin, 1997).

Beginning from the childhood, individuals imitate problem solving methods that they observed in close environment. Common attitudes among the people who have suicidal thoughts are feeling worn down by the weight of problems, thinking that no one would help them and problem would never be solved. At this point, it would be

useful to inform individuals about positive perspectives for insight acquisition of individuals (Kulaksızoğlu, 2013).

Batıgün and Şahin conducted a study on a sample consisted of 619 people between 14 and 62 years old, in order to determine if people would show any difference about thinking suicide as the first solution way in relation to situations or difficulties experienced. He also investigated relationship between this tendency and other variables, such as suicide risk, problem solving skills, anger/aggression. Analyses indicated that age group between 14-24 years old scored higher in all scales than other age groups. Namely, young people perceive themselves as incapable for problem solving, the yact more impulsive, appear angrier and think suicide as the first alternative solution way in relation to stressful event more frequently than other people (Batıgün, Şahin, 2003).

Şahin, Onur and Basım proposed a model that assumed inadequate problem solving skills of individual, severe anger and impulsivity were the significant variables for predicting suicide probability and they assumed that people who scored higher in all these three variables would have a higher risk of suicide. They formed a sample for testing validity of their model which consisted of 792 high school and college graduate civil servant men. Findings revealed that proposal of this model which was defined as people with excessive anger and impulsivity who perceive themselves as incapable at problem solving would have suicide risk, might be valid for this sample (Şahin, Onur and Basım, 2008).

Bu konuda yapılan başka bir çalışmada intihar girişimi olan ve olmayan gençlerin başa çıkma tutumları ve aile işlevselliği açısından değerlendirildiği bir çalışmaya Atatürk Üniversitesi Tıp Fakültesi Psikiyatri Kliniğine intihar girişimi sonrası başvuran 30 gençle kontrol gurubu olarak 30 sağlıklı genç dahil edilmiştir. Yapılan araştırmanın sonucunda intihar girişiminde bulunan gençlerin özellikle problem çözümüne yönelik olan pozitif yeniden yorumlama ve gelişme, aktif baş etme, şakaya vurma başa çıkma tutumlarını daha az kullandıkları saptanmıştır. Bu guruptaki gençlerin aile içinde iletişim ve problem çözme ile ilgili sorunlar yaşadığı ve genel aile işlevselliklerinde bozukluk olduğu belirlenmiştir (Fidan, Ceyhun, Kırpınar, 2010).

1.8 Social Support And Suicide

Social Support can be defined as the social and psychological support the person has obtained through his/her environment. Perceived social support is defined as individual's general impression about sufficiency of the support provided by social support (Sorias, 1989). Factors like individual's family, the most extended family setting, friends, partners from opposite sex, teachers, colleagues, neighbours, ideological, religious or ethnic groups and society that individual lives in constitute their social support resources. Individual's social support level may change due to changes in individual's himself or social supports. For example, situations like marital or family incompatibility, occupational loss experienced by a parent, death of a partner, inadequate social skills, individual's deviant sexuality, ignorance of individual about formal and informal aid resources, immigrations, illness, marrying with someone from a different religious or ethnic origin that is not accepted by family members may decrease individual's social support level (Yıldırım,1997).

In adolescence period, individual needs help for acquiring values that will guide him and learning social responsibilities. Family is the first and necessary social institute that responds this need (Yavuzer, 2005). Quality of family relations is the most important factor that influences adolescent's reaction to stress. Because adolescents are generally exposed to stressful events while they were spending time with their families and family is responsible for providing support to child for coping with stress. Adolescents grown by families, in which adequate support was provided, become brave and well-adjusted individuals with society in future.

Friends are another important resource who provides social support for adolescents. As the friendship gains importance, pressure of peer groups reaches to an equal level with family influence that constitutes an important social support resource by beginning from early years of life. Influence of friends may even become more dominant than family influence. Today, the most important characteristic of adolescents is spending a large amount of attention to their peers and being largely effected by them. Adolescents spent most of their free time away from their families. They generally spend their times with peer group and peer group are more effective on their concerns, attitudes and values. Studies indicated that friendship was a significant factor for psychological recovery and life stress reduction (Cüceloğlu, 1993).

Budak (1999) examined the relationship between perceived social support and problem solving skills of high school students. Sample of this study consisted of 134 females and 133 males which calculated as 267 students in total. It was concluded increase on problem solving skills was significantly related with higher perceived social support that provided by family and friends. Male college students reported lower stress level while female college students reported higher levels.

Bayram (1999) observed that mental health condition got better as the level of perceived social support increased and he also observed an increase in mental illness symptoms as the perceived social support level decreased.

Studies conducted in abroad generally focused on perceived social support provided by parents and friends, importance and rating of social network, importance of social support in the adolescent risk groups, social support for alcohol or drug addiction, social support for physical disorders, socioeconomic level and perceived social support.

Tüzün (1997) studied with 401 college students between 17 and 27 years old that consisted of 203 females and 198 males. Findings of this study indicated that depression was the most important variable that predicts suicide risk of college students. Friend support, family support and reasons for living were also found as important predictors of suicide. This study pointed out depression as an important variable that predicted suicide risk in both clinical and non-clinical samples and also emphasized on situations accompanied by depression that occurred as a result of lack of social support.

To summarize, people who have suicide risk experience lack of appropriate social resources. Social isolation of the individual would be diminished as the social network extended and reliance on social network increased.

1.9. Self -Esteem and Suicide

Adolescence period is a transition and preparation process that involves psychological, mental, social and moral development. Yörükoğlu (2013) defines self-concept as the organizational integrity of emotions, attitudes and behaviours that makes a person distinctive. Self-esteem is a characteristic that acquired in adolescence. It is the state of satisfied with one’s own self without feeling extremely

better or worse than he or she was. Individuals attempts to understand if how what kind of a person they were, what they were wanted to do, how they were perceived by the environment, what were their negative and positive aspects. Young ones who accept themselves as they are existed maintain their life in a positive mood state that brings out self-trust.

Self-images that developed in adolescence by the influence of internal factors and environmental factors determine the self-approach of the adolescents. Orientation of this approach, in other words evaluating one's own self worthy or worthless determines self-esteem. Self-esteem provides a basis for thoughts and behaviours in adolescent's future life that form the core of identity (Erbil, Divan ve Önder, 2006). Yörükoğlu (2013) investigated psychological symptoms manifested by youngsters with lower self-esteem in last 5 years and it was reported that they prominently manifested symptoms of insomnia, anger, in appetence, headache, tremor and restlessness. This finding points out existence of a close relationship between self-esteem and mental health. It can be said that people with higher self-esteem had positive psychic characteristics such as self-trust, optimism, willingness to be successful, coping with difficulties whereas people with lower self-esteem had characteristics such as lower self-trust, feeling hopelessness.

1.10 Intervention And Prevention Studies

General purpose of suicide prevention studies is collecting information about the role of thoughts in suicide and developing preventive attitudes and techniques for suicide risk. It is necessary to evaluate various reasons interacting with each other by maintaining biopsychocialintegrity and inclusively rather than focusing on one single or a few risk factors (Sayıl, 2000).

Köroğlu stated that people chose suicide as a result of desire of getting away from the obstacles that perceived as unsolvable and insurmountable or giving end to painful, endless emotional state and he added that it was not possible to make a precise prediction about timing of the suicide. An individual who express ideas about getting tired with life and suicide thoughts should be taken seriously (Köroğlu,1997; Yörükoğlu,2004). It is important to observe coping skills of an individuals and teaching new strategies to make them acquired positive perspectives (Kulaksızoğlu, 2013).

Suicide attempt is the indicator of existing problems in the family context in addition to youngster's problems. It is an opportunity to review of relationships and assessment of problems. It is important to investigate reasons that broke domestic balance and evaluate life traumatic life events that gave way to depression.

Precautions such as conducting studies that investigate suicide in a multidimensional manner and informing society about those studies; informing and educating professionals who are likely to encounter with people who have suicide risk; providing psychosocial treatment and care for the individual in crisis or individuals who attempted to suicide; determining risk group or people with suicidal tendencies and providing a basis for their treatment; generalizing crisis centres that serves around the clock; informing media about how to broadcast news about suicide; avoiding accessibility to suicide tools can be listed as preventive strategies (Ersoy, 2008; Jamison, 2004).

1.10.1 School Based Prevention Studies

Preventive studies in the field of mental health were taken from public health studies and they were classified in three steps

1.10.1.1 Primary Prevention

Aim of primary prevention is preventing suicide before kill themselves. It is defined as improvement of student's coping skills, acknowledgement of students about signals and risk factors related with suicide, empowerment of the emotional bonds between students and per group or school in order to prevent formation of possible suicide thoughts in future. Skill training program that found in annual education plan aims to make students with suicidal tendencies acquired certain skills such as coping with depression, anger management, diminishing loneliness, solving interpersonal problems, looking for help, coping with critical situations and increasing personal capabilities (Gündoğar, 2006; Öncü 2006).

1.10.1.2 Secondary Prevention

Secondary prevention aims to diminish existing suicidal thoughts, find appropriate approachment to a person with suicidal thoughts and direct them to appropriate experts. Secondary preventive studies are operated just after the occurrence of suicide thoughts or behaviours. The main purpose is decreasing those thoughts or

behaviours to the minimum level. It is necessary to have knowledge about the characteristics of risk groups and intervening efficiently right on the time to realize this purpose (Gündoğar, 2006; Öncü 2006).

Screening surveys applied in schools have crucial value. Those surveys are based on self-report method which enables individual with suicidal tendencies to become aware of them and individualistic interview method. Depressive, alcohol or substance using adolescents and those who had suicide attempts in the past and talks about suicide thoughts determined by means of screening surveys should be considered as prior individuals who need help.

1.10.1.3 Tertiary Prevention

This one is related with intervening individuals who attempted to terminate their lives. Tertiary prevention aims prevent recurrence of suicide attempts.

In tertiary prevention, treating trauma of the family or close friends of the yougsters who attempted to or committed suicide, preventing new suicide attempts in future among youngsters are also worked in addition to working with the youngster who attempted to suicide. On the other hand, existence of a crisis intervention program in the school that prepared previously makes those studies easier.

Application of long term therapy to the youngster who attempted to suicide is ver very important. This therapy includes; a)changing thoughts about being abandoned or rejected, b)increasing self-perception, c) providing healthy identification, d)changing anger reactions against disappointment, e)diminishing depression and hopelessness (Özgüven-Devrimci, 2003).

2. METHOD

2.1. Sample

At the sample formation process, 5 schools consisting in TRNC Ministry of National Education and Culture were chosen and taken into the sample. Data collected for this research obtained from 260 10th and 11th grade students of 19 Mayıs TMK, 20 Temmuz Science High School, Anafartalar High School, LaptaYavuzlar High School and Haydarpaşa Vocational Trade High School. 160 participants are females and 100 participants are males. Age range of this sample is between 15-20 years old. Average age of this sample is 16,56 ± 1,11(15-20)

2.2. Instruments

Sociodemographic form was prepared by researcher and used for determining personal information of the participants. Suicide Probability Scale (SPS) was used in order to determine suicide probability of high school students; Problem Solving Inventory (PSI) was used in order to evaluate problem solving skills; Multidimensional Scale of Perceived Social Support (MSPSS) was used in order to determine the level of perceived social support and Rosenberg Self Esteem Scale (RSES) was used in order to evaluate self-esteem of high school students. All information about validity, reliability, scoring and interpretation of these instruments are given below.

2.2.1 Socio-Demographic Information Form

Sociodemographic Information Form was prepared by researcher in order to determine characteristics of participants such as age, sex, economic status. Information for consist of 13 questions about age, sex, smoking and alcohol use frequency, academic success level, parental birth places, parental marital status, parental economic status and parental education level of participants.

2.2.2 Suicide Probability Scale(SPS)

Suicide Probability Scale, was developed by Kull &Gill (1988) in order to evaluate suicide risk of individuals at 14 years old and older. Scale consist of 36 items which handle emotional, behavioural and cognitive components of suicide all together in

hopelessness, suicide ideation, negative self-evaluation, hostility sub dimensions(Akt., Tüzün, 1997).

In original study, criterion validity of this scale was compared with "Suicide Risk Scale" which was developed by Kull and Gill (1988) and also inspired by Minnesota Multiphase Personality Inventory (MMPI) and correlation number was found as .70. In the same study, it was also observed that SPS was also capable to distinguish adolescents without psychiatric disorder, adolescents with psychiatric disorders and adolescents attempted to suicide before (Cited by: Atlı, 2007). Larzelereet. al. (1996) studied on 855 adolescents in order to determine prediction validity of this scale and they stated that scores provided by SPS predicted suicide attempt.

Internal consistency of scale was analysed on participants numerated with even and odd numbers. Coefficient number of internal consistency was found as .93 in both of two analyses (Cull ve Gill, 1990: Akt., Atlı, 2007).

Cronbach alpha internal consistency coefficient was determined as .95 in a study conducted by Şahin and Durak-Batıgün (2000) on a sample consisted of 133 people in three groups named as patients attempted to suicide, patients diagnosed as depression patients and healthy individual without any diagnosis. Subscale internal consistency coefficients were calculated as .95 for negative self and extinction, .79 for breaking off being attached with life and .53 for anger.

Suicide Probability Scale is a self-evaluation and likert-type scale scored between 1 and 4 points which consists of 36 items. Answers given to items are listed as; "never or rarely" (1), "sometimes" (2), "often" (3) "generally or always" (4). Original scale four subscales;; 1)Hopelessness-HP 2) Suicide Ideation-SI 3) Negative Self Evaluation-NSE 4) Hostility-HS. Hopelessness is scored by (12) items, suicide ideation by (8) items, Negative Self Evaluation by (9) items and Hostility by (7) items of the scale. High scores obtained from every subscale indicate increase of characteristic that evaluated and high scores obtained from the whole scale indicates increase of suicide probability (Akt., Tuğcu, 1996).

Items 2, 6, 7, 10, 11, 18, 20, 21, 22, 24, 25, 26, 27, 30, 32, 35 and 36 processed as reverse items at scoring of suicide probability form used in this study (Şahin and Durak-Batıgün, 2000).

Distribution of scale items according to the subscales is listed as following:

Negative Self and Extinction (OBT-20 items): items 5, 9, 10, 12, 15, 16, 17, 18, 19, 23,25, 26, 27, 28, 29, 30, 32, 33, 35 and 36.

Breaking off being attached with life (HBK-8 items): items 2, 6, 7, 11, 20, 21, 22 ve 24

Anger (A-8 items): items 1, 3, 4, 8, 13, 14, 31 ve 34.

2.2.3 Problem Solving Inventory (PSI)

Problem solving inventory is a likert-type scale scored between 1 and 6 points, consisted of 35 items and it was developed by P. P. Heppner & C. H. Petersen (1982). PSI was adapted into Turkish language by Nail Şahin, Nesrin H. Şahin and Paul Heppner in 1993. Inventory is defined as a scale that enables to individual evaluateshis problem solving style and skill. This scale includes evaluation of perceptions and approaches of individuals about problem solving and people are asked to report frequency of behaviours for themselves that stated in scale items. Alternatives of items are listed as “I always act like this” , “I generally act like this” , “I often act like this” , “I sometimes act like this” , “I rarely act like this” , “I never act like this” .Excessiveness of total score obtained from this scale indicates that individual perceived himself as incapable at problem solving.

Inventory consisted of 3 factors named as “Reliance on problem solving skills” (11 items) “approach-avoidance” (16 items) and “personal control” (5 items) (Cited by: Nezu, 1986).

In a study which aimed to evaluate reliance of the scale, Cronbach Alpha (α) reliance coefficient was determined as .83 for the whole scale and coefficients calculated for subscales showed variation between .68 and .79.

6 factors were found as a result of factor analysis in this scale which were named as “Hasty approach”, “regardful approach”, “evaluative approach”, “assertive approach”, “avoidant approach” , “planned approach” (Savaşır and Şahin, 1997).

Subscales:

1. Hasty Approach (items 13,14,15,17,21,25,26,30,32),

2. Regardful Approach(items 18,20,31,33, 35),
3. Avoidant Approach(items 1,2,3,4),
4. EvaluativeApproach(items 6,7,8),
5. Assertive Approach (items 5,23,24,27,28,34)
6. Planned Approach(items 10,12,16,19)

2.2.4 Multidimensional Scale of Perceived Social Support (MSPSS)

Multidimensional Scale of Perceived Social Support Scale was developed by Zimet, Dahlem, Zimet and Farley (1988) in USA. MSPSS is a likert-style scale which consists of 12 items. It is based on subjective evaluation of social support by individual's himself. Three different groups which determined as the source of support are identified as family, friends and a significant other. Every single group consist of 4 items. Scale is scored in likert-style between 1-7 points. Sum of 4 items in every single subscale gives subscale scores and sum of subscale scores gives total score. High level of total scores indicates high level of perceived social support (Eker, Arkar and Yaldız, 2001).

Validity and reliability study of this scale for Turkish population was conducted by Eker&Akar. Validity and reliability study for young population (ages between 12-22) was conducted by Cakır&Palabıyıkoğlu.

In the first adaptation study of this scale for Turkey, construct validity of the scale was evaluated in terms of anxiety and depression computation.In this study, subscales found in the original form of this scale were supported factor analysis. It was stated that MSPSS and subscales had sufficient internal consistency and it was also accented that scale correlated negatively with anxiety and depression scales (Eker and Arkar, 1995).

Factorial structure, construct validity and reliability of Turkish form of MSPSS were generally found at satisfactory level. However it was stated that some kind of difficulties were experienced at the adaptation process of "significant other" subscale. Evaluations about this sample showed that the term of "significant other" was not a well-known term in Turkey. Because of this some kind of changes were made in subscale named as "significant others" in original form and this term was restated for someone except friends and family (flirt, fiancé, relative, neighbour,

doctor etc). Factors and items related with each factor which were determined by factor analysis conducted on restated scale are given below::

Family: items 3, 4, 8 and 11

Significant Others:items 1, 2, 5, 10

Friends: items 6, 7, 9 12

Three factors explains cumulatively 75.3% of total variance, 45% of "family factor", 17.9% of "significant others factor" and 12.4% of "friend" factor. Values used in order to evaluate internal consistency by using Cronbach alpha method were calculated between .80 and .95 (Eker, Arkar and Yaldız, 2001).

2.2.5 Rosenberg Self Esteem Scale (RSES)

Rosenberg Self-esteem scale (RSES),was developed by Morris Rosenberg in 1965, in order to evaluate self-esteem level of adolescents.This is a 4 graded likert-type scale replied between "very true" and "very false" and consisted of 10 items. Scale consists of five positive expressions, such as "I have a positive attitude towards myself and five negative expressions such as "I have a tendency for evaluating myself as unsuccessful"(Çuhadaroğlu, 1986) .

Scoring process of involves three steps. In the first step, items 1,2,4,6 and 7 replied as false or very false, arescored as 1 point and items replied as true or very true, are scored as 0 point. In the second step if the sum of items1, 2, 3 is foundas at least 2 or more then it is scored as 1 point. If the sum of items 4 and 5 is found as at least 2 or more, then it is scored as 1 and if the sum of same items is found as 0 then it is scored as 0. Sum of items 6, 7, 8 is scored as minimum 0 and maximum 3. I the sum of item 0 and 10 is at least 1, then it is scored as 1 point. In the third step, sum of all items are taken and a score between 0 and 6 is calculated. Scores between 0-2 indicate high self-perception and scores between 3 and 6 indicate low self-esteem (Emil, 2003).

This scale was translated in Turkish by Çuhadaroğlu and internal consistency coefficient value was calculated as .71.

First of all, Permission needed for collecting data in high schools was provided from Ministry of National Education and Culture. Then the application material which

used later was formed by combining data collection means all together. At first, school director and teachers were informed about the aim of study and they were also asked to determine an appropriate time for data collection. Application materials were given to students during the lessons which were determined as appropriate times by teachers. Students were informed about the purpose of data collection just before the beginning of application. They were informed about that materials would be evaluated collectively, not individually and they were not asked to write a name on materials. Importance of giving realistic replies for the study process was also expressed to participants. Brief instructions were given about scoring scales and also help provided for them when they experienced any difficulty about scale items. Application material was completed by participants between 20 and 35 minutes.

During the application process, students who replied items at random without reading were determined, then their materials were marked as invalid after the application process and they were excluded from the sample. Afterwards, scales were investigated and 40 scales determined as replied at random or incompletely were eliminated. Rest of scales were transferred to computer program and prepared for the analysis after making required editing and controls.

3. RESULTS

3.1. Socio-demographic Findings

Data obtained from this study was collected from 260 students between 15 and 20 years old who were chosen among 5 public schools in TRNC.

Table 4. Sex rates of the participants

Sex	n	%
Female	160	61,5
Male	100	38,5
Total	260	100

160 (61.5%) of participants are females and 100 (38.5%) are males. The average age of participants was calculated as 16,56 ± 1,11(15-20).

Table 5. Mother's birth place of the participants

Mother's birth place	n	%
Cyprus	77	29,6
Turkey	168	64,6
Other	15	5,8
Total	260	100

Birth place of mothers of participants was found as 168 (29.6%) Cyprus, 168 (N=168) in Turkey and 5.8% in other countries.

Table 6. Father's birth place of the participants

Father's birth place	n	%
Cyprus	80	30,8
Turkey	172	66,2
Other	8	3,1
Total	260	100

Birth place of fathers of participants was found as 80 (30.8%) in Cyprus, 172 (66.2%) in Turkey and 8 (3.1%) in other countries.

Table 7. Mother's educational levels of the participants

Mother's education level	n	%
Primary school graduate	99	38,1
Junior high school graduate	42	16,2
High school graduate	100	38,5
College or university graduate	19	7.3
Total	260	100

Education level of mothers of participants was found as 99 (38.1 %) graduated primary school , 42 (16.2%) graduated junior high school, 100 (38.5%) graduated college, 19 (7.3'ü%) graduated college or university.

Table 8.Father's educational level of the participants

Father's education level	n	%
Primary school graduate	71	27,3
Junior high school graduate	61	23,5
High school graduate	92	35,4
College or university graduate	36	13,9
Total	260	100

Education level of fathers of participants was found as 71 (27.3 %) graduated primary school, 61 (23.5%) graduated junior high school, 92 (35.4%) graduated college, 36 (13.9'ü%) graduated college or university.

Table 9. Number of siblings

Number of siblings	n	%
1	21	8,1
2	126	48,5
3	68	26,2
4	23	8,8
5	16	6,2
6 and more	6	2,3
Total	260	100

Sibling number of students was found as 21(8.1%) had no sibling, 126 (48.5%) had 2 siblings, 68 (26.2%) had 3 siblings, 23 (8.8%) had 4 siblings, 16 (6.2%) had 5 siblings and 6 (2.3%) had 6 or more siblings**.**

Table 10. Marital status of the parents

Marital status of parents	n	%
Together	220	84,6
Seperated	32	12,3
Divorced	5	1,9
One parent died	3	1,2
Total	260	100

Parental marital status of participants was found as 220 (84.6%) lived together, 32 (12.3%) lived separated. 5 (1.9%) of families was found as divorced and 3 (1.2%) of participants reported of at least one dead parent.

Table 11. Income level per month of the participants

Income level per month	N	%
Minimum wage and below	26	10,0
Between 1300-2500	111	42,7
Between 2500-5000	99	38,1
Between 5000-10 000	18	6,9
10 000 and more	6	2,3
Total	260	100

Income level distributions per month were found as 26 (10%) minimum wage and below, 111(42.7%) between 1300-2500 TL, 99 (38.1%) between 2500-5000 TL, 18 (6.9%) between 5000-10.000 TL and 6 (2.3%) 10.000 TL and more.

Table 12. Life-time frequency of smoking

Smoking frequency	N	%
0	169	65,0
1-2 times	33	12,7
3-5 times	17	6,5
6-9 times	9	3,5
10-19 times	5	1,9
20-39 times	5	1,9
40 or more times	22	8,5
Total	260	100

169 (65%) of participants reported that they had never smoked. Smoking frequency of participants are listed as 33 (12.7%) 1-2 times, 17 (6.5%) 3-5 times, 9 (3.5%) 6-9 times, 5 (1.9%) 10-19 times, 5 (1.9%) 20-39 times and 22 (8.5%) 40 times or more.

Table 13. Life-time frequency of alcohol use

Frequency of alcohol use	N	%
0	68	26,2
1-2 times	45	17,3
13-5 times	35	13,5
6-9 times	18	6,9
10-19 times	30	11,5
20-39 times	11	4,2
40 or more times	53	20,4
Total	260	100

68 (26.2%) of participants reported that they had never used alcohol. Alcohol using frequency of participants are listed as 45 (17.3%) 1-2 times 35 (13.5%) 3-5 times, 18 (6.9%) 6-9 times, 30 (11.5%) 10-19 times, 11 (4.2%) 20-39 times and 53 (20.4%) 40 times or more.

Table 14.Perceived academic success of the participants

Academic success level	N	%
Perfect, I'm among the best students	20	7,7
So good, I'm quite above the average	40	15,4
I'm above the average	118	45,4
I'm below the average	73	28,1
I'm quite below the average	4	1,5
Very unsuccessful, I'm among worst ones	5	1,9
Total	260	100

20 (7.7%) of students reported their academic success level as perfect, they were among the best students, 40 (15.4%) reported as very good, 118 (45.4%) reported as

quite above the average, 73 (28.1%) as above average, 4 (1.5%) as below average and 5 (1.9%) as very unsuccessful, bad level.

Table 15. Attitude towards school of the participants

Attitude towards school	N	%
I like	109	41,9
I hate	46	17,7
I have found it so difficult	66	25,4
I went to school with pleasure	39	15,0
Total	260	100

When the attitudes of participants towards was asked 109 (41.9%) reported they liked so much, 46 (17.7%) reported they hated, 66 (25.4%) reported that they had found school so difficult and 39 (15%) reported they went to school with pleasure.

Table 16. Correlation between mean scores of SPS, PSI, MSPSS, RSS

	SPS (r) (p)	PSI (r) (p)	MSPSS (r) (p)	RSS (r) (p)
SPS	-	0.217 0.001**	-0.442 0.000**	0.491 0.000**
PSI	0.217 0.001**	-	-0.157 0.012*	0,112 0.073
MSPSS	-0.442 0.000**	-0.157 0.012*	-	-0.343 0.000**
RSS	0.491 0.000	-0.036 0.568	-0.343 0.000**	-

*p ≤ 0,05,** p< 0,001

When the correlation between mean scores of PSI, SPS, MSPSS and RSS were compared with Pearson correlation analysis, it was found that SPS had positive mild correlation (r = 0,217) with PSI, negative moderate correlation (r = - 0,442) with MSPSS and had positive correlation (r = 0.491) with RSS. PSI and MSPSS had significant negative mild correlation (p=0.014).

Table 17. Comparison of mean scores of MSPSS-total and MSPSS subscales according to gender

	Female	Male	t df p
MSPSS-total	61,80±14,28 (n=160)	59,33±14,90 (n=100)	1,334 258 0,183
MSPSS-family	21,02±6,31 (n=160)	20,48±5,77 (n=100)	0,699 258 0,485
MSPSS-special	19,11±6,24 (n=160)	18,02±7,32 (n=100)	1,170 258 0,243
MSPSS-friend	21,66±6,24 (n=160)	20,83±6,11 (n=100)	1,054 258 0,293

$^{*}p \leq 0,05, ^{**} p< 0,001$

When mean scores of MSPSS total and MSPSS subscales were compared according to gender with independent t-test analysis, no significant difference was found between the groups.

Table 18. Comparison of mean scores of SPS and PSI, according to gender

	Female	Male	t df p
SPS- Total	70,52±12,12 (n=141)	71,06±13,77 (n=95)	- 0,321 234 0,749
PSI- Total	81,50±14,27 (n=159)	85,66±16,01 (n=100)	- 2,180 257 0,030

*p ≤ 0,05, ** p< 0,001

When mean scores of SPS-total and PSI-total were compared according to gender with Student's t-test analysis, no significant difference was found between the groups.

Table 19.Comparison of RSS mean score of the students according to gender

	Female	Male
RSS- high	124	70
RSS- moderate	19	20
RSS-lower	16	9
Total	159	99

p= 0.341

When different levels of RSS were compared according to gender with Chi-square Test, no significant difference was found between the groups.

Table 20.Comparison of SPS mean score according to origin

	TRNC	Turkey	Other	df f p
SPS	69,97±12,66 (n=73)	71,28±13,14 (n=148)	69,06±9,66 (n=15)	2 0,392 0,676

*p ≤ 0,05, ** p< 0,001

When SPS mean score of the students were compared according to their origin with One-Way ANOVA, no significant difference was found.

When three groups (PSI, MMSPS,RSS) were compared according to mother's origin with One-Way ANOVA, no significant difference was found (p≥0,05).

When three groups (PSI, MMSPS,) were compared according to mother's origin with One-Way ANOVA, no significant difference was found (p≥0,05).

When, RSS were compared according to mother's and father's origin with Chi-square Test, no significant difference was found (p≥0,05)

Table 21.Comparision of mean scores of PSI, SPS and MSPSS according to students with lower, moderate and high self-esteem

	High self esteem	Moderate self esteem	Low self esteem	t df p
MSPSS	63,77±13,93 (n= 194)	55,10±11,16 (n=39)	48,36±14,39 (n=25)	3 13,153 0,000**
PSI	82,01±14,16 (n= 194)	84,21±15,70 (n=38)	89,76±19,31 (n=25)	3 2,069 0,105
SPS	67,19±10,79 (n= 172)	76,46±11,05 (n=39)	85±13,79 (n=23)	3 25,362 0,000**

*p ≤ 0,05, ** p< 0,001

When mean scores of MSPSS,SPS and PSI were compared according to different levels of RSS with One-way Anova, significant difference was found between the groups. Further analysis with Tukey showes that there is a significant difference among high, moderate and low self-esteem groups.

When three groups are compared according to PSI total score, no significant difference was found.

When means scores of MSPSS total was compared among students with high, moderate and low self esteem with One-way Anova, significant difference is found

(p= 0,000).Further Analysis with Tukey shows that students with lower self-esteem have lower MSPSS scores (p= 0,000) than students with moderate self-esteem and students with moderate self-esteem have lower MSPSS scores than students with high self-esteem (p= 0,000).

When means scores of SPS total was compared among students with high, moderate and low self esteem with One-way Anova, significant difference is found(p= 0,000). Further Analysis with Tukey shows that there is significant difference between each group ($p \leq 0.05$).İt is found that students with lower self-esteem have higher SPS scores (p= 0,000) than students with moderate self-esteem and students with moderate self-esteem have higher SPS scores than students with high self-esteem (p= 0,000).

Table 22. Comparison Of SPS, PSI, MSPSS mean score of the students according to frequency of smoking

	No Smoking	Rare Smoking	Frequent smoking	t df p
MSPSS	61,06±4,43 (n= 169)	61,15±15,14 (n=69)	58,31±13,92 (n=22)	2 0,363 0,696
PSI	82,93±14,66 (n= 168)	81,17±14,02 (n=69)	90,50±19,34 (n=22)	2 3,282 0,039*
SPS	68,47±12,57 (n= 149)	73,17±10,78 (n=65)	78,91±15,2 (n=22)	2 8,534 0,000**

*p ≤ 0,05, ** p< 0,001

When MSPSS total mean scores of the students were compared according to their smoking frequency with one-way Anova, no significant difference was found.

When PSI total mean scores of the students were compared according to frequency of smoking with One-way Anova, significant difference was found (p= 0,039). Further Analysis with Tukey shows that students who rarely smoke have significantly lower PSI than frequently smokes (p= 0,030).

When SPS total mean scores of the students were compared according to frequency of smoking with One-way Anova, significant difference was found (p= 0,000). Further Analysis with Tukey is made it is found that students who smoke rarely have higher SPS scores (p= 0,03) than students who never smoke and students who smoke frequently have higher SPS scores than students who smokes rarely (p= 0,001).

Table 23. Comparison Of SPS mean score of the students according to frequency of alcohol use

	No alcohol	Rare alcohol use	Frequent alcohol use	t df p
MSPSS	61,46±13,91 (n= 68)	60,96±14,32 (n=139)	59,77±16,06 (n=53)	2 0,207 0,813
PSI	81,81±15,83 (n= 68)	83,71±13,78 (n=138)	83,19±17,34 (n=53)	2 0,362 0,697
SPS	66,17±9,89 (n= 60)	71,02±12,07 (n=126)	75,52±15,64 (n=50)	2 7,795 0,001**

*p ≤ 0,05, ** p< 0,001

When MSPSS total means scores of the students were compared according to their using alcohol frequences with one-way Anova, no significant difference was found.

When PSI total mean scores of the students were compared according to frequence of using alcohol with One-way Anova, no significant difference was found.

When SPS total mean scores of the students were compared according to frequence of using alcohol with One-way Anova, significant difference was found (p= 0,001). Further Analysis with Tukey shows that students who never take alcohol have lower scores than the students who take alcohol moderately and frequently(p=0.000).

Table 24.Comparison of SPS mean scores of the students according to perceived academic success

	SPS	df f p
Perfect	73,11±14,49 (n=17)	
Very good	65,05±11,17 (n=38)	
Above average	69,46±11,48 (n=103)	5 6,856 0,000**
Mildly below average	73,06±12,47 (n=69)	
Quiet below average	77,25±14,86 (n=4)	
One of the lowest academic performance	99,00±13,58 (n=5)	

*p ≤ 0,05, ** p< 0,001

When SPS mean scores of the students were compared according to perceived academic success with one-way Anova, significant difference was found (p=0,001). Further analysis with Tukey showed that there was significant difference for mean scores of SPS at group who perceived themselves as ‘one of the students with lowest academic success’ and ‘mildly below average ‘ group (p=0,002) and ‘above average’ group (p=0,000) and ‘perfect’ group (p=0,006) and also between ’mildly below average’ group and ‘above average’ group (p=0,015). The students who perceived themselves as ‘one of the students with lowest academic success have higher SPS scores than mildly below average group and ‘above average’ group and ‘perfect’ group and also between ’mildly below average’ group and ‘above average’ group.

	MSPSS	df

		f p
Perfect	66,85±14,65 (n=20)	
Very good	63,80±12,81 (n=40)	
Above average	61,93±14,68 (n=118)	5 3,762 0,003**
Mildly below average	57,57±13,46 (n=73)	
Quiet below average	47,75±11,02 (n=4)	
One of the lowest academic performance	46,00±21,71 (n=5)	

When MSPSS mean scores of the students were compared according to perceived academic success with one-way Anova, significant difference was found (p=0,001). Further analysis with Tukey showed that

	PSI	df f p
Perfect	101,00±25,83 (n=19)	
Very good	96,52±14,92 (n=40)	
Above average	100,42±16,81 (n=118)	5 1,431 0,214
Mildly below average	101,71±17,74 (n=73)	
Quiet below average	104,00±21,58 (n=4)	
One of the lowest academic performance	117,60±21,36 (n=5)	

When SPS mean scores of the students were compared according to perceived academic success with one-way Anova, significant no difference was found (p0,005).

4. DISCUSSION

Findings of this study revealed existence of meaningful relationship between tendency of high school students for committing suicide and problem solving skills. It was observed that probability of committing suicide increased as problem solving success decreased. So it can be said that providing education to adolescents about problem solving skills might play a key role at suicide prevention process. Those findings are consistent with previous studies in literature. For instance, Eskin et. al. (2006) conducted a study on sample consisted of psychiatric patients in order to examine the relationship of problem solving skills and also traumatic life events with suicidal behaviours. 121 patients (females 57%) who received outpatient treatment were included in the sample. Finally, they found that both suicidal thoughts and suicide attempts were more frequent among the patients who had inadequate problem solving skills and they added that inadequacy in problem solving skills was determined as an independent predictor of suicidal thoughts and suicide attempts. Orbach et. al. compared problem solving skills of individuals who attempted to suicide or who had suicidal thoughts with a healthy control group who had never attempted to suicide. They reported that problem solving skills of the individuals who had suicide attempt history followed less diverse strategies for problem solving, exhibited more avoidant approach, produced more inappropriate solution strategies and exhibited more signs of negative affection themes than healthy controls (Orbach et al.1990). A study conducted with 1277 university students examined the relationship between suicidal thoughts and problem solving skill with negative life experiences. Findings obtained by this study indicated that problem solving skills and negative life experiences were independent predictors of suicidal thoughts at meaningful level (Dixon, 1991).

Consistent with all those previous findings, inadequate problem solving skills were found as a powerful component and predictor of suicidal behaviours once again. This conclusion supports the idea of providing problem solving skills education courses to the students might serve as protective factor that reduces risk of suicide.

Relationship between social support and perceived social support of adolescents was also examined in this study. A negative significant relationship was found between two variables. In this context, it was observed that suicide probability of individuals considerably decreased in relation to increase of social support level. Previous

studies in literature support the accuracy of those findings. For instance, Tüzün (1997) studied variables such as life events, depression, social support and reasons for living in order to determine the best predictor of suicide probability of university students. Findings of that study revealed that peer support, family support and reasons for living were important factors that predicted suicide probability. Özgüven et. al . (2003) examined the frequency of depression accompanied by anxiety symptoms, problem solving skills and perceived social support on sample consisted of individuals who attempted suicide. 277 participants were separated into three subgroups as following: 83 crisis cases (suicide group) who attempted suicide during the week; 64 cases who were in acute crisis state without suicide attempts (crisis group); and 70 participants who had no psychological problem (normal control group). Results of this study revealed that lower levels of social support perception and frequent use of impatient problem solving skills were important risk factors. Namely, it can be said that suicide probability of adolescent individuals would decrease in direct portion to enlargement of social support network and empowerment of those social bonds.

Findings of this study point out existence of a meaningful relationship between problem solving skills and perceived social support of adolescents. It was found that adolescents who had lower levels of social support tended to have inadequate problem solving skills. This finding provides enough evidence to support the positive influence of higher social support level on development of problem solving skills. By this point of view, it will be appropriate to mention some studies in literature that examined the relationship between social support and problem solving skills. Budak (1999) examined the relationship between social support and problem solving skills of high school students. Sample of this study consisted of 267 students from both general high schools and Anatolian high schools. In conclusion, it was found that social support provided by peers and parents had influence on problem solving skills and problem solving skills developed as the social support provided by peers and parents increased. A study conducted recently by Baltacı&Hamarta (2013) examined the relationship of problem solving approach with social anxiety and social support on a sample consisted of 811 students from various faculties of Seljuk and AhiEvran Universities. In conclusion, it was found that problem solving approach predicted social support along with social anxiety. Similarly, a study conducted by Sivrikaya

et. al. (2013) aimed to investigate relationship of perceived social support received from families and friends with problem solving skills on a sample consisted of 190 students who attended to Physical Education Academy of Atatürk University at the academic year of 2007-2008. Results obtained in this research revealed existence of a meaningful relationship between the scores of Perceived Social Support Received from Families/Friends Scale and Problem Solving Scale. To summarize, it can be said that social support systems were the most useful accessories that contributed to cope with life problems. Especially in adolescence period, existence of supportive systems in environment when an individual failed to cope with problems brings out positive outcomes such as feeling a state of well-being. As the individual receives support, problem solving skills become less complex and more powerful. This fact may be helpful for individual's adjustment into daily life.

In this study, relationship between esteem level and suicide probability of adolescents was examined by the point of view that assumes adolescents with inadequate self-confidence would have less tolerance for being traumatized or prevented and eventually they would consider committing suicide as an alternative solution way. Data analysis indicate existence of a meaningful relationship between those two variables. In the frame of literature, it was emphasized that the individuals who committed suicide might have lower self-esteem level

No significant difference was found between two sexes in terms of social support and self-esteem. However, unlike current study, various studies in literature examined the variables of sex and suicide revealed different results. The main cause of this differentiation is thought to be derived from the differences between the concepts of suicide attempt and suicide thoughts/probability. In our country "Suicide Probability Scale" was used in two different studies. Both of those studies revealed that males had significantly higher scores than women (Tüzün 1997, Batıgün 2005). Studies conducted on adolescents also revealed different results. For instance, a researcher aimed to determine suicide models and examine the influence of sex on suicide with a sample consisted of 370 adolescents aged between 11 and 18 years who committed suicide between the dates of January 2000 and November 2006 in Canada, Ontario. At the end of study, results revealed that males attempted suicide two times more than females (Soor et.al., 2012). Another study was conducted in order to identify characteristics involved in child and adolescent suicides on a sample consisted of 19

patients who applied to public hospital in Kocaeli because of suicide attempts. Data analysis indicated that suicide attempts were 4 times more frequent among females than males and the most frequent suicide attempt rate was observed at the age 15 years old (Tezcan, Oğuzhanoğlu, Ülkeroğlu, 1995).

Sayaret. al. studied psychological factors that influenced suicide intention and mortality of suicide attempt on a sample consisted of adolescent subjects who attempted to suicide by taking overdose medication. Data analysis indicated that that female adolescents formed majority of subjects who attempted to suicide and females used more mortal methods. However, no difference was found between males and females in terms of suicide intention (Sayar et. al., 2000). Absence of statistically meaningful differences in terms of sex for the variables of suicide probability, social support and self-esteem may be explained by indirect relationship of sex with those variables and interruption of different variables.

This study reveals a meaningful difference between two sexes in terms of problem solving skills. According to this, male adolescents had more inadequate problem solving skills when compared with female adolescents. This finding shows consistencies with some studies, while it was inconsistent with other studies in literature. A study conducted by Sezen&Paliç (2011) investigated problem solving skills perception of high school students. Findings indicated that female students had more positive perceptions about problem solving skills than male students. Kazu&Ersözlü (2008) aimed to investigate problem solving skills of candidate teachers according to the sex, department and scientific field that they preferred university entrance examination. Findings revealed that there was no meaningful difference in terms of sex.

In this study, it was also found that male and female adolescents did not differ in terms of perceived social support level. However, it is possible to see the studies in literature which revealed a meaningful relationship between sex and social support. Soylu (2002) investigated if psychological symptoms of adolescents who attended to 3rd grade of high school and university examination courses would differ according to the variables like perceived social support level, sex, socioeconomical level, parental education level and number trials for attending university. Findings indicated that females had lower levels of perceived social support. Another study

was conducted on a sample consisted of 198 students from Denizli Medical Sciences Academy in order to determine factors involved in perceived social support states and systems provided by family or peers. In conclusion, average mean of perceived family and peer support scores were found as higher among females than males (Kartal and Çetinkaya, 2009).

Findings of this study indicated that there was no significant difference between two sexes in terms of self-esteem. Özkan (1994) investigated factors involved in self-esteem on a sample consisted of 550 participants between the ages of 17 and 21 years old. It was reported that self-esteem was related with sex and females had 15% more self-esteem level than males.

At the beginning of the study it was assumed that children whose family emigrated to TRNC from Turkey for working would tend to have lower social support systems, problem solving skills, self-esteem level and higher suicide probability than the children of Turkish Cypriot families. However, data analysis indicated that there were no significant differences between nationalities in terms of social support, suicide probability and problem solving skills. Philips et. al. proposed that immigration and related social changes weakened family bonds and this situation would eventually lead to inadequate social support, increased domestic conflicts, divorce rates and alcohol or drug consumption. Most of the immigrants are working at temporary jobs. This fact leads to increases on social and economic differences between income level groups. As a result of social and economic dissatisfactions, most of those people experience health problems including psychiatric disorders as well (1999). Main cause of failure to find a relationship between nationalities in this study is thought as evaluation of cultural characteristics according to birth place of parents. Moreover, participants who grew up in TRNC from the families immigrated approximately 40 years ago and those whose family immigrated recently were evaluated in the same context. However, life standards and needs of adolescents who grew up in Turkish Cypriot culture and who immigrated to TRNC because of economic reasons show variations. This incidence was thought as a factor that affected the results of this study.

A positive relationship was found between perceived social support and self-esteem level of adolescents. So it can be said that self-esteem level increased in relation to increase of perceived social support level.

Moreover, a negatively significant relationship was found between suicide probability and self-esteem level of adolescents. Suicide probability increased in relation to decreased self-esteem level. Çakar&Karataş (2012) conducted a study to test a model that proposed existence of a causal relationship of self-esteem with perceived social support and hopelessness on a sample consisted of 257 adolescents from various high schools in Burdur. Consistent with current study, they found that causal relationship existed between self-esteem and variables.A lower level of hopelessness was found among the adolescents who acquired higher self-esteem by means of receiving more social support. In addition to parental support, social support provided by peers also plays a key role in self-esteem development. People who have higher self-esteem tend to form more powerful social relationship since they had less fear of rejection. Higher levels of social support and self-esteem contribute to individual's capacity to cope with problems in a protective and improving way and also enable individualsasking for help in case they needed. Individuals who had lower levels of self-esteem were found to have excessive rejection sensivities, lower levels of socialization and poor peer relations ( ). As a result of those findings, it can be said that, adolescent individuals experienced psychological problems and considered suicide as a solution way since they attempted to cope with problems by their own method. Those adolescents eventually fail to find a solution due to lack of social support.

Evaluation of the link between problem solving skills and self-esteem level did not reveal a significant relationship.

A positively significant relationship was found between suicide probability and smoking and alcohol using frequency of adolescents. Participants who were smoking or using alcohol rarely had higher suicide probability than those who had never smoked or used alcohol. Namely, suicide probability increases as the alcohol use and smoking became more frequent. Some of previous studies in literature also reported consistent results with this finding. For instance, Dilbaz&Aytekin (2003) aimed to investigate life-time suicide attempt frequency, suicide thoughts, intentions, and

behaviours. They applied a survey study on a sample consisted of first 50 patients who were diagnosed as alcohol dependent and hospitalized for detoxification treatment. Findings obtained by those surveys were evaluated according to existence of suicide attempt history. Findings revealed that 26% of patients who were diagnosed as alcohol dependents had suicide attempt history. It was also found that alcohol dependent patients had significantly higher risk for recurrence of suicide behaviour. A review study was conducted through the collection of related studies published between the years of 1988 and 2006 in order toexamine treatment methods and determine factors associated with suicide such as alcohol or drug abuse. This review study revealed that rates of suicide attempt and completed suicide commitments were significantly higher among the people who had alcohol or substance abuse history (Bakımet.al., 2007).

When problem solving skills of adolescents were compared in terms of smoking frequency, rarely smoking adolescents were found to be more successful than frequently smoking adolescents. So, it can be said that frequently smoking adolescents perceived themselves as unsuccessful at problem solving.

Relationship of academic success with problem solving skills of adolescents and alcohol using frequency was also examined. However, data analysis did not reveal a meaningful relationship between those variables. Similarly, no meaningful relationship was found between social support and alcohol using or smoking frequency of adolescents. Namely, there is no difference between frequently alcohol using adolescents and those who have never used alcohol in terms of social support and problem solving skills.

A meaningful relationship was found between suicide probability of adolescents and academic success. Suicide probability of adolescents who expressed themselves as the one of most unsuccessful students in their classroom was found as higher than other groups. Similarly, a meaningful relationship was also found between social support level and academic success of adolescents. Adolescents who expressed themselves as one of most successful students in the classroom were found to have lower social support level. Namely, it was observed that students who received more social support were successful in their classroom.

It is not possible to evaluate this issue according to circumstances of TRNC since any study about adolescent suicides has not been conducted yet in this country.

5. CONCLUSION

This study emphasized on certain issues such as determination of risk factors and reasons which motivate adolescent to think about suicide, prediction of risk factors earlier especially for the adolescents under risk and improvement of possible preventive strategies. Findings obtained at the end of this study can be listed as follows: Inadequate problem solving skills of adolescents, lower levels of perceived social support provided by environment and lower self-esteem are the factors that increase suicide probability. On the other hand, it was also observed that adolescents who had lower social support perceived their problem solving skills as inadequate and tended to have lower self-esteem levels.

Suicide probability, perceived social support and self-esteem level did not differ according to sex while problem solving skills differed in terms of sex. In this context, it can be said that female students had better problem skills than male students.

On the other hand, suicide probability increases in relation to increased frequency of smoking and alcohol use among adolescents. Finally, suicide risk of adolescents who expressed themselves as "one of the most unsuccessful students" was found as higher than other groups. It was also determined that adolescents who expressed themselves as "one of the most unsuccessful students" had lower social support. Namely, it was observed that students who had higher level of social support reported themselves as successful at school.

One of the most important limitations of this study is being a correlational study since correlational studies do not reveal a causal relationship between variables.

Another limitation of this study is the sample consisted of adolescents from 5 public schools. Inclusion of the students from private schools will provide a more representative sample that consists of different socioeconomic levels.

To sum up, increase of suicide attempts and completed suicide commitments necessitate carrying out inclusively and systematically preventive studies. Schools play a key role on development process of students. Because of this, it is thought that

improvement of emotional and social supportive programs in addition to mental improvement programs would be beneficial for students. On the other hand, factors involved in suicide such as problem solving skills, communication, self-esteem, social skills should be included in the frame of protective guidance programs and teachers should be also acknowledged about how to approach to suicide cases. Adolescents under the risk who think suicide as a solution should be determined right on time and necessary steps to protect them should be taken urgently. Additionally, it is thought that providing adequate family support and improvement of problem solving skills will make it easier to step in suicide attempts and prevent suicide.

APPENDİCES

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Elinizde bulunan form KKTC çapında gençler arasında yapılmakta olan bir çalışmadır. Bu çalışma genç insanların ne yaptıkları, ne düşündükleri ve gelecek hakkında ne planladıkları ile ilgilidir.

Size ait bilgiler kesinlikle gizli kalacaktır.

Anket tamamen bilimsel amaçlar ile düzenlenmiştir. Yanıtlarınızı içten ve doğru olarak vermeniz bu anket sonuçlarının toplum için yararlı bilgi olarak kullanılmasını sağlayacaktır.

Yanıtlarını bilmediğiniz veya yanıt vermek istemediğiniz soruları lütfen boş bırakınız.

Bu bir sınav değildir. Dolayısıyla doğru ve yanlış yanıtlar yoktur. Vereceğiniz yanıtları birer oy gibi düşünebilirsiniz.

Yanlış veya aldatıcı bilgi verirseniz, çalışma ile ilgili bütün çabalar boşa gidecektir.

Anket bilgileri okul yönetiminin ve ailelerin eline geçmeyecek, tarafsız bir bilim kuruluşu tarafından değerlendirilecektir.

1. Cinsiyetiniz ?

   A) Kız B) Erkek

2. Yaşınız ?

   A) 15 B) 16 C) 17 D) 18 E) 19 F) 20 ve üzeri
   B)
3. Annenizin doğum yeri neresidir?
   A) Kıbrıs B) Türkiye C) Diğer

4. Babanızın doğum yeri neresidir?
   A) Kıbrıs B) Türkiye C) Diğer

5. Annenizin eğitim durumu nedir?

   A) İlkokul mezunu B) Ortaokul mezunu C) Lise mezunu

   D) Yüksekokul veya üniversite mezunu E) Yüksekokul ve üniversite mezunu

6. Babanızın eğitim durumu nedir ?

   A) İlkokul mezunu B) Ortaokul mezunu C) Lise mezunu

   D) Yüksekokul veya üniversite mezunu E) Yüksekokul ve üniversite mezunu

7. Siz dahil kaç kardeşsiniz ?

   A) 1 B) 2 C) 3 D) 4 E) 5 F) 6 ve üstü
8. Anne babanızın birliktelik durumu nedir ?

A) Beraber yaşıyorlar. B) Boşandılar

C) Ayrı yaşıyorlar D) Anne yada babadan biri öldü

9. Ailenizin toplam aylık geliri ne kadardır ?

A) Askeri ücret ve altı
B) 1 300 – 2 500 arası
C) 2.500 – 5000 arası
D) 5000 - 10 000 arası
E) 10 000 ve üstü

10. Hayatınız boyunca kaç kez sigara içtiniz ?

A) 0 B) 1- 2 C) 3- 5 D) 6-9 E) 10-19

F) 20- 39 G) 40 veya daha fazla

11. Hayatınız boyunca kaç kez alkollü bir içecek içtiniz ?

A) 0 B) 1- 2 C) 3- 5 D) 6-9 E) 10-19

F) 20- 39 G) 40 veya daha fazla

12. Geçtiğimiz yıl boyunca aşağıdakilerden sıklıkla hangisini hissettiniz ?

A) Okulda bulunmak hoşuma gitti.

B) Okuldan nefret ettim.

C) Okulu çok ağır buldum.

D) Okula sevinerek geldim.

13. Sizin yaşınızdaki diğer insanlar ile karşılaştıracak olursanız, okulda ne derece başarılı olduğunuzu düşünüyorsunuz?

A) Mükemmel, en iyilerden biriyim.

B) Çok iyi, ortalamanın üstündeyim.

C) Ortalamanın üstündeyim

D) Ortalamanın biraz altındayım.

E) Ortalamanın oldukça altındayım.

F) Zayıf, en kötülerden biriyim.

Aşağıda kişilerin çeşitli duygu ve davranışlarını anlatmak için kullanabilecekleri bazı cümleler verilmiştir. Lütfen sırayla her bir cümleyi okuyun ve okuduğunuz cümlenin sizin için hangi sıklıkla doğru olduğunu belirtiniz. Sizden istenen, her cümlenin sağ tarafındaki seçeneklerden size uygun olana X koymanızdır.

İOÖ	Hiçbir Zaman	Bazen	Çoğu Zaman	Her Zaman
1. Öfkelendiğim zaman elime geçen herşeyi fırlatırım.				
2. Birçok insanın benimle içtenlikle ilgilendiklerini hissederim.				
3. Ani ve kontrolsüz (dürtüsel) davrandığımı hissederim.				
4. Başkalarıyla paylaşamayacağım kadar kötü şeyler düşünürüm.				
5. Çok fazla sorumluluk yüklendiğimi düşünürüm.				
6. Yapabileceğim daha birçok yararlı şey olduğunu hissederim.				
7. Başkalarını cezalandırmak için intihar etmeyi düşünürüm.				
8. Başkalarına karşı düşmanca duygular beslediğimi hissederim.				
9. İnsanlardan koptuğumu hissederim.				
10. İnsanların bana ben olduğum için değer verdiklerini hissederim.				
11. Eğer ölürsem birçok insanın üzüleceğini hissederim.				
12. Öylesine yalnızlık hissederim ki buna dayanamam.				
13. Başkalarının bana karşı düşmanca duygular beslediklerini hissederim.				
14. Eğer hayata yeniden başlayabilsem, yaşamımda birçok değişiklik yapacağımı hissederim.				
15. Pekçok şeyi iyi yapamadığımı düşünürüm.				
16. Beğendiğim bir işi bulmak ve sürdürmekte güçlüğüm vardır.				

17. Gittiğim zaman hiç kimsenin beni özlemeyeceğini düşünürüm.				

18. Benim için işler yolunda gidiyor gibi görünür.				
19. İnsanların benden çok fazla şeyler beklediklerini hissederim.				
20. Düşündüğüm ve yaptığım şeyler için kendimi cezalandırmam gerektiğini hissederim.				
21. Dünyanın yaşamaya değer olmadığını hissederim.				
22. Gelecekle ilgili çok titiz bir şekilde plan yaparım.				
23. Kendisine güvenebileceğim kadar çok arkadaşım olmadığını düşünürüm.				
24. Eğer ölmüş olsaydım insanların daha rahat edeceğini hissederim.				
25. Bu şekilde yaşamaktansa ölmenin daha az acılı olacağını hissederim.				
26. Anneme duygusal açıdan yakın olduğumu hissederim/hissederdim.				
27. Eşime duygusal açıdan yakın olduğumu hissederim/hissederdim.				
28. İşlerin düzeleceğine ilişkin umutsuzluk hissederim.				
29. İnsanların beni ve yaptıklarımı onaylamadıklarını hissederim.				
30. Kendimi nasıl öldüreceğimi düşündüm.				
31. Parayla ilgili endişelerim var.				
32. İntihar etmeyi düşünürüm.				
33. Kendimi yorgun ve birçok şeye ilgisiz hissederim.				
34. Çok öfkelenince bazı şeyleri kırıp dökerim.				
35. Babama duygusal açıdan yakın olduğumu hissederim/ hissederdim.				
36. Nerede olursam olayım, mutlu olamadığımı hissederim.				

Ek 3

PROBLEM ÇÖZME ENVANTERİ

Bu envanterin amacı, günlük yaşantınızdaki problemlerinize (sorunlarınıza) genel olarak nasıl tepki gösterdiğinizi belirlemeye çalışmaktır. Bu problemler kendini karamsar hissetme, arkadaşlarla geçinememe ,bir mesleğe yönelme konusunda yaşanan belirsizlikler ya da boşanıp boşanamama gibi kararların verilmesi zor konularda ve hepimizin başına gelebilecek türde sorunlardır .Lütfen aşağıdaki maddeleri elinizden geldiğince samimiyetle ve bu tür sorunlarla karşılaştığınızda tipik olarak nasıl davrandığınızı gözönünde bulundurarak cevaplandırın. Cevaplarınızı bu tür problemlerin nasıl çözülmesi gerektiğini düşünerek değil, böyle sorunlarla karşılaştığınızda gerçekten ne yaptığınızı düşünerek vermeniz gerekmektedir. Bunu yapabilmek için kolay bir yol olarak her soru için kendinize şu soruyu sorun: ' Burada sözü edilen davranışı ben ne sıklıkla yaparım?'

Yanıtlarınızı aşağıdaki ölçeğe göre değerlendirin ;

1. Her zaman böyle davranırım.
2.Çoğunlukla böyle davranırım
3.Sık sık böyle davranırım .
4.Arada sırada böyle davranırım.
5.Ender olarak böyle davranırım.
6.Hiçbir zaman böyle davranmam.

1.Bir sorunu çözmek için kullandığım çözüm yolları başarısız ise bunların neden başarısız olduğunu araştırırım.	1 2 3 4 5 6
2. Zor bir sorunla karşılaştığımda ne olduğunu tam olarak belirleyebilmek için nası bilgi toplayacağımı uzun boylu düşünmem.	1 2 3 4 5 6
3.Bir sorunu çözmek için gösterdiğim ilk çabalar başarısız olursa o sorun ile başa çıkabileceğimden şüpheye düşerim.	1 2 3 4 5 6
4.Bir sorunu çözdükten sonra bu sorunu çözerken neyin yaramadığını ayrıntılı olarak düşünmem.	1 2 3 4 5 6
5.Sorunları çözme konusunda genellikle yaratıcı ve etkili çözümler üretebilirim.	1 2 3 4 5 6
6.Bir sorunumu çözmek için belli bir yolu denedikten sonra durur ve ortaya çıkan sonuç ile olması gerektiğini düşündüğüm sonucu karşılaştırırım.	1 2 3 4 5 6
7.Bir sorunum olduğunda onu çözebilmek için başvurabilececeğim yolların hepsini düşünmeye çalışırım.	1 2 3 4 5 6
8.Bir sorunla karşılaştığımda neler hissettiğimi anlamak için duygularımı incelerim.	1 2 3 4 5 6

9.Bir sorun kafamı karıştırdığında duygu ve düşüncelerini somut ve açık seçik	1 2 3 4 5 6
10.Başlangıçta çözümünü fark etmesemde sorunlarımın çoğunu çözme yeteneğim vardır.	1 2 3 4 5 6
11.Karşılaştığım sorunların çoğu, çözebileceğimden daha zor ve karmaşıktır	1 2 3 4 5 6
12.Genellikle kendimle ilgili kararları verebilirim ve bu kararlarlardan hoşnut oluurum.	1 2 3 4 5 6
13.Bir sorunla karşılaştığımda onu çözmek için genellikle aklıma gelen ilk yolu izlerim.	1 2 3 4 5 6
14.Bazen durup sorunlar ım üzerinde düşünmek yerine gelişigüzel sürüklenip giderim.	1 2 3 4 5 6
15.Bir sorunla ilgis olası bir çözüm yolu üzerinde karar vermeye çalışırken seçeneklerimin başarı olasılığını tek tek değerlendiririm.	1 2 3 4 5 6
16.Bir sorunla karşılaştığımda başka konuya geçmeden önce durur ve sorun üzerinde düşünürüm.	1 2 3 4 5 6
17.Genellikle aklıma ilk gelen fikir doğrultusunda hareket ederim.	1 2 3 4 5 6
18.Bir karar vermeye çalışırken her seçeneğin sonuçlarını ölçer, tartar birbirleriyle karşılaştırır sonra karar veririm.	1 2 3 4 5 6
19.Bir sorunumu çözmek üzere plan yaparken o planı yürütebileceğime güvenirim.	1 2 3 4 5 6
20.Belli bir çözüm planını uygulamaya koymadan önce nasıl bir sonuç vereceğin tahmin etmeye çalışırım.	1 2 3 4 5 6
21.Bir soruna yönelik olası çözüm yollarını düşünürken çok fazla seçenek üretmem.	1 2 3 4 5 6
22.Bir sorunumu çözmeye çalışırken sıklıkla kullandığım bir yöntem daha önce başıma gelmiş benzer sorunları düşünmektirr.	1 2 3 4 5 6
23.Yeterince zamanım olur ve çaba gösterirsem karşılaşştığım ortaya çıkabilecek sorunların çoğunu çözebileceğime inanıyorum.	1 2 3 4 5 6
24.Yeni bir durumla karşılaştığımda ortaya çıkabilecek sorunları çözebileceğime inancım vardır.	1 2 3 4 5 6

25.Bazen bir sorunu çözmek için çabaladığım halde bir türlü esas konuya giremediğimi gereksiz ayrıntılarla uğraşırım duygusunu yaşarım.	1 2 3 4 5 6
26.Ani kararlar verir ve sonra pişmanlık duyarım.	1 2 3 4 5 6
27.Yeni ve zor sorunları çözebilme yeteneğime güveniyorum.	1 2 3 4 5 6
28.Elimdeki seçenekleri karşıştırırken ve karar verirken kullandığım sistematik bir yöntem vardır.	1 2 3 4 5 6
29.Bir sorunla başa çıkma yollarını düşünürken çeşitli fikirleri birleştirmeye çalışmam.	1 2 3 4 5 6
30.Bir sorunla karşılaştığımda bu sorunun çıkmasında katkısı olabilecek benim dışımdaki etmenleri genellikle dikkate almam.	1 2 3 4 5 6
31.Bir konuyla karşılaştığımda ,ilk yaptığım şeylerden biri, durumu gözden geçirmek ve konuyla ilgiliolabilecek hertürlü bilgiyi dikkate almaktır.	1 2 3 4 5 6
32.Bazen duygusal olarak öylesine etkilenirim ki sorunumla başaçıkma yollarından pek çoğunu dikkate bile almam.	1 2 3 4 5 6
33.Bir karar verdikten sonra ortaya çıkan sonuç genellikle benim beklediğim sonuca uyar.	1 2 3 4 5 6
34.Bir sorunla karşılaştığımda o durumla başa çıkabileceğimden genellikle pek emin değilimdir.	1 2 3 4 5 6
35.Bir sorunun farkına vardığımda ilk yaptığım şeylerden biri sorunun tam olarak ne olduğunu anlamaya çalışmaktır.	1 2 3 4 5 6

Ek 5

ROSENBERG BENLİK SAYGISI ÖLÇEĞİ

Aşağıdaki maddeler, kendinizi hakkında ne düşünüp genel olarak nasıl hissettiğinize ilişkin olarak hazırlanmıştır. Lütfen her bir maddeyi dikkatlice okuyun ve kendiniz hakkında nasıl hissettiğinizi maddelerin karşısındaki a, b, c, d'den uygun olan birini işaretleyerek belirtin.

	Hiç katılmıyorum	Katılmıyorum	Katılıyorum	Tamamen Katılıyorum
1. Kendimi en az diğer insanlar kadar değerli buluyorum.	a	b	c	d
2. Bazı olumlu özelliklerim olduğunu düşünüyorum.	a	b	c	d
3. Genelde kendimi başarısız bir kişi olarak görme eğilimindeyim.	a	b	c	d
4. Ben de diğer insanların birçoğunun yapabileceği kadar bir şeyler yapabilirim.	a	b	c	d
5. Kendimde gurur duyacak fazla bir şey bulamıyorum.	a	b	c	d
6. Kendime karşı olumlu bir tutum içindeyim.	a	b	c	d
7. Genel olarak kendimden memnunum.	a	b	c	d
8. Kendime karşı daha fazla saygı duyabilmeyi isterdim.	a	b	c	d
9. Bazen kesinlikle kendimin bir işe yaramadığını düşünüyorum.	a	b	c	d
10. Bazen kendimin hiç de yeterli bir insan olmadığını düşünüyorum.	a	b	c	d

ÇOK BOYUTLU ALGILANAN SOSYAL DESTEK ÖLÇEĞİ

Aşağıda 12 cümle ve her bir cümle altında da cevaplarınızı işaretlemeniz için 1'den 7'ye kadar rakamlar verilmiştir. Her cümlede söylenenin sizin için ne kadar çok doğru olduğunu veya olmadığını belirtmek için o cümle altındaki rakamlardan yalnız bir tanesini daire içine alarak işaretleyiniz. Bu şekilde 12 cümlenin her birine bir işaret koyarak cevaplarınızı veriniz.
Lütfen hiçbir cümleyi cevapsız bırakmayınız. Sizce doğruya en yakın olan rakamı işaretleyiniz.

1. Ailem ve arkadaşlarım dışında olan ve ihtiyacım olduğunda yanımda olan bir insan (örneğin; flört, nişanlı, sözlü, akraba, komşu, doktor) var.

Kesinlikle hayır Kesinlikle Evet
1 - 2 – 3 – 4- 5 – 6 – 7

2. Ailem ve arkadaşlarım dışında olan ve sevinç ve kederlerimi paylaşabileceğim bir insan var.

Kesinlikle hayır Kesinlikle Evet
1 - 2 – 3 – 4- 5 – 6 – 7

3. Ailem (örneğin; annem, babam, kardeşlerim) bana gerçekten yardımcı olmaya çalışır.

Kesinlikle hayır Kesinlikle Evet
1 - 2 – 3 – 4- 5 – 6 – 7

4. İhtiyacım olan duygusal yardım ve desteği ailemden alırım.

Kesinlikle hayır Kesinlikle Evet
1 - 2 – 3 – 4- 5 – 6 – 7

5. Ailem ve arkadaşlarım dışında olan ve beni gerçekten rahatlatan bir insan (örneğin; flört, nişanlı, sözlü, akraba, komşu, doktor) var.

Kesinlikle hayır Kesinlikle Evet
1 - 2 – 3 – 4- 5 – 6 – 7

6. Arkadaşlarım bana gerçekten yardımcı olmaya çalışırlar.

Kesinlikle hayır Kesinlikle Evet
1 - 2 – 3 – 4- 5 – 6 – 7

7. İşler kötü gittiğinde arkadaşlarıma güvenebilirim.

Kesinlikle hayır Kesinlikle Evet
1 - 2 – 3 – 4- 5 – 6 – 7

8. Sorunlarımı ailemle (örneğin; annem, babam, eşim, çocuklarım, kardeşlerim) konuşabilirim.

Kesinlikle hayır Kesinlikle Evet
1 - 2 – 3 – 4- 5 – 6 – 7

9. Sevinç ve kederlerimi paylaşabileceğim arkadaşlarım var.

Kesinlikle hayır Kesinlikle Evet
1 - 2 – 3 – 4- 5 – 6 – 7

10. Ailem ve arkadaşlarımın dışında olan ve duygularıma önem veren bir insan var.

Kesinlikle hayır Kesinlikle Evet
1 - 2 – 3 – 4- 5 – 6 – 7

11. Kararlarımı vermede ailem bana yardımcı olmaya isteklidir.

Kesinlikle hayır Kesinlikle Evet
1 - 2 – 3 – 4- 5 – 6 – 7

12. Sorunlarımı arkadaşlarımla konuşabilirim.

Kesinlikle hayır Kesinlikle Evet
1 - 2 – 3 – 4- 5 – 6 – 7

ÖZGEÇMİŞ

NİLGÜN KAYA

Doğum Yeri : İzmir
Doğum Tarihi : 08/09/1982
Medeni Durum: Evli
Uyruk : TC- KKTC
Sürücü Belgesi: B

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Üniversite	Mersin Üniversitesi – Psikoloji – 2005
Lise	Naci Şensoy Süper Lisesi – İzmir- Türkçe-Matematik – 2000

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Uygulamalı Davranış Analizi İlkeleri (ABA)- Prof.Dr.David Holmes
Yapılandırılmış Öğretim Stratejiler-Catherine Feherty
Aile Eğitim Programları- Prof. Dr. Bülbin Sucuoğlu

BİLGİSAYAR BİLGİSİ

Word, Excel, Powerpoint, Outlook, SPSS : Çok iyi

YABANCI DİL BİLGİSİ

İngilizce	Okuma: Çok iyi, Yazma:Çok iyi, Konuşma:İyi

HOBİLER

Sinema,tiyatro, voleybol

DERNEK VE KULÜP ÜYELİKLERİ

Kıbrıs Türk Psikologlar Derneği, Kıbrıs Türk Psikolojik Danışmanlık ve Rehberlik Derneği

REFERANSLAR

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