

Relationship between dysfunctional beliefs and stress coping methods in drug-addicted patients: A sample of Turkey

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ABSTRACT

Background: Dysfunctional beliefs are believed to have an effect on substance abuse. Drug-addicted individuals experience difficulties with coping in stressful situations and therefore, start reusing these drugs.

Aim: This study was conducted to determine the relationship between dysfunctional beliefs and stress coping methods in drug-addicted patients.

Materials and Methods: The population of this descriptive and cross-sectional research study comprised 51 patients who were admitted to the Alcohol and Drug Addiction Treatment Center of a state hospital, diagnosed with drug addiction, and consented to participate in our study. The data were collected by using the Sociodemographic Information Form, the Dysfunctional Attitude Scale (DAS), and the Coping Assessment Questionnaire (COPE). The data obtained were evaluated by percentage, correlation, one-way analysis of variance, Mann–Whitney U-test, and Kruskal–Wallis test.

Results: The average COPE score of the drug-addicted patients was found to be 171.60 ± 23.35 . The average DAS score of the drug-addicted patients was determined to be 161.66 ± 36.94 . A statistically significant difference was found between the DAS and COPE scores of the patients ($P < 0.05$).

Conclusions: It can be concluded that these patients have dysfunctional beliefs and exhibit emotion-focused coping attitudes. More comparative studies investigating the dysfunctional beliefs of alcohol- and drug-addicted people and coping methods should be conducted.

Key words: Addicted patients, coping methods, drug addiction, dysfunctional beliefs, stress

INTRODUCTION

Addiction is defined as the frequent and excessive use of substance and the inability to stop the desire to take substance in such a way as to disrupt the individual's physical and mental health, family, social and work harmony.^[1] Drug addiction has a structure that may have negative outcomes

such as breakdowns in relationships with parents and the social lives of the people involved. According to estimations of the United Nations International Drug Control Program, there are 180 million drug addicts in the world.^[2] It has been reported that the lifetime prevalence rate of substance abuse for those aged 18 and over is 16.7% in the United States, whereas the rate of substance abuse by those living in Turkey at least once in a lifetime is 1.3%. The substance abuse rates in males were found to be higher than females

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in the 15–24 years' age group. Many negative factors, such as rapid increase of the population; weakening of cultural and social ties; and open and free use of the Internet, have increased the prevalence of substance abuse in Turkey. Inappropriate Internet use by children and adolescents can especially cause them to establish identification with negative lifestyles and break with the traditional social and family life, perhaps facilitating the use of these substances.^[3] Social, psychological, biological, and familial factors may affect the etiology of substance abuse. The dysfunctional attitudes, which are one of the psychological factors, have an important role in the onset of drug use and addiction.

The process associated with dysfunctional attitudes, beliefs, and psychological disorders is often associated with the stress-coping mechanisms of an individual. If the perspective of an individual to the outside world has a solid and perfectionist structure, coping strategies that are not adaptive, such as denial or avoidance, are observed in stressful situations. Stress is an important factor leading individuals to the use of drugs. Earlier studies suggest that individuals either learn how to live with stressful situations or cope with them. Lazarus and Folkman identified three types of coping methods, namely problem focused, emotion focused, and avoidance. Problem-focused coping is often adaptation oriented.^[4,5] The problem-focused coping method has been determined to be underused by drug-addicted people. Several studies have suggested that substance-use behavior is associated with coping methods that are not directed toward adaptation. Adaptive stress coping leads to improvement and better adaptation, according to stress-coping research.^[6]

Most Turkish people are Muslim by religion. According to the Islamic religion, Allah (God) determines the destiny of all people. This can lead to a situation where a drug-addicted person thinks that “My Allah, give me disease and strength, if Allah wills, I can get rid of the addiction.” Individuals pray to God to cope with stressful events and generally feel serenity and rest after praying. If a person accepts the situation, there is no need to do anything. It is noted that this coping method is most frequently reported in literature.^[7] Cultural influences on the individual choice of coping strategies have been reported. Religion is one example of an emotional coping strategy. This example of a Muslim praying to Allah is a common Turkish cultural coping strategy. According to cognitive behavioral theory, dysfunctional beliefs can be affected by cultural and social patterns.^[7,8] Conflict resolution has been negatively related to dysfunctional beliefs in Turkish people. Dysfunctional beliefs associated with conflict resolution may also play an important role in substance abuse behavior. Dysfunctional beliefs may also play an important role in the substance use behavior. Recognizing and breaking down your false beliefs will help you manage your cravings. Dysfunctional beliefs cause substance use, but also increased number of reasons

to use the high-risk situations followed by substance-related dysfunctional beliefs and automatic thoughts can lead to substance abuse relapse.^[9]

The processes that determine drug addiction are the relapse and remission periods. Interventions in drug addiction are mostly based on preventing relapses and extending the remission period as long as possible. Relapse prevention methods have been developed for this purpose. These methods include cognitive behavioral treatments, awareness therapy, and motivational interviews. Besides cognitive therapy, the behavioral method is also an effective method in the treatment of drug addiction. In particular, cognitive behavioral therapy has been determined to be effective in the management of stress, anger, and sadness in drug-addicted patients.^[10] The main principle of these methods is to determine the dysfunctional beliefs of the patient regarding addiction, help the patient develop more effective beliefs and behaviors, and build more effective coping strategies.^[11] According to Beck, addicts must first become aware of what goes on in their minds, so they must identify their incorrect, dysfunctional thoughts and beliefs and begin replacing them with the correct ones. Then, they can use effective coping strategies in all areas of life.^[8] The number of studies comparing drug-addicted people in Turkey within the framework of cognitive processes of Beck's cognitive theory is very limited. Understanding the belief systems of drug addicts and their coping methods is important for several reasons namely crafting more effective treatment and nursing care; identifying treatment goals; providing insight to the treatment team about compliance to treatment; and potentially reducing repeated hospitalization.

There is a lot of literature knowledge about interactions between coping motives and alcohol expectancies. To our knowledge, substance and coping have been less studied. On the other hand, knowledge of the dysfunctional beliefs of drug addicts is also extremely limited. Accordingly, nonadaptive coping strategies and dysfunctional beliefs are thought to be effective in substance use. This study was designed to examine the relationship between dysfunctional beliefs and stress coping methods in drug-addicted patients. It was hypothesized that coping strategies and dysfunctional beliefs would be effective in drug-addicted, such that types of coping strategies and dysfunctional beliefs would partially explain the predictive severity of substance dependence.

Objectives

This study aimed to identify the relationship between dysfunctional beliefs and stress coping methods in drug-addicted patients.

The study aims to answer the following questions:

- What are the dysfunctional attitudes of drug-addicted patients under stressful situations?

- Which coping methods do drug-addicted patients use under stressful situations?
- Is there a relationship between the average scores of drug-addicted patients on the Coping Assessment Questionnaire (COPE) and the Dysfunctional Attitudes Scale (DAS) based on some variables?

MATERIALS AND METHODS

Participants and procedure

This descriptive, cross-sectional research was conducted to determine the relationship between dysfunctional beliefs and stress coping methods in drug-addicted patients.

The population of the research study comprised patients admitted to the Alcohol and Drug Addiction Treatment Center (ADATC) of a state hospital. Patients who were diagnosed with drug addiction according to the Diagnostic and Statistical Manual of Mental Disorders IV TR (DSM IV TR) and hospitalized for withdrawal treatment were included in the study. This study, conducted between November 1, 2013, and April 30, 2014, included 51 patients who consented to participate in the study and met the inclusion criteria.

Negotiations with patients with alcohol/substance use disorders were carried out after detoxification, at least 2 weeks after substance use, after evaluating the clinician's symptoms of withdrawal to complete disappearance.

Substance dependence in the cases was often alcohol comorbid. We wanted the results of our research to reflect only substance dependency. For this reason, our case count was very limited. The coping mechanism from our study parameters in alcoholism and substance addiction is different. This can also affect the results of the study. Our study results show that higher scores of ways of stress coping were found for drug-addicted patients comparing to alcohol addicts.

Inclusion criteria of the study

The rate of drug-addicted individuals in terms of recurrence and quitting the treatment program was higher than that of alcohol-addicted patients. This may be due to the educational background, dysfunctional beliefs, and ineffective coping with stress. For this purpose, the population of the study was selected from individuals already diagnosed with drug addiction according to the DSM IV TR, who had completed withdrawal treatment and were over 18 years of age.

Exclusion criteria of the study

Individuals who were diagnosed with schizophrenia or mental retardation; had received a diagnosis of hearing impairment, visual loss, and cognitive impairment that significantly affected their communication ability; had dementia or other organic mental disorders; or had

physical disorders that prevented them from completing the self-report scales; and had used benzodiazepine derivative drugs were excluded from the study. Effective anxiolytic benzodiazepines can cause side effects such as an increase in anxiety, dysphoria, hyperactivity, and aggressive behavior in a paradoxical way. In this regard, 11 patients were excluded from the study: two patients had comorbid alcohol use, three had hearing problems, one was diagnosed with schizophrenia, and five patients had comorbid physical diseases that prevented them from responding to the tests. Thus, the study was conducted on a total of 51 patients.

Patients who were admitted to the ADATC, met the substance abuse criteria according to the DSM IV TR, and completed their deprivation therapy were informed about the research, and tests were administered on them. In the study, the Sociodemographic Information Form, DAS, and COPE scale were administered randomly in a single session.

Measures

Sociodemographic Information Form

This form, prepared by the researchers, includes questions on age, gender, marital status, occupation, and education level of the patients, as well as the use of substances.

Dysfunctional Attitude Scale

The DAS has been developed by Weissman and Beck.^[12] In order to measure the beliefs and attitudes underlying different forms of psychopathology according to the Beck's cognitive theory.^[13] The score range is 40–280, and a high score indicates that the patient often exhibits dysfunctional attitudes. The scale consists of four factors, including perfectionist attitude (17 items; $\alpha = 0.80$), need for approval (11 items; $\alpha = 0.70$), independent attitude (6 items; $\alpha = 0.24$), and varying attitude (5 items; $\alpha = 0.10$). The DAS has been adapted to Turkish by Savaşır and Şahin.^[14] The Cronbach's α value of the scale is found between 0.87 and 0.92.

Coping Assessment Questionnaire (COPE)

This questionnaire developed by Carver *et al.* in 1989 was adapted to Turkish by Ağargün *et al.* The scale consists of 60 questions and 15 subscales, each of which consists of four questions. High scores received from the subscales show which coping attitudes are frequently used by individuals.^[11,15] Cronbach's α value of the scale is found to be 0.82.

COPE subscales are as follows: (1) positive reinterpretation and growth ($\alpha = 0.76$) (positively review and assess the behavior which has been displayed against stress), (2) mental disengagement ($\alpha = 0.39$) (giving up thinking about the problem), (3) focus on and venting of emotions ($\alpha = 0.62$) (expressing feelings), (4) seeking social support for instrumental reasons ($\alpha = 0.78$) (calling for suggestions, help, or information), (5) active coping ($\alpha = 0.92$) (concentrating efforts on doing

something about the stress), (6) denial ($\alpha = 0.69$) (denying the existence of stress), (7) turning to religion ($\alpha = 0.90$), (8) humor ($\alpha = 0.73$) (mocking/humor about the situation), (9) behavioral disengagement ($\alpha = 0.63$) (reduction of coping efforts), (10) substance use ($\alpha = 0.92$) (waiting for the appropriate opportunity to act), (11) seeking emotional social support ($\alpha = 0.85$) (receiving moral support), (12) substance use ($\alpha = 0.68$), (13) acceptance ($\alpha = 0.56$), (14) suppression of competing activities ($\alpha = 0.59$) (putting aside other activities in order to concentrate on the problem), and (15) planning ($\alpha = 0.70$) (thinking hard about coping with the stress). The Turkish validity and reliability study was carried out by Ağargün *et al.* (2005).

Statistical analysis

The data were analyzed using the Statistical Package for Social Scientists software version 15 (SPSS Inc., Chicago, IL, USA). for Windows. In the statistical evaluations, the Mann–Whitney U-test was used to evaluate the difference between the average scores of two groups that do not show normal distribution; the Kruskal–Wallis (KW) H-test was used to evaluate the difference between the average scores of three or more groups; and the Spearman’s correlation analysis was used to determine the direction and level of the relationship between DAS and COPE variables. While the *post hoc* Bonferroni test was used to determine differences within the group. We used a regression analysis to examine the strength of the relationship between dysfunctional beliefs and coping mechanisms. The significance level was accepted as $P < 0.05$ for all statistical analyses.

Ethical aspects of the research

Written permission was obtained from the ADATC center of the relevant state hospital to conduct the study. Verbal consent was obtained from the patients who participated in the study. Written approval dated March 25, 2014, with number 60116787-020/19039, was obtained from the Ethics Committee of Noninterventional Clinical Studies of Pamukkale University.

RESULTS

Findings related to the sociodemographic characteristics and substance abuse status of the patients

The average age of the patients who participated in the study was 35.13 ± 12.25 years. Frequencies for each group with regard to the sociodemographic characteristics of the patient were calculated and reported in Table 1. The characteristics of the patients regarding substance abuse are presented in Table 2.

Findings related to the relationship between Dysfunctional Attitude Scale and total scale and subscales of COPE of the patients

The average COPE score of the patients diagnosed with drug addiction was found to be 171.60 ± 23.35 . As shown

in Table 3a, the average score of the patients on the DAS was 161.66 ± 36.94 .

A significant positive relationship was found between the perfectionist attitude subscale of the COPE scale of the patients and emotion-focused coping, dysfunctional coping attitudes of the mental disengagement subscale, denial subscale, and COPE total scale of the patients. There was a significant positive relationship between the need for approval subscale of the DAS, the religiously coping subscale of the COPE, and the emotion-focused coping subscale. As shown in Table 3b, there was also a statistically significant positive relationship between DAS total scale and the emotion-focused coping subscale of COPE.

Table 1: Distribution of sociodemographic characteristics of the patients (n=51)

Sociodemographic characteristics	n (%)
Age	
18-27	15 (29.4)
28-37	16 (31.4)
38-47	10 (19.6)
48-57	7 (13.7)
58 and older	3 (5.9)
Gender	
Female	5 (9.8)
Male	46 (90.2)
Degree	
Elementary school	21 (41.2)
Middle school	11 (21.6)
High school	12 (23.5)
College-university	7 (13.7)
Marital status	
Married	20 (39.2)
Single	19 (37.3)
Divorced	8 (15.7)
Separated	4 (7.8)
Years of marriage	
Unmarried	27 (52.9)
0-5 years	4 (7.8)
6-10 years	5 (9.8)
11-15 years	4 (7.8)
16-20 years	1 (2.0)
21 and above	10 (19.6)
The realization of divorce to show the cause of the patient’s addiction	
Yes	5 (9.8)
No	27 (52.9)
Single	19 (37.3)
The count of marriage	
First	30 (58.8)
>1	2 (3.9)
Single	19 (37.3)
Child status	
Kids	28 (54.9)
No kids	4 (7.8)
Single	19 (37.3)
Employment status	
Employed	23 (45.1)
Unemployed	20 (39.2)
Retired	8 (15.7)

Table 2: Distribution of characteristics of the patients regarding drug addiction (n=51)

Characteristics of the patients regarding drug addiction	n (%)
Duration of substance use (years)	
1-5	12 (23.5)
6-10	11 (21.6)
11-15	12 (23.5)
16-20	2 (3.9)
21 and above	14 (27.4)
The age at which the patient first used the substance (years)	
5-10	3 (5.9)
11-15	11 (21.6)
16-20	27 (52.9)
21-25	5 (9.8)
26-30	2 (3.9)
31-35	3 (5.9)
The age at which the patient started to use the substance regularly (years)	
10-14	3 (5.9)
15-19	13 (25.5)
20-24	19 (37.3)
25-29	7 (13.7)
30-34	5 (9.8)
35 and above	4 (7.8)
The reason why the patient started using drugs	
Encouraged by a family member	1 (2.0)
Negative life events (conflicts during military service and losing a child)	2 (3.9)
Getting rid of pain	3 (5.9)
Pleasure and curiosity	14 (27.5)
Friendship environment	31 (60.8)
Having previous treatment due to substance use	
Yes	27 (52.9)
No	24 (47.1)
Treatment frequency due to substance use	
First time	24 (47.1)
1-5 times	20 (39.2)
6-10 times	7 (13.7)
The longest time of abstinence	
First-time treatment	24 (47.1)
1 day-5.5 months	16 (31.4)
6 months-1 year	3 (5.9)
13 months-2 years	2 (3.9)
25 months-3 years	5 (9.8)
37 months and above	1 (2.0)
The reason why the patient reused the drugs	
First-time treatment	24 (47.1)
Because he/she couldn't forget it	4 (7.8)
To test him/herself	5 (9.8)
Unemployment and feeling empty	4 (7.8)
Boredom and desire	7 (13.7)
Unable to change the friendship environment	5 (9.8)
Some family issues	2 (3.9)
Thoughts of the patient regarding his/her addiction	
Yes, I am addicted	38 (74.5)
No, I am not addicted	13 (25.5)
Tried to commit suicide	
Yes	22 (43.1)
No	29 (56.9)
The presence of another family member being drug addicted	
Yes	23 (45.1)
No	28 (54.9)
Being sentenced due to a crime committed	
Yes	17 (33.3)
No	34 (66.7)

Contd...

Table 2: Contd...

Characteristics of the patients regarding drug addiction	n (%)
Presence of a physical disease	
Yes	13 (25.5)
No	38 (74.5)
Having a psychological disease in the family	
Yes	7 (13.7)
No	44 (86.3)

Findings related to average scores of the patients on the Dysfunctional Attitude Scale and COPE subscales according to independent variables

Table 4a and b shows the distribution of average scores the patients received on COPE subscales depending on some independent variables. There was no statistically significant difference between the average COPE score and its subscale scores of the patients depending on their age; gender; marital status; number of children; working status; separation or divorce due to the substance abuse; type of substance; treatment history; longest time remaining sober; prison sentence; thoughts on being addicted; suicidal attempts; or having physical or psychiatric diseases ($P > 0.05$). Except this result, there was a significant difference between subscale scores of the patients depending on their education degree and the average “turning to religion ($F = 4.61, P = 0.007$),” “acceptance ($F = 3.85, P = 0.020$),” “emotion-focused ($F = 3.60, P = 0.020$),” “mental disengagement ($F = 3.22, P = 0.030$),” and “dysfunctional coping ($F = 2.93, P = 0.040$)” subscales of COPE and COPE total scale ($F = 3.67, P = 0.020$). The Bonferroni correction test was conducted to determine the difference between the primary school graduates and the university graduates in “turning to religion, acceptance, and emotion-focused” subscale scores of COPE and COPE total scores. It was determined that the primary graduates had the highest score. On the other hand, the Bonferroni correction test was conducted to determine the difference between the primary school graduates and the high school graduates in the mental disengagement subscale. There was a difference between middle school and high school graduates in dysfunctional coping subscale (Bonferroni correction). It was determined that the high school graduates had the lowest score in “mental disengagement subscale and dysfunctional coping” subscales [Table 4a].

There was a significant difference between subscale scores of the patients depending on their occupation and the average “turning to religion” ($KW = 9.92, P = 0.040$). Officers had the lowest score in turning to religion subscale (*post hoc* Bonferroni correction). In addition, there was a significant difference between subscale scores of the patients depending on their economic status and the average “turning to religion” ($KW = 9.92, P = 0.04$). Those with high incomes had the lowest score in turning to religion subscale (*post hoc* Bonferroni correction) [Table 4a].

Table 3a: Distribution of average scores of the patients received from the Dysfunctional Attitude Scale and COPE subscales (n=51)

Average scores received from the DAS and COPE subscales	Minimum-maximum	$\bar{X} \pm SS$
Problem-focused coping		
Seeking social support for instrumental reasons	4-16	11.17±4.22
Active coping	4-16	12.11±3.32
Restraint coping	4-16	10.84±2.99
Suppression of competing activities	4-16	11.39±2.83
Planning	4-16	13.17±2.79
Total	20-80	58.70±10.43
Emotion-focused coping		
Positive reinterpretation and growth	4-16	12.82±3.09
Turning to religion	4-16	14.43±3.34
Humor	4-16	8.25±4.18
Seeking emotional social support	4-16	11.03±3.87
Acceptance	4-16	12.52±2.76
Total	35-80	59.07±10.62
Dysfunctional coping		
Mental disengagement	4-16	10.72±3.45
Focus on and venting of emotions	4-16	11.98±3.37
Denial	4-16	8.37±3.74
Behavioral disengagement	4-16	8.39±2.88
Substance use	4-16	14.35±3.76
Total	23-68	53.82±9.63
General total of COPE	78-228	171.60±23.35
Average scores of DAS and its subscales		
Perfectionist attitude	11-119	72.80±23.40
Need for approval	11-77	54.19±13.24
Independent attitude	42	18.47±6.78
Varied attitude	35	16.39±5.60
DAS total	40-280	161.66±36.94

DAS – Dysfunctional Attitude Scale; SS – Standard deviation; COPE – Coping assessment questionnaire

Table 3b: The relationship between distribution of average scores of the patients received from the Dysfunctional Attitude Scale and COPE subscales (n=51)

COPE and subscales	DAS and subscales									
	Perfectionist attitude		Need for approval		Independent attitude		Varied attitude		DAS total	
	<i>r</i>	<i>P</i>	<i>r</i>	<i>P</i>	<i>r</i>	<i>P</i>	<i>r</i>	<i>P</i>	<i>r</i>	<i>P</i>
Average scores from subscales										
Seeking social support for instrumental reasons	0.18	0.200	0.23	0.100	0.06	0.690	-0.15	0.280	0.210	0.150
Active coping	0.15	0.310	0.21	0.15	-0.09	0.511	-0.26	0.061	0.13	0.370
Restraint coping	0.05	0.150	0.13	0.370	-0.12	0.411	0.07	0.611	0.08	0.601
Suppression of competing activities	-0.02	0.920	-0.18	0.200	-0.30	0.030*	-0.08	0.570	-0.15	0.300
Planning	0.06	0.690	0.14	0.340	-0.14	0.330	-0.19	0.190	0.04	0.781
Problem-focused coping, total	0.15	0.310	0.18	0.200	-0.16	0.260	-0.20	0.180	0.12	0.411
Positive reinterpretation and growth	0.12	0.401	0.21	0.150	0.04	0.760	-0.17	0.230	0.15	0.290
Turning to religion	0.26	0.070	0.29	0.040*	-0.03	0.860	-0.14	0.330	0.25	0.080
Humor	0.19	0.181	0.06	0.690	0.02	0.910	-0.26	0.070	0.12	0.411
Seeking emotional social support	0.18	0.210	0.22	0.120	0.13	0.370	0.06	0.700	0.24	0.091
Acceptance	0.27	0.060	0.21	0.140	-0.18	0.200	-0.16	0.270	0.20	0.170
Emotion-focused coping, total	0.33	0.020*	0.31	0.030*	0.01	0.940	-0.22	0.130	0.31	0.030*
Mental disengagement	0.33	0.020*	0.23	0.110	-0.10	0.490	-0.30	0.030*	0.25	0.080
Focus on and venting of emotions	-0.02	0.910	-0.24	0.090	-0.05	0.730	-0.04	0.770	-0.11	0.430
Denial	0.28	0.040*	0.21	0.130	-0.15	0.280	-0.19	0.190	0.21	0.140
Behavioral disengagement	-0.02	0.910	-0.11	0.460	0.01	0.930	0.02	0.900	-0.04	0.760
Substance use	0.07	0.610	0.09	0.520	0.24	0.090	0.19	0.190	0.16	0.290
Dysfunctional coping, total	0.24	0.090	0.08	0.560	-0.01	0.920	-0.12	0.411	0.18	0.211
COPE, total	0.31	0.030*	0.26	0.090	-0.07	0.610	-0.24	0.100	0.27	0.060

**P*<0.05. DAS – Dysfunctional Attitude Scale; COPE – Coping assessment questionnaire

Table 4a: The distribution of average scores of the patients received from the Coping Assessment Questionnaire (COPE) subscale by some independent variables

Independent variables	n	$\bar{X} \pm SD$					COPE total
		Turning to religion	Acceptance	Emotion-focused coping	Mental disengagement	Dysfunctional coping	
Degree							
Elementary school	21	15.57±0.87	13.90±2.46	62.90±10.54	12.09±2.84	55.23±9.41	181.42±22.35
Middle school	11	14.90±0.00	12.18±2.96	60.18±11.94	10.90±3.88	57.36±9.86	174.63±26.25
High school	12	14.16±0.00	11.41±2.15	57.16±8.83	8.50±2.54	47.16±8.50	159.91±20.65
University	7	10.71±0.00	10.85±2.79	49.14±3.76	10.14±4.29	55.42±7.82	157.42±9.30
F, P		4.61, 0.007*	3.85, 0.020*	3.60, 0.020*	3.22, 0.030*	2.93, 0.040*	3.67, 0.020*
Occupation							
Worker	3	15.66±0.57	12.66±0.57	60.33±11.59	12.00±6.92	51.33±9.86	161.66±33.70
Officer	2	9.00±1.41	9.00±4.24	43.50±0.70	7.50±3.53	43.00±1.41	142.00±9.89
Self-employed	7	14.42±4.15	11.71±2.56	56.57±9.50	9.57±3.20	51.14±9.00	168.00±19.18
Other (masseur, farmer, textile worker, or doing printing business)	14	13.21±4.47	13.07±2.58	59.64±13.33	11.64±3.60	52.57±11.47	172.00±26.92
Unemployed	25	15.40±1.89	12.72±2.90	60.56±8.97	10.64±2.95	56.44±8.52	175.00±21.09
KW, P		9.92, 0.040*	3.35, 0.500	5.93, 0.200	4.22, 0.380	5.12, 0.280	4.98, 0.290
Income (TL)							
0-900	30	15.03±2.25	12.73±2.69	59.43±9.70	10.56±3.52	53.26±9.59	172.46±23.65
1000-1900	13	15.07±3.32	12.92±2.75	61.30±12.34	11.15±3.38	57.53±10.01	177.53±24.51
2000 and above	8	11.12±5.05	11.12±2.99	54.12±10.86	10.62±3.70	49.87±8.02	158.75±17.05
KW, P		8.11, 0.020*	2.28, 0.320	2.94, 0.230	0.19, 0.910	2.81, 0.250	3.85, 0.150

*P<0.05. F – Analysis of variance; KW – Kruskal–Wallis tests; SD – Standard deviation; TL – Turkish lira

Table 4b: The distribution of average scores of the patients received from the Coping Assessment Questionnaire (COPE) subscale by some independent variables

Independent variables	n	$\bar{X} \pm SD$			COPE total
		Behavioral disengagement	Substance use	Dysfunctional coping	
Duration of substance use (years)					
1-5	12	7.33±2.96	12.33±5.24	52.75±12.30	175.58±22.21
6-10	11	8.09±2.70	12.72±5.00	53.27±10.93	168.18±22.88
11-15	12	9.16±2.91	16.00±0.00	52.16±8.68	166.66±27.33
16-20	2	8.50±2.12	16.00±0.00	55.00±4.24	183.00±28.28
26-30	9	8.22±3.11	15.55±1.33	55.55±7.07	174.22±25.56
31 and above	5	10.00±3.00	16.00±0.00	58.00±9.51	172.20±18.86
KW, P		0.22, 0.19	0.44, 0.010*	0.15, 0.280	0.03, 0.850
The age at which patient first used the substance (years old)					
5-10	3	8.66±2.30	16.00±0.00	55.66±2.51	178.00±5.29
11-15	11	8.63±2.29	15.63±1.20	54.63±8.80	172.00±21.80
16-20	27	8.51±2.28	14.63±3.50	55.11±9.61	170.29±23.63
21-25	5	9.60±2.30	13.60±5.36	55.80±12.25	188.20±26.47
26-30	2	6.00±2.82	10.00±8.48	44.50±3.53	165.50±41.71
31-35	3	5.66±0.57	9.33±4.61	40.33±4.04	151.66±17.00
KW, P		-0.25, 0.740	-0.42, 0.001*	0.33, 0.020*	-0.78, 0.590
The age at which the patient started using drugs regularly (years old)					
10-14	3	9.00±1.73	16.00±0.00	60.00±3.46	184.66±6.42
15-19	13	8.53±3.23	15.69±1.10	55.38±9.46	170.00±20.44
20-24	19	9.47±2.56	14.73±3.78	54.78±9.56	170.52±26.12
25-29	7	7.57±3.20	14.28±4.53	58.78±8.13	189.57±21.52
30-34	5	7.60±2.07	12.80±3.34	47.20±6.83	148.40±14.58
35 and above	4	4.75±0.95	9.00±6.00	40.00±2.70	169.75±15.52
KW, P		-0.29, 0.040*	-0.44, 0.001*	-0.28, 0.050*	-0.07, 0.620
The reason to start using substance					
Encouraged by a family member	1	10.00±0.00	16.00±0.00	53.00±0.00	180.00±0.00
Negative life events (conflicts during military service and losing a child)	2	9.00±1.41	16.00±0.00	46.00±5.65	131.50±6.36
Getting rid of pain	3	5.33±1.15	6.66±4.61	40.33±4.04	163.33±25.96
Pleasure and curiosity	14	8.14±2.98	15.71±1.06	55.21±7.51	172.92±22.27
Friendship environment	31	8.70±2.96	14.32±3.83	55.03±10.16	174.12±22.88
KW, P		5.18, 0.270	14.92, 0.040*	7.70, 0.100	5.44, 0.250

*P<0.05. KW – Kruskal–Wallis tests; SD – Standard deviation

When patient COPE scores were evaluated according to the use of substance, there was a significant difference between the average “substance use” COPE subscale and their duration of substance use ($KW = 0.44, P = 0.010$), age at which the patient first used the substance ($KW = -0.42, P = 0.001$), age at which the patient started using drugs regularly ($KW = -0.44, P = 0.001$), and the reason to start using substance ($KW = 14.92, P = 0.040$). The nonparametric Bonferroni correction test was conducted to determine the difference between the 5–10-year-old and 31–35-year-old patients in “substance use” subscale on age at which the patient first used the substance and age at which the patient started using drugs regularly. Patients aged 1–5 years (duration of substance use) had the lowest score in “substance-use” subscale [Table 4b]. In addition, Bonferroni correction test was conducted to determine the difference between “the negative life events” and “getting rid of pain” in “substance-use” subscale on the reason to start using substance. Substance use rates were found to be high in those who declared the existence of Negative Life Events (conflicts during military service, child loss).

There was a significant difference between the average “behavioral disengagement” scale score and age at which patients first used the substance subscale score ($KW = -0.29, P = 0.040$). The nonparametric Bonferroni correction test was conducted to determine the difference between the 5–10-year-old and 31–35-year-old patients in the substance use subscale according to age at which the patient started using drugs regularly. Patients aged 5–10 years who started using drugs regularly had the highest score in substance-use subscale [Table 4b].

There was a significant difference between the average “dysfunctional coping” subscale score, the age at which patients first used the substance subscale score ($KW = 0.33, P = 0.020$), and the age at which patients started using drugs regularly ($KW = -0.28, P = 0.050$). The nonparametric Bonferroni correction test was conducted to determine the difference between the 5–10-year-old and 31–35-year-old patients in the substance-use subscale according to age at which patients started using drugs regularly and age at which patients first used the substance. Patients aged 5–10 years (age at which patients first used the substance) had the highest score in the substance-use subscale [Table 4b].

Table 5 shows the distribution of average scores of the patients on the DAS subscale depending on some independent variables. There was no statistically significant difference between the average DAS score and subscale scores of the patients depending on their age; gender; marital status; educational degree; number of children, working status, separation or divorce due to the substance abuse, type of the substance; previous treatment; longest time of remaining sober; thoughts on being addicted;

suicidal attempts; prison sentence; or having physical or psychiatric diseases ($P > 0.05$).

There was a significant difference between the “average independent attitude” subscale score of DAS according to the occupations of the patients ($KW = 11.25, P = 0.020$) and the age at which patients first used the substance ($KW = 0.33, P = 0.020$).

There was a significant difference between the average “varied attitude subscale” of DAS and subscale scores of age at which patients first used the substance ($KW = -0.32, P = 0.020$). Spearman’s correlation analysis showed that duration of substance use was negatively correlated with “varied attitude” subscale of DAS ($r = -0.31, P = 0.030$).

Multiple regression analysis was conducted to determine the coping mechanism considered to be effective on the patients’ dysfunctional beliefs. Using regression equation, the predictor variables were evaluated independently to examine their contribution in the prediction of patients’ dysfunctional beliefs. Results showed that the patients’ dysfunctional beliefs were affected by their coping mechanism. The coping mechanism explained an additional 29.5% of the variance in patients’ dysfunctional beliefs.

DISCUSSION

Stress and dysfunctional thoughts are important determinants that lead individuals to start using substances or make them more addicted to drugs, stimulating worsening substance-abuse issues. In this study, the age of individuals when they first started using drugs ranged from 16 to 20, and the age when they started using drugs every day on a regular basis ranged from 20 to 24. These results are consistent with the results of several studies conducted in Turkey.^[16,17] According to earlier studies, using drugs at an early age increases the risk of being addicted. In the literature, it has been stated that 80% of drug-addicted individuals first used these drugs when they were younger than 18 years of age. In a study conducted on alcohol-addicted males, it has been reported that participants were in their 20s when they started drinking regularly. In our study, a negative relationship was found between dysfunctional coping type subscale and substance abuse of the patients depending on their age at which they first started using these drugs. The mental and physical characteristics of childhood and adolescence may facilitate the formation of a variety of maladaptive behaviors and substance abuse. Children and young teenagers are often incapable of refusing offered substances because they have not completed their intellectual development. Therefore, it becomes easier to start using drugs at early ages and more difficult to quit using them.^[18]

Table 5: The distribution of average scores of the patients received from the Dysfunctional Attitude Scale subscale by some independent variables

Independent variables	DAS and subscales		
	<i>n</i>	Independent attitude	Varied attitude
Occupation			
Employee	3	20.33±6.80	13.00±9.16
Officer	2	18.00±0.00	20.50±9.19
Self-employment	7	22.57±4.31	19.57±3.69
Other (masseur, presser, farmer, and doing textile business)	14	14.71±5.42	14.64±3.65
Unemployed	25	19.24±7.56	16.56±6.06
KW, <i>P</i>		11.25, 0.020*	6.23, 0.181
Duration of substance use (years)			
1-5	12	19.75±8.97	14.83±7.45
6-10	11	17.72±4.88	16.18±4.62
11-15	12	20.75±6.46	16.41±6.11
16-20	2	13.00±1.41	14.50±3.53
26-30	9	18.11±7.40	18.44±4.50
31 and above	5	14.40±3.28	17.60±4.44
<i>r</i> , <i>P</i>		-0.88, 0.541	-0.31, 0.030*
The age at which patient first used the substance (years old)			
5-10	3	23.33±5.03	19.00±3.46
11-15	11	20.90±8.79	18.09±7.98
16-20	27	17.77±6.24	15.96±5.22
21-25	5	12.80±1.30	14.00±3.00
26-30	2	24.00±8.48	17.00±8.48
31-35	3	16.66±1.52	15.00±1.00
KW, <i>P</i>		-0.33, 0.020*	-0.32, 0.020*

**P*<0.05. KW – Kruskal–Wallis tests; DAS – Dysfunctional Attitude Scale

The origin of dysfunctional beliefs and practices can be found in childhood. Although these may develop partially over a lifetime, they are often subjected to very little change, and these thoughts and beliefs, often supported by cognitive distortions, offer no benefit to individuals. Beck defines a schema as a cognitive structure that includes stable beliefs and assumptions about the self, others, and the world, and it functions as a broad organizing principle.^[19] Schemas are formed in early life and affect people throughout their life span. For example, a child exposed to family violence at an early age may later develop maladaptive schemas.^[20] Maladaptive schemas – defined as cognitive, emotional distortions affecting the interpretation and understanding of people – affect the beliefs and practices of an individual.

Dysfunctional beliefs and practices generate negative thoughts, which are often accompanied by negative feelings. In our study, it was found that perfectionist attitude was associated with coping mechanisms such as mental disengagement. Perfectionism is a cognitive schema that can be characterized by setting high standards and being too worried about making mistakes. Perfectionism is associated with many psychopathologies. Dysfunctional cognitive characteristics of perfectionist people related to expectations of stress, emergency situations, as well as the development and maintenance of stress make them prone to the development of psychopathology. In fact, higher stress is more common in perfectionists. In this sense, negative events may be interpreted as “terrible”

or “impossible to deal with” to perfectionists, who often describe such events as a disaster.^[21] In another study, the number of problems related to alcohol faced by perfectionists was found to be more in those who are open to being well adjusted compared to others. This indicates that perfectionists, who are not open to being well adjusted, are more stressed and use more negative coping methods.^[22] In addition, perfectionism that cannot be well adjusted is considered to be a part of dysfunctional attitudes in addicted people. On the other hand, the scores of the participants in this study on the need for approval scale, considered to be related to happiness for a person that depends on the approval and support of others, were also found to be higher. Failure to obtain the approval of others may be perceived as a threat that disrupts the integrity of the individual. This dysfunctional attitude causes depressive symptoms by triggering negative thoughts about the self, the outside world, and the future. The main cause of this need for approval from others may be addiction. In people who need a high level of social approval, there may be an increase in alcohol use caused by this observational learning model. In fact, this constant need for approval is defined as “approval addiction” in literature.^[23]

Patients in this study often used emotion-focused coping strategies, which have quite positive aspects in terms of facilitating the use of problem-focused coping attitudes by reducing the intense stress of the individuals and providing response to some stressors. However, long-term use may

cause some drawbacks such as preventing problem-focused actions by immobilizing the individual. Emotion-focused coping is considered to be a variation of ineffective coping attitudes, and is generally observed with severe psychopathology and deterioration of function.^[24] Emotion-focused coping involves attempts regulate the emotions evoked by the occurrence of a stressful event. Previous studies have reported that emotion-focused coping attitudes pose a risk for the development of emotional disorders and have a tendency to lead to substance abuse. Dysfunctional attitudes are reportedly associated with maladaptive coping strategies. According to Penedo *et al.*, there is a relationship between dysfunctional thinking patterns and coping attitudes such as avoidance and an inability to solve problems. A positive relationship was found between the perfectionist attitudes of the patients and emotion-focused coping, mental disengagement subscale, denial subscale, and total COPE scores.^[25] Accordingly, the use of emotion-focused coping methods, dysfunctional coping attitudes, mental disengagement, and denial attitudes is highly observed in people with more perfectionist attitudes. Mental disengagement is considered to be helpful in preventing the loss of behavioral interest that emerges as a different shape of behavioral disengagement. Mental disengagement is a mechanism that often attempts to delay thinking about the stressor. In short, mental disengagement helps individuals avoid problematic thinking. Denial means ignoring unresolved problems mentally and behaviorally, and it has a structure similar to mental disengagement. If stress is not successfully removed, an avoidant attitude can lead to the emergence of additional problems. Çetinkaya *et al.* suggested that, although avoidant attitudes in stressful events may be helpful in the earlier stages, they might make it more difficult to cope in later stages. Using noneffective coping methods such as maladaptive perfectionism, mental disengagement, and denial, which are parts of dysfunctional attitudes observed in addicted people, may lead to ignorance of psychological and familial problems. Considering that the substance abuse of an individual cannot be controlled in addition to ignoring the problems, the use of emotion-focused coping attitudes, mental disengagement, and denial will increase in order to reduce anxiety.^[26]

In this study, a positive relationship was determined between the need for approval of DAS and the turning to religion and emotion-focused coping subscales of COPE. The need for approval and a fear of rejection may lead individuals to be nervous about their relationship with others and avoid expressing themselves. Individuals cannot be sure of the feelings of other people in this way, which can lead to social anxiety as they begin thinking that they are not understood by others. The need for approval, which is an important indicator of interpersonal sensitivity, is directly related to an increased desire to be accepted by others and expectations of not being rejected.

Turning to religion is defined as an emotion-focused attitude. An individual may tend toward religious practices under stressful conditions for several reasons. Religion is often seen as a source of emotional support. It may help individuals cope with stressful situations by allowing them to interpret these conditions in a positive way. Although turning to religion is sometimes considered ineffective, it has been reported that religion can function as an important source of moral support and that it can prevent mental health problems.^[27] Drug-addicted people may receive the need for approval and support from religious practices because they cannot receive what they expect from other people.

Coping attitudes may be individualized and can vary depending on factors such as age, gender, education, culture, diseases, and the load of stressors.^[11,26] In our study, a statistically significant difference was found between the emotion-focused coping, turning to religion, and acceptance, dysfunctional coping, mental disengagement subscales and the total COPE scores according to their education levels ($P < 0.05$). The scores of the patients for emotional coping methods, turning to religion, acceptance, dysfunctional coping, mental disengagement subscale increased as they graduate from low-level educational institutions. This indicates that individuals experience difficulties while coping with stress as their educational level declines. Education is one of the most important support systems for individuals trying to cope with difficulties. Furthermore, individuals improve their problem-solving skills as they become more educated, potentially making them more successful in coping with drug addiction and solving problems related to this addiction.^[28]

A negative relationship was found between the scores of behavioral disengagement, drug use, and dysfunctional coping according to age of at which the patients when they first started using these drugs. Dysfunctional coping attitudes are observed more in individuals who started using drugs at an early age. Dysfunctional coping attitudes have an important impact on creating a negative stress response. Behavioral disengagement, which is one of the dysfunctional coping attitudes that include giving up the fight and ignoring the source of stress, can predispose people to the formation of thoughts that make it impossible to quit using substances and can eventually lead to hopelessness.^[18] Adopting behavioral disengagement, which is an avoidant style of coping, may increase anxiety in individuals. On the other hand, this coping attitude is reportedly observed more often in patients dealing with hopelessness. In fact, it is considered to be “maladaptive” when the disorder is accompanied by an avoidant coping style. However, in cognitive behavioral interventions, behavioral disengagement is sometimes used as a method to reduce distress and improve the inner vision.

A statistically significant difference was found between the scores of patients on the turning to religion subscale of the emotional-focused coping type depending on their income levels. In other words, these patients use turning to religion methods more commonly as their income levels decrease. There are ways to reduce or eliminate the effects of stress. First, psychotherapy and medical treatment may help individuals solve the problems that are causing stress. Second, individuals may try to solve the problems that cause stress by themselves. The most effective factor in the second method is religious belief. Religion is one of the core values affecting the determination of attitudes and choices of individuals. Religion guides people in all areas of life and helps them cope with stress by giving them a sense of hope and a larger perspective on the meaning of life.^[29] The chances of a drug-addicted person receiving help from others decrease as income levels decline. In this case, it may be that such individuals become more religious because it is believed that religion offers some help and motivation to cope with their problems.

In the present study, a statistically significant positive relationship was found between scores of the patients on the substance-use subscale of dysfunctional coping type depending on the duration of substance use. Among those using drugs for at least 10 years, dysfunctional coping scores were quite high. Camatta and Nagoshi tested a hypothesis suggesting that substance use and alcohol intake can be ways of coping and observed that individuals with irrational thoughts start using alcohol and drugs as a coping strategy in stressful situations. In fact, a significant relationship between dysfunctional coping attitudes and the emergence and continuity of psychopathological symptoms has been presented.^[30] In our study, patient scores on the DAS independent attitude subscale were found to be quite high in individuals who started using substances at an early age. Addressing these age groups is very important in terms of taking preventive measures.

Limitations

Despite these findings, there are also some limitations in our study. The small number of cases included in our study can be considered as a limitation. Because there are no similar institutions to the ADATC, the number of individuals participated in our study necessarily remained quite limited. In addition, the low probability of being volunteered in dependent study groups has affected the sample size of our study. Our study comprises patients admitted and hospitalized at an ADATC center in a city; therefore, it may not represent all patients in every society. Another limitation of the study is that the scales used in the study are of self-reported. Because these scales are based on self-statements, they may not always give the correct answer, and the participant may view the situation from a different perspective based on the individual social environment and cultural characteristics.

CONCLUSIONS

In the present study, cognitive dysfunctional beliefs, especially perfectionist attitudes, were observed in individuals who demonstrate a need for approval from other people. Such people use emotion-focused coping methods to cope with these dysfunctional beliefs. In our study, dysfunctional beliefs were found to trigger maladaptive coping attitudes. Focusing on functional-specific cognition instead of general dysfunctional cognition is useful and important. From this point of view, it should be a priority to provide preventive services by nurses as a team to those with higher risk of developing dysfunctional beliefs. For this purpose, it is critical to offer regular education programs for this high-risk group by using the principles of cognitive behavioral therapy. It is very important to establish support programs for individual or group therapies within the 1st year in order to change wrong thoughts that cause recurrence of such behaviors in drug-addicted individuals instead of creating new coping methods. Including nurses in these programs is also very important. Comparative studies toward investigating the dysfunctional beliefs of alcohol- and drug-addicted people and coping methods should also be conducted.

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Conflicts of interest

There no conflicts of interest.

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