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THE RELATIONSHIP BETWEEN SUICIDE RISK AND COPING STRATEGIES AMONG PATIENTS WITH DEPRESSION

DEPRESYON HASTALARINDA İNTİHAR RİSKİ İLE BAŞA ÇIKMA STRATEJİLERİ ARASINDAKİ İLİŞKİ

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ABSTRACT

Objective: The aim of study is to determine the relationship between suicide risk and coping strategies with stress in depressed patients.

Materials and Methods: This descriptive study includes 102 patients. Data were collected by "Beck Suicidal Ideation Scale-BSIS" and "Stress Coping Strategies Scale-SCSS." Descriptive statistics and T-test and ANOVA were applied in the comparison of the scale point averages for the independent groups. Kruskal-Wallis and Mann Whitney U tests were used in the analysis of nonparametric measurements. The relationships among the measures were tested via Pearson Correlation.

Results: Significant differences were determined among the BSIS, age, educational background, marital status, family type, suicide history, number of suicides, suicide type and suicide history in the family. Significant differences were discovered between the presence of previous suicide attempts and leaving a note prior to the suicide and the desperate approach as measured on the SCSS subscales, between the optimistic approach and the presence of previous attempts, between the social support and age, and among the marital status, family type and the presence of previous attempts. A significant negative relationship was determined between the BSIS total point and the SCSS optimistic approach.

Conclusion: It is concluded that depressed patients have quite high risks and use much more passive strategies for emotions in order to cope with stress. Improving coping skills and providing effective emotion regulation by reducing stress level will help preventing suicide and lessening the intensity of depression.

Keywords: Suicide, Depression, Coping Strategies

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ÖZET

Amaç: Bu çalışmanın amacı, depresyon hastalarında intihar riski ve stresle başa çıkma stratejileri arasındaki ilişkiyi belirlemektir.

Gereç ve Yöntem: Bu tanımlayıcı çalışma 102 hastayı içermektedir. Veriler "Beck İntihar Düşüncesi Ölçeği-BSIS" ve "Stresle Başa Çıkma Stratejileri Ölçeği-SCSS" ile toplandı. Bağımsız gruplar için ölçek puan ortalamalarının karşılaştırılmasında betimsel istatistikler ile t-testi ve ANOVA uygulandı. Parametrik olmayan ölçümlerin analizinde Kruskal-Wallis ve Mann Whitney U testleri kullanıldı. Ölçümler arasındaki ilişkiler Pearson Correlation ile test edildi.

Bulgular: BSIS, yaş, eğitim durumu, medeni durum, aile tipi, intihar öyküsü, intihar sayısı, intihar türü ve ailede intihar öyküsü arasında anlamlı fark saptanmıştır. SCSS alt ölçeklerinde; daha önce intihar girişiminde bulunma ve intihardan önce not bırakma ile SCSS alt ölçeklerinde ölçülen umutsuz yaklaşım arasında, iyimser yaklaşım ile önceki girişimlerin varlığı arasında, sosyal destek ve yaş ile medeni durum, aile tipi ve daha önce girişimde bulunma durumu arasında anlamlı fark bulunmuştur. BSIS ile İyimser Yaklaşım arasında negatif korelasyon bulunmuştur.

Sonuç: Depresyon hastalarının risklerinin oldukça yüksek olduğu ve stresle baş edebilmek için duygulara yönelik çok daha pasif stratejiler kullandıkları sonucuna varılmıştır. Başa çıkma becerilerinin geliştirilmesi ve stres düzeyinin düşürülerek etkin duygu düzenlemesinin sağlanması intiharın önlenmesine ve depresyonun yoğunluğunun azaltılmasına yardımcı olacaktır.

Anahtar Kelimeler: İntihar, Depresyon, Başa Çıkma Stratejileri

INTRODUCTION

Suicide is a crucial health problem, and the global suicide mortality rate equals 1.4% of all the death tolls in the world. Most of the suicides are correlated with psychiatric disease. Depression, substance use disorders, and psychosis are the most significant risk factors (Bachmann, 2018). According to the World Health Organization (WHO, 2014), approximately 800.000 suicides are documented worldwide every year, and many more people attempt suicide. About 50-120 million people are estimated to be affected by suicide behavior. It is reported that those who attempt suicide have 10 to 15% of the lifelong suicide risk. It is assumed that suicide attempts are up to 20 times more common compared to completed suicides (Öncü, 2017). Suicide rates in our country are high. While the number of suicides resulting in deaths according to Turkish Statistical Institution in 2014 was 3169 it was increased by % 1,3 to 3211 people in 2015 (TÜİK, 2015).

Mood disorders are the most significant risk factors. The depressive attack, in particular, is a common diagnosis. Longitudinal studies have found that suicide risk is very high in major depression cases (APA, 2003). Clinical predictors for suicide in people with major depression include the following: suicide attempt history, high level of despair, and a high degree of proclivity to suicide (Hawton and Van Heeringen, 2009). Considering that depression impairs life quality and negatively affects coping with stress, it is a fact that such rates of suicide are significant in estimating the probability of suicide (Karataş and Çelikkaleli, 2018).

As stated in research, individuals who face the stressful situation, which is one of the suicide factors, have difficulties overcoming. In research indicating that suicide and stress are

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associated with each other (Apaydın et al., 2016, Buzlu, 1999), suicide covers a wide range of populations from people who react to the living conditions creating stress for patients with severe mental disorders. It is stated that this situation is very complicated as it involves the combination of many variables. It is mentioned in one research that psychological symptoms and coping strategies have had a significant impact on the probability of suicide. People with psychological symptoms and those who use simple coping strategies are more likely to commit suicide (Avcı et al., 2016).

We determined that people guided by appropriate techniques have improved skills to react to the stressors and cope with their depressions. In our country, coping with stress has been studied mostly for chronic medical diseases but coping with stress strategies has not been researched sufficiently for the diagnosis of depressive disorder (Özarslan et al., 2013). The aim of this study is to determine the relationship between suicide risk and styles of coping with stress in depressed patients, and also to investigate the relationship between variables.

METHOD

Depressed patients who applied to the Psychiatry Clinic of a Training and Research Hospital form the universe of this descriptive study. G Power program was used to calculate the sample size. Previous studies were examined (Öztürk et al., 2018), and while the confidence interval was $\alpha = 0.05$, the strength of the test ($1-\beta$) was 0.95, and the effect size was dz = 0.3994709 a total of 84 patients were calculated. The study was conducted with 102 patients who met the inclusion criteria between specified dates. Inclusion criteria can be listed as follows; Being admitted to the psychiatry unit, being diagnosed with depression, being 18 or older, being literate, speaking Turkish, capable of understanding the study, and giving informed consent.

Data Collection

The data were collected through face-to-face interviews using the ‘Personal Information Form’ prepared by the researcher, ‘Beck Suicidal Ideation Scale’ and ‘Stress Coping Strategies Scale’.

-Personal Information Form: This form consists of questions including information about the patient, disease, and suicidal thought.

-Beck Suicidal Ideation Scale (BSIS): The Turkish validity of the scale, which was developed by Beck et al. (1979), was made by Dilbaz et al. (1995) and Özçelik et al. (2016). The scale explores the concept of suicidal thought in five sections. The scale's total score is the lowest 0, and the highest score is 38, and the high score means that suicidal thought is evident and serious. In the validity and reliability study of the scale, the Cronbach alpha value was found to be 0.84, and in this study, we found it to be 0.82.

- Coping Stress Styles Scale (SCSS): ' Coping Ways Inventory', developed by Folkman and Lazarus in 1980, is a 68-item form. The Turkish validity and reliability study of the scale was performed by Şahin and Durak (1995) and named as the Stress Coping Strategies Scale. The scale measures the way to deal with two main stresses. These are ‘Problem-oriented / active’ and ‘Emotional / passive’ styles. While the active styles show the sub-scales of ‘Applying for social support’, ‘Optimistic approach’ and ‘Self-confident approach’ passive styles show the subscales of ‘Desperate approach’ and ‘Submissive approach’. High scores

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show that the person uses those strategies more. Cronbach alpha internal consistency coefficients of the scale are as follows: .68 for the optimistic approach subscale, .80 for the self-confident approach subscale, .73 for the desperate approach subscale, .72 for the submissive approach subscale, and .47 for the sub-scale of applying for social support. (Şahin and Durak, 1995). In this study, the statistical values for the following variables are self-confident approach .57, desperate approach .41, submissive approach .42, optimistic approach .49, and social support seeking approach .61.

Data Analysis

IBM SPSS Statistics 22.0 (IBM Corp. Armonk, New York, AB) program was used in the analysis of data. To determine statistical significance, the value, <0.05 was considered. Descriptive statistics (percentile, arithmetic mean, etc.), T-Tests, and Anova Tests (Tukey test in advanced analysis) were used to make comparisons between the independent groups involving Beck Suicidal Ideation Scale and Stress Coping Strategies scale measures. Kruskal-Wallis (KW) and Mann Whitney U (MW) tests were used to analyze data involving non-parametric measures. The relationship between the scales was tested through Pearson correlation tests.

Ethical Principles of The Research

Before starting the research, written and verbal permission was obtained from the center where the research is conducted, and presented to the Clinical Research Ethics Committee of Gaziantep University and approved. Before starting to collect research data to protect the rights of individuals in the scope of the research. Informed Consent was obtained by explaining the purpose, duration, and process of the study.

RESULTS

41.2% of the patients within the scope of the study are between the ages of 18-27, and the average age is 33.11 ± 12.22 (min: 18, max: 57). 66.7% of the patients are women, and more than half (54.9%) are married. Considering the education levels, the proportion of high school and primary school graduates is high (29.4%, 26.5%, respectively). 79.4% of the patients are of the nuclear family type, and 85.3% of them live in the city center. In terms of professional status, it stands out that 40.2% are housewives, 17.6% are unemployed, and 14.7% are workers. Half of the patients (51%) have low income. 66.7% of the patients applied with a suicide attempt, 33.3% applied with suicidal ideation, and 78.4% still had suicidal thoughts at the time of application. 38.2% of the patients have been followed up with the diagnosis of depression for 0-11 months and 36.3% for 1-3 years. 70.6% of the patients in the study have attempted suicide in the history of the disease. When the causes of suicide attempts are examined, family incompatibility (31.9%), economic causes / financial difficulties (26.4%), and presence of mental illness (19.4%) are on the top of the list. When the mode of attempt was examined, it was seen that 47.2% of the patients had chemical substances (drug using). 77.8% of the patients reported that they did not make any plans before the attempt, and 87.5% did not leave any notes. 93.1% of the patients have no family suicide history.

The mean score of the Beck Suicidal Ideation Scale of the patients is 22.22 ± 6.51. When Stress Coping Strategies Scale subscale item averages are taken into consideration; The highest average was determined as Helpless Approach, Submissive Approach, Social Support Search, Optimistic Approach, and Self-Confident Approach respectively (Table 1).

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Table 1: Mean Scores of Patients Received from BSIS and SCSS Subscales

	X±SD	Min-Max Value
BSIS	22.22±6.51	9-35
SCSS		
Self-confident approach (SCA)	7.51±2.84	0-21
Desperate approach (DA)	17.31±3.08	0-24
Submissive approach (SA)	11.37±1.81	0-18
Optimistic approach (OA)	5.60±1.84	0-15
Applying social support (ASA)	6.13±2.16	0-12

We found a negative correlation between the total score of the BSIS and the subscales of the SCSS Optimistic Approach (r=-.385; p=.001). Further, a negative correlation was also found between age and BDI (r = -.341; p=.001) (Table 2).

Table 2: The Relationship Between the Mean Scores of Patients Received from BSIS and SCSS Subscales

Variable	Test ve p value	Age	BSIS	SCA	DA	SA	OA	ASA
Age	**r**	1						
	p							
BSIS	**r**	-.338	1					
	p	**.001**						
SCA	**r**	-.012	-.138	1				
	p	.907	.168					
DA	**r**	-.129	.192	-.368	1			
	p	.197	.053	**.001**				
SA	**r**	-.001	.069	-.138	.069	1		
	p	.497	.249	.084	.246			
OA	**r**	.043	-.385	-.368	-.003	-.222	1	
	p	.668	**.001**	**.001**	490	**012**		
ASA	**r**	.070	.084	.209	.042	-.119	.287	1
	p	.242	.202	**.018**	.338	117	**.002**	

A significant difference was ascertained in the BISS mean score concerning age (p = .001), educational status (p=.040), marital status (p=.008), family type (p=.030). No significant difference was found in the mean scores of BISS based on the gender, study, and income status of the patients (p> 0.05) (Table 3). There is a significant difference between the BSIS mean scores according to the presence of suicidal thoughts in patients (p = .001), suicide attempts in the past (p=.001), family history of suicide (p=.011), number of suicide attempts (p=.001), and suicide attempts (p=.014). When the causes of suicide are analyzed, the difference between the mean scores of BSIS scores according to the causes of suicide is not significant (p> 0.05) (Table 4).

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Table 3: Comparison of the BSIS Mean Scores According to the Sociodemographic Characteristics of the Patients

	N	n	%	X±SD	Test value	p
Age						
18-27	102	42	41.2	25.66±5.82	F=9.007	**.001**
28-37		23	22.5	19.78±6.31		
38-47		17	16.7	18.23±3.41		
48-57		20	19.6	21.20±6.88		
Gender						
Women	102	68	66.7	22.17±6.59	t=-0.107	.911
Male		34	33.3	22.32±6.44		
Education Status						
Literate	102	10	9.8	19.60±5.64	F=2.620	**.040**
Primary school		27	26.5	20.03±5.83		
Middle School		24	23.5	22.75±6.64		
High school		30	29.4	24.86±5.99		
University And Above		11	10.8	21.63±7.99		
Marital Status						
Married	102	56	54.9	20.73±6.05	F=5.063	**.008**
Single		33	32.4	25.06±6.01		
Widow/ Divorced		13	12.7	21.46±7.69		
Family Type						
Core	102	81	79.4	21.55±6.42	KW=6.789	**.034**
Large		7	6.9	28.14±4.84		
Broken		14	13.7	23.14±6.52		
Working Status						
Working	102	33	32.4	23.03±6.49	t=0.862	.391
Not working		69	67.6	21.84±6.53		
Income status						
Income and expense	102	40	39.2	20.57±6.64	KW=4.447	.108
Revenue is less than expenses		52	51.0	23.50±6.11		
Income more than expenses		10	9.8	22.20±7.17		

Table 4: Comparison of BSIS Mean Scores According to Some Features of Patients

	N	n	%	X±SD	Test Value	p
Suicidal Thought						
There is	102	80	78.4	23.31±6.52	t=3.375	**.001**
No		22	21.6	18.27±4.80		
Previous Story of Suicid						
There is	102	72	70.6	24.43±5.94	t=-6.201	**.001**
No		30	29.4	16.93±4.50		
Family Suicide Story						
There is	102	7	6.9	22.64±6.50	MW=-2.538	**.011**
No		95	93.1	16.57±3.40		
Suicide Count						
No	102	31	30.4	16.93±4.42	t=-6.403	**.001**
1 and above		71	69.6	24.53±5.91		
Form of Suicide Attempt						

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Chemical Substance	72	34	47.2	22.14±5.22	KW=10.671	**.014**
Cutting tool		13	18.1	26.30±5.17		
High jump		7	9.7	26.28±7.45		
Multiple (Different methods)		18	25.0	26.66±6.00		
Suicidal Causes						
Mental illness	72	14	19.4	26.42±7.29	KW=8.685	.192
Chronic Disease		5	6.9	22.00±3.80		
Rape		2	2.8	25.50±3.53		
Domestic Violence		3	4.2	22.33±6.80		
Family Incompatibility		23	31.9	24.08±6.08		
Economic / Livelihood Trouble		19	26.4	22.84±5.08		
Loneliness		6	8.3	28.83±4.62		

Comparison of the mean scores of SCSS according to the socio-demographic and disease and suicide data of the patients in the scope of research is shown in Table 5.

Table 5: Comparison of SCSS Mean Points According to Some Features of Patients

		SCSS				
Features		**Self-confident approach**	**Desperate approach**	**Submissive approach**	**Optimistic approach**	**Applying social support**
		X±SS	**X±SS**	**X±SS**	**X±SS**	**X±SS**
Age	18-27	7.73±2.66	17.64±3.43	11.38±1.80	5.61±1.79	6.26±2.02
	28-37	7.30±3.02	17.39±2.12	11.13±1.45	5.47±1.85	5.04±1.84
	38-47	6.70±1.68	17.70±2.20	11.82±2.06	5.70±2.05	7.23±2.16
	48-over	8.00±3.68	16.20±3.77	11.25±2.04	5.65±1.87	6.20±2.37
	p value	0.510	0.343	0.678	0.383	**0.014**
Marital Status	Married	7.37±2.43	17.53±2.69	11.33±1.90	5.73±1.74	6.66±2.01
	Single	8.03±2.78	17.24±3.51	11.36±1.93	5.63±1.88	5.90±2.17
	Widow/ Divorced	6.84±4.33	16.53±3.61	11.53±1.05	5.00±2.16	4.46±1.98
	p value	0.383	0.574	0.939	0.436	**0.003**
Family Type	Core	7.64±2.58	17.33±3.03	11.28±1.91	5.70±1.86	6.48±2.01
	Large	6.85±2.60	18.57±2.14	12.14±1.57	5.00±1.00	5.57±2.63
	Broken	7.14±4.22	16.57±3.73	11.50±1.28	5.35±2.06	4.42±2.06
	p value	0.682	0.377	0.473	0.542	**0.003**
Suicide Attempt Story	There is	7.27±3.12	17.70±3.25	11.47±1.69	6.70±1.53	7.03±1.95
	No	8.10±1.93	16.36±2.44	11.13±2.09	5.15±1.77	5.76±2.15
	p value	0.184	**0.045**	0.394	**0.001**	**0.006**
Leave a Note	Gave	8.55±5.79	14.66±5.76	11.55±1.33	5.44±1.01	6.11±0.78
	I quit	7.09±2.56	18.14±2.51	11.46±1.74	5.11±1.85	5.71±2.28
	p value	0.191	**0.002**	0.876	0.601	0.608

A significant difference was found between the desperate approach subscale (one of the subscales of the SCSS) and the presence of previous attempt (p=.045) and leaving a note before suicide (p=.002); Between the optimistic approach subscale score averages and the presence of previous attempt (p=.001); Between social support search subscale mean scores

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and age (p=.014), marital status (p=.003), family type (p=.003) and previous intervention presence (p=.006).

DISCUSSION

We found that the risk of suicide in depressed patients participating in the study is high. It is stated that psychiatric diseases may be important risk factors in suicidal behavior. Mood disorders, especially depressive attack, are considered the most important risk factor for suicide (APA, 2003). The result of this study confirms this risk. Considering that depression can negatively affect overcoming stress, coping methods are significant in the probability of suicide (Karataş and Çelikkaleli, 2018). Lazarus (1993) defined coping as the process of managing specific, internal, or external psychological stress sources through cognitive or behavioral efforts. Lazarus propounded in his theory that there are two coping strategies, problem-oriented and emotion-oriented. Problem-oriented is used to solve stress factors, and emotional-oriented is used to control the emotional consequences of stress (Biggs et al., 2017). It is asserted that problem-oriented coping attitudes are mostly adaptive, protecting and improving the individual; emotion-oriented coping attitudes are disruptive, advocating and preventing development (Konkan et al., 2014). Holahan et al. (2005) come up with the idea that people who use avoidance to cope with stress may have difficulties in overcoming difficulties and therefore may have problems that may lead to additional stress factors. As described in previous literature, effective methods of dealing with stress include resorting to social support, a self-confident approach, and an optimistic approach, whereas the ineffective methods are desperate and submissive approaches (Şahin and Durak, 1995). Social support is a protective factor against depression, which reduces the sense of loneliness (Sayar, 2002). It is stated that social support can prevent the formation of stress. It changes the meaning given to stress in case of stress, provides help in case of stress management, and affects the way of controlling stress, and it is emphasized that it has important effects on physical and mental health (Ardahan, 2006). It was observed that the patients in this study used the Desperate Approach, Submissive Approach, that is, Emotional/ Passive styles, more than Problem-oriented/Active Coping methods in coping with stress. Therapeutic interventions for depressed patients, especially for patients with high suicide risk, may be recommended to gain active methods of coping with stress. In addition to psychiatric diseases, sociodemographic characteristics may also be the most significant risk factors in suicidal behavior. Evaluation of the relationships between sociodemographic characteristics and suicide attempts is essential in understanding and preventing suicides (Atay et al., 2012).

Young age has been reported as a crucial risk factor for recurring suicide attempts (Vaiva et al., 2011, Şevik et al., 2012, Tarsuslu et al., 2018). In the suicide prevention report that WHO (2014) published, it was stated that suicide ranks second among the young people between the ages of 15-29 as the cause of death and is a common health problem. 41.2% of the patients in the study are between the ages of 18-27. Patients in the 18-27 age group were found to have significantly high suicide risk compared to others, and a negative correlation was found between age and suicidal ideation in the correlation analysis. As age decreases, suicidal ideation increases. At the end of this study, in line with the literature review, we can say that depression patients in the younger age group are at risk in terms of suicide compared to those in the older age group.

The majority of patients in our study consists of women (66.7%). This finding indicates that depression is more common in women. As a result of the analysis, it was found that there

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was no difference in suicidal thoughts between men and women ($p>0.05$). Our finding is compatible with other studies that have found evidence against differentiation based the on possibility of suicide by gender (Kjoller and Helweg Larsen, 2000, Emir Öksüz and Bilge, 2014, Dilli et al., 2010).

Education level is one of the significant social indicators. It has been reported that the effect of educational differences may be determinative when we consider that there may be a decrease in thinking abilities and problem-solving skills of individuals who have suicide risk due to despair and hopelessness (Atasoy et al., 2014). In our study, suicide risk was higher among high school graduates. In the advanced analysis, the difference between the averages was determined because of high school and primary school graduates.

In our study, the suicide risk of single and widowed / divorced patients is higher than that of married people. It is reported in the literature that singles prefer suicide more than other groups (Tel and Uzun, 2003, Acar, 2009). Our finding is compatible with the sources, and it can be considered that being married is protective in terms of suicide attempt. Also, single and widowed / divorced individuals might not be able to benefit from social support systems effectively.

The majority of the patients (79.4%) in our study have a nuclear family structure. When evaluating the suicide risk according to the family characteristics of the patients, we determined that the suicide risk of the patients with a large family structure was higher. Half of the patients in our study had low socioeconomic levels (51%), and the percentage of those who have regular jobs is low (32.4%). Taking the unemployment and economic challenges into consideration, difficulties in meeting basic needs can cause individuals to become helpless.

Working for a job and the low-income level was thought to increase the probability of suicide, but the results of the analysis were not significant. That may stem from the high number of housewives in our study and the low number of unemployed.

The presence of suicide attempts in history is an important indicator that the risk of suicide is high (Hawton and Van Heeringen, 2009). In this study, patients who attempted suicide in the past were pretty high at 70.6%, and those who had a suicide attempt history were found to have a significantly higher risk of suicide than those who didn't have. The fact that having suicidal attempts in patients with a diagnosis of depression in the past is stated as an important risk factor in terms of new suicidal attempts (Takahashi, 2001, Hawton et al., 2013, Şevik et al., 2012).

In this study, the risk of suicide was found to be higher in the family with a suicide history than those without it. Even though it is uncertain whether genetic is a preparative factor in those with a family history of suicide, it is asserted that the genetic factor may be related to impulsivity (Sayıl et al., 2000). WHO (2014) stated that having a family suicide history is related to suicide risk. In the studies of Şevik et al. (2012) and Atay et al. (2012), it was stated that the presence of family history is one of the main risk factors of suicide. Since the family has a suicidal history, people think that this behavior may have either been learned or imitated.

Amongst patients with suicidal ideation or attempts, the presence of repeated suicidal thoughts and behaviors is around 78.4%, which underscores the necessity of regular psychiatric follow-ups. The existence of many suicide attempts is an important risk factor in suicidal behavior (Özdemir, 2010), we determined in our study that suicide risks were higher

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in the analysis between only patients with suicidal thought (not attempting) and those who performed one or more attempts. Considering that suicide will be attempted after incomplete suicides, necessary precautions should be taken, close observation should be made and treatment should be maintained.

Although the ranking varies by country, the first three suicide methods are stated as taking chemicals, hanging, and shooting with a firearm (Şenol et al., 2005). In our study, nearly half of the cases (47.2%) who attempted suicide followed through a suicide attempt by taking medication in various amounts and types orally. The most frequently used method in many studies in the literature review is taking medication (Arslan et al., 2008, Şevik et al., 2012, Asoğlu et al., 2013, Atasoy et al., 2014, Ercan et al., 2016). It is possible to attribute this to the ease of obtaining medication. It is shown in the literature review that non-lethal suicidal behaviors are more common in women, and they attempt suicide, especially by medication (Türker et al., 2000, Bradvik, 2007, Nock et al., 2008). The fact that the majority of the patients who form the sample of this study are women may explain this rate to be high.

While mental disorders are seen as a challenging factor among the causes of suicide attempts, other significant factors such as physical illnesses, financial and social problems, and family incompatibilities are found as well (Rutz 2006, Şevik et al., 2012). When the causes that triggered suicide are examined, it was noticed that the highest rates were listed as family incompatibility, economic problems/livelihood difficulties, and presence of mental illness. When the mean scores of suicidal thoughts are examined, the highest suicide scores are listed as loneliness, mental illness, abuse/rape, family incompatibility, economic problems/livelihood difficulties, family violence, and chronic disease. Although the analysis result is not significant, these rates indicate that all factors that affect the coping levels of patients increase the risk.

Since the coping attitudes used in stressful situations are peculiar to an individual, they can vary depending on various factors such as age, gender, and disease. In this study, it was confirmed that the social support seeking approach, stated as an effective method of coping with stress, is significantly preferred more among the 38-47 age group who are married, have a nuclear family, and have previously attempted suicide. The optimistic approach, which is another effective method of dealing with stress, was determined to be used more in individuals who had attempted suicide before. In one study, it is reported that the presence of previous suicide attempts is an important indicator of high suicide risk and differs from those with a single attempt to cope with repetitive suicidal behavior (Beghi et al., 2010). It can be stated that the desperate approach, which is expressed as an ineffective method of coping with stress, is used more in those who have attempted suicide before and suddenly prefer suicide without leaving a note.

It has been reported that emotion-oriented and avoiding coping is significantly related to suicidal ideation in the studies (Horwitz et al., 2011). In the literature review, problem-oriented active coping strategies (such as seeking help) have been reported to be associated with lower suicide risk (Gould et al., 2004, Zhang et al., 2012, Sugawara et al., 2012, Knafo et al., 2015). In this study, it is seen that those who have a history of suicide attempts and those who do not leave notes before the suicide attempt use the desperate approach more significantly than those who leave notes. A suicide note is one of the elements reflecting the mental state of individuals (Karbeyaz et al., 2014). In our study, there were 9 (12.5%) patients who wrote a suicide note. Three of these patients stated that they committed suicide due to loneliness, 5 for economic reasons and 1 for loss. Patients who decide to commit suicide at

once without making any plan before the suicide attempt consists of the majority (77.8%). The impulsive realization of the majority of attempts in this study suggests that suicide attempts may have been triggered by psychosocial stressors and desperation.

In this study, the negative relationship between suicidal ideation and the optimistic approach, one of the effective methods of coping, once again indicated the importance of strengthening effective coping. While analyzing the relationships between other sub-categories, it is thought that improving the skills to cope with stress may be beneficial in preventing suicide.

CONCLUSION

The study found that depressed patients had a high risk of suicide and used emotions/passive styles more to deal with stress. Researches have shown that training programs for coping skills are effective in reducing suicide risk (Eggert et al., 2002) and reducing depression intensity (Keliat et al., 2015). Therefore, improving coping skills, reducing stress levels, and providing more effective emotion regulation will help prevent suicide and reduce depression intensity. These results show that it is significant to motivate people who use emotion-oriented coping methods to change their strategies to cope with stress. Establishing a real and original relationship with patients who attempt suicide or express suicidal thoughts can save lives. That's why using motivational interviews can provide benefits in coping skills and suicide prevention trainings.

Limitations

The most important limitation of our study is that it is a single-center study. Risk factors can be identified better by planning studies excluding multi-center, large sample, cultural and local factors. However, the cross-sectional research design of this study limited our ability to conclude concerning the relationships between stress coping styles and suicidal tendencies examined in this study.

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