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INVESTIGATION OF SUBSTANCE USE AMONG LATE ADOLESCENTS IN TERMS OF ITS RELATIONSHIP WITH PARENTAL ACCEPTANCE REJECTION, SELF-CONTROL, ANGER, AND PEER DEVIANCE

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INVESTIGATION OF SUBSTANCE USE AMONG LATE ADOLESCENTS IN TERMS OF ITS RELATIONSHIP WITH PARENTAL ACCEPTANCE REJECTION, SELF-CONTROL, ANGER, AND PEER DEVIANCE

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ABSTRACT

INVESTIGATION OF SUBSTANCE USE AMONG LATE ADOLESCENTS IN TERMS OF ITS RELATIONSHIP WITH PARENTAL ACCEPTANCE REJECTION, SELF-CONTROL, ANGER, AND PEER DEVIANCE

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Substance use is a multifaceted psychosocial problem resulting from interaction among several different level factors. The current thesis aimed to examine substance use problem among late adolescents in terms of its relationship with parental acceptance-rejection, self-control, anger, and peer deviance. Data were collected from 160 male using substances aged between 18-25 via using Demographic Information Form, Adult Parental Acceptance-Rejection Questionnaire, Brief Self-Control Scale, Trait Anger-Anger Expression Inventory, Peer Deviance Scale, Drug Use Disorders Identification Test, University Form of Risk Behaviors Scale. Two separate one-way Multivariate Analysis of Variance (MANOVA) and multiple regression analyses were conducted. According to the results, high severity and low severity substance use group differed significantly in terms of maternal hostility,

maternal undifferentiated rejection, self-control, trait anger, anger control, anger-out expression, and peer deviance. Nevertheless, no significant group differences were observed in terms of total paternal rejection score and its sub-dimensions, maternal rejection total score, maternal warmth, maternal neglect, and anger-in expression. By contrast, the clinical group and non-clinical group showed significant differences in paternal hostility, paternal undifferentiated rejection, maternal hostility, maternal undifferentiated rejection, trait anger, anger-out expression, and peer deviance, while there were no significant differences in terms of paternal rejection total score, paternal warmth, paternal neglect, maternal rejection total score, maternal warmth, maternal neglect, self-control and anger-in expression. In addition, paternal undifferentiated rejection and peer deviation were found to significantly predict late adolescents' substance use problem. Obtained results were discussed in relation to the relevant literature, and clinical implications and limitations were presented.
Keywords: Substance Use, Parental Acceptance-Rejection, Self-control, Anger, Peer Deviance

ÖZET

GEÇ ERGENLERDE MADDE KULLANIMININ EBEVEYN KABUL REDDİ, ÖZ KONTROL, ÖFKE VE AKRAN SAPMASI İLE İLİŞKİSİ AÇISINDAN İNCELENMESİ

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Madde kullanımı, farklı seviyelerdeki pek çok risk faktörünün etkileşime girmesiyle ortaya çıkan çok yönlü bir psiko-sosyal problemdir. Bu tezde, geç ergenlerde madde kullanımının ebeveyn kabul ve reddi, öz kontrol, öfke ve akran sapması ile ilişkisinin incelenmesi amaçlanmıştır. Veriler, 18-25 yaş arasındaki 160 erkek madde kullanıcısından Demografik Bilgi Formu, Yetişkin Ebeveyn Kabul-Red Ölçeği, Kısa Öz Kontrol Ölçeği, Sürekli Öfke-Öfke İfade Tarzı Ölçeği, Akran Sapması Ölçeği, Madde Kullanım Bozukluklarını Tanılama Testi ve Riskli Davranışlar Ölçeği Üniversite Formu aracılığı ile toplanmıştır. Araştırma sorularını incelemek için iki ayrı tek yönlü Çok Değişkenli Varyans Analizi (MANOVA) ve çoklu regresyon analizi yapılmıştır. Elde edilen sonuçlara göre, yüksek şiddette madde kullanan grup

ile düşük şiddette madde kullanan grup arasında anne düşmanlığı, anne farklılaşmamış reddi, öz kontrol, sürekli öfke, öfke kontrolü, öfke-dışa ifadesi ve akran sapması açısından anlamlı düzeyde fark varken, baba reddi toplam puanı ve alt boyutları, anne reddi toplam puanı, anne sıcaklığı, anne ihmali ve öfke-içe ifadesi açısından iki grup arasında anlamlı bir fark bulunamamıştır. Öte yandan, klinik grup ve klinik olmayan grup arasında baba düşmanlığı, baba farklılaşmamış reddi, anne düşmanlığı, anne farklılaşmamış reddi, sürekli öfke, öfke-dışa ifadesi ve akran sapması açısından anlamlı farklılıklar görülürken, baba reddi toplam puanı, baba sıcaklığı, baba ihmali, anne reddi toplam puanı, anne sıcaklığı, anne ihmali, öz kontrol ve öfke-içe ifadesi açısından iki grup arasında anlamlı fark bulunmamıştır. Ayrıca, baba farklılaşmamış reddinin ve akran sapmasının madde kullanımını anlamlı olarak yordadığı görülmüştür. Sonuçlar ilgili literatürle ilişkilendirilerek tartışılmış, klinik çıkarımlar ve çalışmanın sınırlılıkları sunulmuştur.
Anahtar Kelimeler: Madde Kullanımı, Ebeveyn Kabul-Reddi, Öz kontrol, Öfke, Akran Sapması

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CHAPTER 1

INTRODUCTION

Adolescence is a transition period during which several biological, psychological, emotional and social changes take place (Santrock, 2016). The developmental processes of adolescents might be compromised by some risky behaviors that particularly begin to be exhibited during this life span (Avcı et al., 2017). Amongst others, substance misuse is one of the most important risky behaviors that might have debilitating consequences on the physical and psychological health of the youth (Hemphill et al., 2011; Kann et al., 2013; Kessler et al., 2005). Substance misuse is a life-threatening yet preventable problem that particularly begins in adolescence between the ages of 10 and 19 (WHO, 2006), and might progress into addiction leading to significant psychosocial impairments (Hemphill et al., 2011; Sussman et al., 2008). The majority of adolescents start to use substances as early as 12 years of age (Lesly, 2008; Parrott et al., 2004). The problem of substance use typically begins with smoking cigarettes and then, other substances, such as alcohol, cannabis, and hard drugs, are experimented as a result of the cross use of varying substances (Berk, 2007; Donald et al., 2007). Well then, some young people with risk factors start using substances, while others do not, or some just experiment with them and some become addicted. Hence, the question is what are the specific risk factors resulting in substance misuse problem among youth. Existing evidence suggests that the biopsychosocial model explains all these individual differences, and those biological, personal, familial, and environmental factors have a combined influence on the substance use behavior (Skewes & Gonzales, 2013). According to this model, in addition to biological factors, personal factors such as self-efficacy, personality, temperament, self-control, anxiety and anger level and social factors such as family, parents and peers affect substance use, and adolescents usually use substances due to interaction on of several familial, environmental, cultural, cognitive, biological and psychological factors (Avcı et al., 2017; Liddle & Rowe 2006; Rice & Dolgin, 2008; Skewes & Gonzales, 2013).

Although there are studies examining separate roles of personal (i.e., impulse control, anger expression and personality traits) and familial factors (i.e., parenting,

parental psychopathology etc.) in the development of substance misuse (Caliendo et al, 2017; Laitano et al., 2021; Mathna et al., 2020; Smith, 2021), the current study is amongst the few investigating roles of different yet theoretically related psychosocial variables in the maintenance of substance use problem using a comprehensive framework. Accordingly, this thesis aimed to understand the roles of parental acceptance-rejection, self-control, anger, and peer deviance in substance use behaviors among youth. The introduction started with a brief background on the relationship between perceived parental acceptance-rejection and substance use in youth. Then, the roles of youth's self-control and anger states on substance use problem were presented, which was followed by the explanation of the possible association of peer deviance on substance misuse. Finally, the introduction part ended by covering the scope, aims and hypothesis of the current thesis.

1.1. Perceived Parental Acceptance-Rejection and Substance Use

Parental acceptance-rejection has been known to influence children's lifelong behaviors in several domains (Khaleque & Rohner, 2012; Rohner, 2015). Interpersonal Acceptance-Rejection Theory (IPAR-Theory) is an evidence-based theory of socialization and lifelong development aiming to explain the antecedents, consequences, and other correlates of parental acceptance and rejection in terms of the parent-child relationship (Ali et al., 2014; Khaleque & Rohner, 2002; Rohner, 2015; Rohner et al., 2005; Rohner & Khaleque, 2002). Research on this subject proves that all children, regardless of their gender, age, ethnicity or culture need acceptance and love from their parents or from other caregivers for healthy psycho-social development (Khaleque & Rohner, 2002; Rohner, 2015; Rohner et al., 2005; Rohner & Khaleque, 2002).

Parental acceptance and rejection form the warmth dimension of the parenting. The warmth dimension is a continuum in which all people are located, no matter which end they are close to. One end of the continuum represents parental acceptance, referring to the affection, care, comfort, support, and love that children can obtain from their parents and other caregivers. The other end of the continuum indicates parental rejection, which refers to the absence or withdrawal love and affection, and the presence of a variety of physically and psychologically harmful behavior (Rohner, 2015; Rohner et al., 2005).

An important conceptual feature of the theory in question is its emphasis on individuals' subjective perceptions of parenting behaviors. Here, rather than the behavior of the parents, how the offspring perceive and interpret their parents' behavior within the framework of acceptance and rejection is of utmost importance determining mental health outcomes (Rohner et al., 2005). Although parental behaviors are judged in accordance with cultural and personal lenses, cross-cultural research reveals that parental rejection can be universally experienced with any combination of the four key expressions that are 1) warm and affectionate; 2) hostile and aggressive; 3) indifferent and neglecting; and 4) undifferentiated rejection. In that respect, *warmth/affection* expresses positive attitudes and behaviors such as love, understanding, care and support shown to the child verbally or nonverbally. *Hostility/aggression* refers to depriving the child of these and, on the contrary, exposing them to hostile and offensive words and behaviors. *Indifference/neglect* can be defined as depriving the child of the attention that should be given, ignoring and not meeting his/her needs. Undifferentiated rejection, on the other hand, refers to the individuals' beliefs that their parents do not genuinely care or love them, even if there are no clear behavioral indications that the parents are neglecting, unloving, or aggressive towards them. (Rohner, 2015; Rohner et al., 2005).

Several attempts have been made to understand how perceived parental acceptance-rejection impact on personality development and mental health (Khaleque, 2015; Rohner, 1999; Yang et al., 2019). Accordingly, parental rejection predicted personality development and psychological adjustment problems (Rohner & Khaleque, 2010). Khaleque and Rohner (2002), in their cross-cultural meta-analysis study, in which they comprehensively examined the relationship between perceived parental acceptance-rejection and psychological adjustments, showed that twenty six percent of the variability in psychological adjustment scores of children were explained by the perceptions of acceptance or rejection by the primary caregivers. Similarly, twenty one percent of the variability in adults' psychological adjustment have also been accounted for by the perceptions of acceptance-rejection in childhood (Khaleque & Rohner, 2002). In conclusion, this study showed that perceived parental acceptance-rejection alone is a strong predictor of psychological and behavioral adjustment universally. Moreover, individuals who perceived themselves as parentally rejected were more likely to develop mental health problems such as conduct disorder, depression or depressed mood, and substance and

alcohol abuse compared to the individuals who reported to receive greater levels of parental acceptance (Rohner & Britner, 2002). Theoretically, these problematic behaviors are expected to arise as a consequence of the intense psychological pain caused by the perceived parental rejection. More specifically, children and adults with greater parental rejection are likely to experience increased anger, resentment, and other destructive emotions that can be intensely painful. As a result, their propensity to develop maladaptive psychological and behavioral responses might increase to protect themselves from further rejection (Hay, 2001; Rohner, 2015).

When the parental acceptance-rejection literature is examined with respect to substance use, it has been found that parental rejection is associated with substance use problems across different cultures. More specifically, as the perceived parental rejection levels increased, the likelihood of misusing substances increased (Furstenberg & Weiss, 2000; Rohner & Britner, 2002; Rohner & Veneziano, 2001; Söderström & Skårderud, 2013; Veneziano, 2000, 2003). By contrast, greater parental warmth and acceptance is associated with fewer substance use problems among young people (Broman et al., 2006; Lee et al., 2013). In addition to the above theoretical explanation about the relationship of parental acceptance-rejection with psychological and behavioral problems, the influence of parents on children's risk taking behavior becomes more pronounced when the offspring face aggravated environmental risks and uncertainty. Life History Theory proposed that individuals have a mental representation of the availability and predictability of the resources based on the interaction of individual and environmental factors (Kaplan & Gangestad, 2005). Accordingly, parental rejection leads to the perception of short life expectancy and the notion that resources are not available and unpredictable, which in turn might result in the belief that life is short and must be lived quickly (Belsky, 2012; Del Giudice et al., 2011). Therefore, individuals with these kinds of beliefs tend to prefer current risks (e.g. substance use) over future gains (Hill & Chow, 2002), increasing their likelihood of engaging in risky behaviors.

Although there are several studies examining the association between substance use and parental rejection (Caliendo et al., 2017; Rai, 2008; Yang et al, 2019), the unique contribution of paternal rejection has usually been overlooked in the related literature. Although few in number, existing studies gave support to the conclusion that father acceptance-rejection can be as strongly involved as the

maternal rejection in the development of behavioral and psychological problems including substance misuse among offspring (Hay, 2001; Rohner & Veneziano 2001; Veneziano 2000; 2003). In fact, these studies suggested that paternal acceptance-rejection explains a unique and independent amount of the variance in certain child outcomes beyond the variance explained by the maternal rejection (Veneziano, 2003). On the other hand, other studies have yielded that maternal rejection is more strongly related to the child's substance use (Baron et al., 2010; Glavak et al., 2003; Yang et al., 2019) and paternal rejection did not have a significant association with offspring substance misuse problems (Yang et al., 2019). As the empirical confusion is still present, the current thesis aimed to understand separate roles of maternal and paternal rejection with respect to substance misuse problems among late adolescents.

Although familial factors are one of the important psychosocial predictors of substance use, emotion regulation problems also predicted risk of substance misuse among youth (Aldao et al., 2010). Amongst others, self-control is long to be known to predispose adolescents for several risk-taking behaviors including substance use related problems (Pratt et al., 2010).

1.2. Self-control and Substance Use

Existing studies have yielded that psychological factors are as important as familial factors in the development and maintenance of substance use behavior. Studies sampling adolescents in the United States and other developed countries have provided robust evidence with regard to the association between self-control and substance use based on two comprehensive theoretical frameworks, which are Gottfredson and Hirshi's (1990) Self-Control Theory and Akers' (1998) Social Learning Theory (Pratt & Cullen, 2000; Pratt et al., 2010).

According to Self-Control Theory, individuals make decisions consciously and rationally by weighing the advantages and disadvantages of the possible behaviors (Gottfredson & Hirschi 1990). Self-control Theory suggests that delinquency and other problematic behaviors like substance abuse are driven by two main factors, that are (1) variation in levels of self-control and (2) the opportunity for delinquency. While the opportunity for delinquency indicates the environmental risk factors, self-control refers to one’s ability to exert control over their emotions, cognitions and behaviors particularly in challenging situations. Generally, the opportunity for delinquency is assumed to be present for all to some extend making low self-control

the most prominent factor in the etiology of delinquency and antisocial behavior (Beaver et al., 2015). According to Self-Control Theory, individuals with poorer self-control prefer activities that are risky, unpremeditated, and immediately gratifying (Gottfredson & Hirschi 1990). In that sense, individuals with low self-control are more likely engage in criminal or deviant acts (i.e. substance use), because the criminal or deviant acts provide more immediate gratification preventing to judge the long-term harmful consequences of their actions (Gottfredson & Hirschi 1990; Schaefer et al., 2015a; Vito et al., 2019). Hence, researchers show that poor self-control is significantly associated with cocaine (Malouf et al., 2012) and marijuana misuse (Jones et al., 2011).

On the other hand, impulsivity resulting from low self-control, includes several behaviors that generally lead to undesirable psychosocial outcomes, are not suitable for the environment or are extremely risky, and have not been considered adequately with regard to its consequences (Ögel, 2001). Thus, adolescents with impulse control problems suffer more from deficiencies in self-control systems. That is, youths with impulse control problems are more likely to respond to the temptation to participate in risky activities, particularly when faced with risk-taking opportunities (e.g., substance use) that offer some kind of immediate emotional or behavioral reinforcement (Winters et al., 2009). In fact, this deficiency in regulatory systems might explain why adolescents with impulse control problems tend to abuse substances more (Colder & Stice, 1998; Donoghue, 2001; Winstanley et al., 2010; Winters et al., 2009). This relationship between impulsivity and substance use has also been supported by the longitudinal and cross-sectional studies, which indicate that the rate of developing substance misuse, regular substance use, and substance use disorders was higher in impulsive individuals (De Wit, 2009, Moeller et al., 2001, Madden et al., 1997).

One important dimension of the self-control is closely related with emotion regulation skills. In that respect, expression and regulation of anger has been known to be important in understanding substance use related problems among adolescents (Cole, 2008; Eftekhari et al., 2004; Hofvander et al., 2011).

1.3. Anger and Substance Use

Anger is a universal and non-pathological emotion emerged as a consequence of the unsatisfied wishes, undesirable outcomes, and unfulfilled expectations (Cole, 2008). How this universal emotion is managed, controlled and expressed is related to many psychosocial factors. Individuals who have problems with controlling anger, or who markedly suppress or express their anger outward, have more negative psychosocial and physiological profiles than individuals who can control their anger better or express it at more optimal levels (Speilberger, 1996; Everson et al., 1998; Melnick & Hinshaw, 2000). Despite being a natural and humanly emotion, anger can trigger physical, mental, and social problems when left uncontrolled (Cole, 2008; Eftekhari et al., 2004; Hofvander et al., 2011).

When the etiology of substance use is considered from the perspective of individual differences, risky behaviors such as substance abuse has been found to be closely related with anger regulation problems and high stress responses (Elkins et al., 2004; Ellis et al., 2012; Laitano et al., 2021; Swendsen et al., 2002). One of the theoretical explanations for this anger-substance use relationship is that individuals who are more prone to experience anger and have anger control issues might not evaluate the consequences of their behavior adaptively. As a result, they might resort to using substances to regulate and express their hostile feelings, leading to the development of a self-destructive cycle (Colder & Stice, 1998; Sharma et al., 2011). Therefore, existing studies have shown that higher levels of anger is positively related with substance use problems among adolescents (Cole, 2008; Hofvander et al., 2011; Khakbaz et al., 2014; Nichols et al., 2008) and the severity of the problem varies depending on the anger level and expression styles (Eftekhari et al., 2004). In other words, the positive relationship between anger and substance use is particularly pronounced for individuals with high levels of outward expressed anger (Baharvand & Malekshahi, 2019; Cautin et al., 2001; Eftekhari et al., 2004). According to the results of a large scale study conducted with 270 convicted adolescents, outward manifestations of anger (i.e., acting out) was significantly correlated with the misuse of marijuana while anger-in was more closely related with decreased use of the same substance (Eftekhari et al., 2004). A similar result was also obtained in a similar study conducted in Turkey. Accordingly, the correlation between anger-out and severity of substance use was found to be stronger than the correlation between

anger-in and substance use severity. In addition, this study showed that there is a negative relation between anger control and substance use severity. (Avcı et al., 2017). In fact, both studies have supported the view that people with higher levels of hostility and anger management problems have difficulty in evaluating the consequences of their behavior and as a result, they show more frequent and intense substance use problems (Colder & Stice, 1998; Eftekhari et al., 2004). Therefore, in terms of substance use, it is known that higher levels of anger, anger control problems, and anger expression styles have a strong relationship with substance use problems (Avcı et al., 2006; Baharvand & Malekshahi, 2019; Cole, 2008; Eftekhari et al.,2004; Hofvander et al., 2011; Laitano et al., 2021).

Investigation of substance use problems only focusing on familial and personal risk factors would lead to underestimating importance of environmental factors associated with development and maintenance of substance misuse. It has been well-established in the literature that aggravation of environmental risk factors (e.g., poor neighborhood, low SES, peer relations etc.) gave payment to development of substance abuse when combined with personal level psychological vulnerabilities (Karriker-Jaffe, 2013; Mason et al., 2009). In that respect, a robust environmental risk factor the importance of which gradually increases especially during adolescence is the effects of peers with regard to substance misuse problems among youth (Barnes et al., 2006; Mason et al., 2009).

1.4. Peer Deviance and Substance Use

As a necessary developmental task, peers start to become more central to the social life of the offspring as they have reached through adolescence (Carrington, 2009; Duan et al., 2009). This increasing impact of peer relations is an important factor in the psychosocial development of adolescents (Li et al., 2002; Mason et al., 2009). Accordingly, several studies have underlined that peer deviance is a potent risk factor for alcohol and substance abuse disorders among youth (Barnes et al., 2006; Mohasoa, 2010; Mudavanhu, 2013; Ramirez et al., 2012; Tucker et al., 2011).

Social Learning Theory (Akers, 1998) argues that people learn deviant behaviors through negative role models, deviant definitions, and interactions with primary groups appreciating and reinforcing deviant acts. The theory contains four main components, which are (1) differential association, (2) definitions, (3)

imitation, and (4) differential reinforcement. Firstly, *differential association* refers to the influence of deviant peers on behavior through exposure. Exposure to deviant peers can vary in priority, intensity, frequency and duration. As the offspring is exposed to deviant peers more, the deviant behavior begins to appear normal and accepted through differential association. Secondly, *definitions* refer to the attitudes and beliefs that an individual holds towards the wrongness of a deviant behavior. The more an individual believes that a particular behavior is acceptable, the more likely s/he is to participate in that behavior. In that sense, when an offspring associates with a deviant peer who has positive thoughts about substance use, that offspring is more likely to adopt similar positive thoughts on deviant acts. Thirdly, *imitation* component refers to the extent that individuals model others' behaviors (e.g., family members, close friends etc.) by taking them as role models. With regard to substance use, an offspring's probability to engage in deviant behaviors increases as his/her role models are deviants themselves. Finally, *differential reinforcement* is the costs and benefits of acquiring certain behaviors. A person who receives positive rewards from his/her immediate environment for using substances is more likely to misuse substances through differential reinforcement (Akers, 1998; Schaefer et al., 2015a).

Existing research have shown that each of these four components are predictors of several deviant behaviors, including but not limited to substance use (Miller et al., 2011; Pratt et al. 2010). Akers et al. (1979) surveyed more than 3,000 young people to test the usefulness of the four main concepts of the theory in explaining adolescents' cannabis and alcohol use. The results revealed that those who witnessed substance use more frequently and whose friends misused psychoactive drugs had more positive attitudes towards substance use, and were more likely to abuse substances later on. In total, their model explained 68 percent of the variance in cannabis use (Akers et al., 1979). Subsequent studies have yielded results consistent with those of Akers et al. (1979). Using data from the National Youth Survey, Warr and Stafford (1991) showed that friends' behaviors were significantly more effective in predicting substance use. Later, Warr (1993) found a direct positive relationship between the number of deviant friends and self-reported substance use.

More recently, Social Learning Theory have been used to explain misuse of a variety of different substances such as cannabis (Gray et al., 2015; HeavyRunner-Rioux & Hollist, 2010; Miller et al., 2008), heroin (Schaefer et al., 2015a), cocaine

(Schaefer et al., 2015b), ecstasy (Norman & Ford, 2015; Whaley et al., 2011) and amphetamines (Whaley et al., 2011; Yun & Kim, 2015). In a study conducted with more than 1.4 million Swedish youth, Kendler et al. (2014) identified a strong positive association between exposure to peer deviance and substance use. More specifically, each percentage increase in peer deviance was found to increase substance use 1.32-fold, even after controlling for the genetic susceptibility, familial dynamics and demographic factors. Similarly, in the study of Shakya et al. (2012), it was found that having a friend who uses cannabis increased cannabis misuse by 146%. In support of these findings, Friedman and Glassman (2000) reported that the strongest predictor of substance use in childhood and adolescence was the interaction with a deviant peer group. All of these obtained findings have indicated that peer deviance leads to increased substance use among adolescents, through a socialization process in which the deviant behavior is acquired and reinforced by deviant peers (Barnes et al., 2006; Ellickson et al., 2004; Li et al., 2002; Mason et al., 2009; Oetting & Beauvais, 1987; Windle, 2000; Wood et al., 2004).

1.5. The Scope of the Thesis and Hypotheses

According to reciprocal determinism, human behavior is determined by the functional relationship among personal factors, external environment and the behavior itself. From the perspective of reciprocal determinism, substance use problem is an important public health issue encompassing both internal and external dimensions of the individual (Bandura, 1977; Smith, 2020). It was well-established in the literature that substance abuse usually results from the interaction of several individual, environmental and familial level factors (Beaver et al., 2015; Hay, 2001; Schaefer et al., 2015a; 2015b). Although different level factors have been investigated separately, there is a paucity of research with regard to aggravation of different level risk factors in explaining substance use problem among youth. Such a multifaceted study is particularly not present in Turkey, although substance abuse poses several risks for the psychosocial functioning of the youth in our country (Sönmez et al, 2016). Thereof, the current thesis aimed to investigate contributions of familial (i.e., parental acceptance-rejection), personal (i.e., self-control/impulsivity and anger) and environmental (i.e., peer deviance) risk factors together in understanding adolescents' substance use problem. Accordingly, parental acceptance and rejection, individual's self-control and anger, and peer deviance were examined

from a psychosocial perspective. Therefore, this study is among the few studies examining the roles of different psychosocial variables in the maintenance of substance use problem through a comprehensive and holistic framework.

Based on the relevant literature, the following hypotheses were formed:

1) Individuals with high severity substance use will report significantly higher paternal rejection and its sub-dimensions of hostility, neglect, and undifferentiated rejection, while they will report significantly lower paternal warmth than individuals with low severity substance use.
2) Individuals with high severity substance use will report significantly higher maternal rejection and its sub-dimensions of hostility, neglect, and undifferentiated rejection, while they will report significantly lower maternal warmth than individuals with low severity substance use.
3) Individuals with high severity substance use will report significantly lower self-control level than those with low severity substance use.
4) Individuals with high severity substance use will report significantly higher trait anger level and outward anger expression, while they will report significantly lower anger control level and inward anger expression than individuals with low severity substance use.
5) Individuals with high severity substance use will report significantly higher peer deviance than those with low severity substance use.
6) The clinical sample will report significantly higher paternal rejection and its sub-dimensions of hostility, neglect, and undifferentiated rejection, while they will report significantly lower paternal warmth than the non-clinical sample.
7) The clinical sample will report significantly higher maternal rejection and its sub-dimensions of hostility, neglect, and undifferentiated rejection, while they will report significantly lower maternal warmth than the non-clinical sample.
8) The clinical sample will report significantly lower self-control level than the non-clinical sample.
9) The clinical sample will report significantly higher trait anger level and outward anger expression, while they will report significantly lower anger control level and inward anger expression than the non-clinical sample.

10) The clinical sample will report significantly higher peer deviance than the non-clinical sample.
11) Paternal rejection and its sub-dimensions (i.e., warmth, hostility, neglect, and undifferentiated rejection) will significantly predict substance use in youth.
12) Maternal rejection and its sub-dimensions (i.e., warmth, hostility, neglect, and undifferentiated rejection) will significantly predict substance use in youth.
13) Self-control level will significantly predict substance use among youth.
14) Trait anger level, anger-control level, outward anger expression and inward anger expression will significantly predict substance use among youth.
15) Peer deviance will significantly predict substance use among youth.

CHAPTER 2

METHOD

2.1. General Research Design

Because it is one of the most appropriate methods to analyze the relationship between several variables (perceived father-child relationship, self-regulation, anger, peer deviance and substance use); quantitative method was preferred in order to answer the research question and hypotheses. Considering the time frame and the use of quantitative methods, a cross-sectional design was the most appropriate design to perform this study (Ritchie & Lewis, 2003; Van der Poel, R., 2016). Cross-sectional design involves collecting data simultaneously to include all variables (Ritchie & Lewis, 2003). Data were collected through self-report questionnaires by male late adolescents who use substances.

2.2. Participants

In the present study, data were collected from 160 male using substances aged between 18-25 from different cities in Turkey (Ankara, İstanbul, İzmir, Çorum, Denizli, Antalya). The data were collected from those who are officially diagnosed and hospitalized in the Ministry of Health Treatment Center (AMATEM) and from those who are undiagnosed yet using soft substances on a regular basis. The inclusion and exclusion criteria for sampling are given below.

The inclusion criteria were as follows (1) being male, (2) being aged between 18 and 25 and (3) being regular user of psychoactive substances. Purposive sampling method was used to obtain a homogeneous sample meeting these criteria (Etikan et al., 2016).

The exclusion criterion was only-misusing nicotine and alcohol since it was thought that the psychosocial mechanisms behind substance abuse would be different due to differences such as easier access to nicotine and alcohol, and legality of nicotine and alcohol although drug use is not legal in Turkey. No differentiation were made among different substances (e.g. marijuana, heroin, cocaine, bonsai etc.) as these substances have also been clustered together in the studies examining psychosocial predictors of substance misuse.

The prevalence of drug use among male is much higher compared to female (Brady et al, 1999; NIDA, 2021; TUBİM, 2021). In addition, according to the Turkish Drug Report 2021, 91.3% of those who received inpatient drug use treatment in 2020 were male and 8.7% were female. In addition, 96.8% of drug-related deaths were male and 3.2% were female in 2018; 97.4% of deaths in 2019 were male, 2.6% were female; 93.3% of deaths in 2020 are male and 6.7% are female (TUBİM, 2021). Therefore, in this study, male who are predominant in substance use were chosen as the sample so all participants were male. The mean age of the participants was 22,59 (*SD* = 1,80), ranging from 18 to 25. More than three quarters of the participants had a high school or higher education level (*N* = 121, 75,6%). About half of the participants reported their income level as equal or more than 5001 TL (*N* = 84, 54,2%), 26,5% as 3001-5000 TL (*N*= 41), 16,8% as 2001-3000 TL (*N*= 26), 1,9% as 1001-2000 TL (*N* = 3), and 0,6% as equal or below 1000 TL (*N*= 1). About half of the participants were students (*N* = 71, 49,3%), while almost all of the other half were employed (*N* = 70, 48,6%) and only 2,1% of them were not employed (*N* =3). Most of the participants were banchelor (*N* = 141, 88,1%), 5,0% of the participants were married (*N* = 8), and 6,9% were divorced (*N* = 11). More than half of the participants lived with their families (*N* = 99, 62,3%), 28.3% at home with friends (*N* = 45), 5,7% at home alone (*N* = 9), 2,5% at home with a romantic partner (*N* = 4) and 0,6% with relatives (*N* = 1).

All of the participants were using substances and tobacco (*N* = 160) and 84,4 % of them stated that they used alcohol (*N* = 135). (See Table 2.1 for detailed characteristics of the participants.)

Table 2.1

Demographic Information of Participants

Variable	F	%	M	SD	Range
Gender	160				
Male	160	100			
Age	160		22.59	1.80	7,00
18	2	1,3			
19	9	5,6			
20	12	7,5			

21	20	12,5	
22	25	15,6	
23	37	23,1	
24	28	17,5	
25	27	16,9	
Education level	160		
Literate	0	0,0	
Primary school	2	1,3	
Secondary school	37	23,1	
High school	77	48,1	
Undergraduate	43	26,9	
Graduate	1	0,6	
Income level	155		4,00
Equal or below 1000 TL	1	0,6	
1001-2000 TL	3	1,9	
2001-3000 TL	26	16,8	
3001-5000 TL	41	26,5	
Equal or more than 5001 TL	84	54,2	
Job status	144		
Employed	70	48,6	
Student	71	49,3	
Unemployed	3	2,1	
Marital Status	160		
Bachelor	141	88,1	
Married	8	5,0	
Divorced	11	6,9	
Where you live now?	159		
Dormitory	0	0.0	
Alone at home	9	5,7	
With my friends at home	45	28,3	
With my romantic partner, at home	4	2,5	
With my family	99	62,3	
With relatives	1	0,6	
Others	1	0,6	
Tobacco use	160	100,0	
Alcohol use	135	84,4	
Substance use	160	100,0	

2.3. Measures

In this section, seven instruments used in the current study were introduced. The instruments were Demographic Information Form, Adult Parental Acceptance-Rejection Questionnaire, Brief Self-Control Scale, Trait Anger- Anger Expression Inventory, Peer Deviance Scale, Drug Use Disorders Identification Test, University Form of Risk Behaviors Scale, respectively. Psychometric properties of the aforementioned instruments were presented below.

2.3.1. Demographic Information Form

A demographic information form was prepared by the researchers, composing of 48 questions. The form also included questions regarding the demographic characteristics of the participant (gender, age, education level, occupation, monthly income, marital status, chronic illness), their substance use behaviors (types of substances he used, age at which he started using the substance, how he started using drugs), demographic information of their mother and father (such as age, occupation, chronic disease, substance use status).

2.3.2. Adult Parental Acceptance-Rejection Questionnaire

Parental Acceptance-Rejection Questionnaire (PARQ) was developed by Rohner, Saavedra and Granum in 1978 to measure perceived parental acceptance and rejection levels and remembered childhood experiences with parents (Varan, 2003). The scale has two forms: adult and child. Only the adult form was used in the current study. In the adult form, participants solve the scale by evaluating their early years of life and the relationship between thems and their parents. The scale has mother and father forms, and each consists of 4 subscales and 60 items; 20 items belong to (1) warmth / affection subscale, 15 items to (2) hostility/aggression subscale, 15 items to (3) indifference/neglect subscale and 10 items are categorized as undifferentiated rejection (Rohner, 1984). Items are answered on 4 point Likert type scale from (1) almost never true to (4) almost always true. While all items of the warmth / affection subscale and 7 items of the indifference / neglect subscale are reverse scored, the other subscales are not scored in reverse. The sum of the points obtained in line with the answers given to these four subscales gives the total score of the PARQ and presents the measurement regarding the acceptance-rejection perceived by

individuals about their mother or father in their childhood. When the total score is taken, the highest score is seen as 240, and the lowest score is 60. Higher scores indicate greater rejection from both parents. Coefficient alphas of the scale were found to be ranging from .86 and .95 and the test-retest reliability of the scale was .93.

Turkish adaptation of the scale was carried out by Varan (2003) with a sample of 1700 people, both "normal" and "clinical". The individuals in the sample are between the ages of 17-78. The internal consistency coefficients of the subscales varied between .86 and .96. The total internal consistency coefficient was found to .97. As a result of the factor analysis conducted to examine the construct validity of the scale, it was seen that 16 clusters of 3 or 4 items loaded on 2 factors and these were named as "rejection" and "acceptance" (Bayat, 2015; Varan, 2003). The coefficient alphas of the scale in the current thesis were found to be ranging from .93 and .97.

2.3.3. Brief Self-Control Scale

This scale was developed by Tangney, Baumeister and Boone in 2004. The scale consists of 13 items, based on self-reports of the participants. Individuals rate each item from 1 (*not at all true of me*) to 5 (*totally true of me*) on a 5 point Likert type scale. Nine negative items (2, 3, 4, 5, 7, 9, 10, 12 and 13) had reversed scores. Increasing scores on the scale indicate higher self-control. Sample items are as follows: “I am good at resisting temptation”, “I do certain things that are bad for me, if they are fun”, “I am able to work effectively toward long-term goals”, “Sometimes I can’t stop myself from doing something, even if I know it is wrong”.

Turkish adaptation of the scale was carried out by Nebioğlu, Konuk, Akbaba and Eroğlu (2012) with a sample of 523 individuals without a psychiatric diagnosis. Differential validity studies consisted of 86 individuals, 36 of whom were diagnosed with bipolar I disorder according to DSM-IV-TR, and 50 of whom had no psychiatric diagnosis. Test-retest studies were conducted with 145 individuals selected among 523 individuals. The adaptation study yielded two-factors called impulsiveness and self-discipline. The Cronbach’s alpha coefficients for the total scale and the subscales of self-discipline and impulsivity were found to be .83, .81, and .87, respectively. The internal consistency coefficient of the scale, the whole of which

was considered in this study, was found to be .75. (Nebioğlu, et al., 2012). The Cronbach's alpha coefficients for the total scale and the subscales of self-discipline and impulsivity in the current thesis were found to be .85, .69, and .77, respectively.

2.3.4. Trait Anger – Anger Expression Inventory

Trait Anger–Anger Expression Inventory (TAXI) was developed to measure the experience and the expressions of anger by Spielberger, Jacobs, Russel and Crane in 1983 and was adapted to Turkish by Özer in 1994 (Safrancı, 2015). The scale has 10 items assessing trait anger and 24 items assessing three styles of anger expression, namely "anger in" (internalizing anger), "anger out" (externalizing anger) and "anger control". Items are rated on a 4-point Likert scale ranging from 1 "almost never" to 4 "almost always". There is no reverse item in the scale and the total score of the scale is calculated by adding each item score. Sample items are as follows: "It makes me furious when I am criticized in front of others", "When I get mad, I say nasty things", "I am quick tempered", "I control my angry feelings", "I can stop myself from losing my temper". The internal consistency with alpha coefficient of the scale ranges from .73 to .84.

Turkish version of the scale was adapted by Özer in 1994. For the Turkish form of the scale, the Cronbach's alpha coefficients for trait anger, anger in, anger out, and anger control were found to be .79, .62, .78 and .84, respectively (Özer, 1994). Additionally, the Cronbach's alpha coefficients for trait anger, anger in, anger out, and anger control in the current thesis were found to be .88, .71, .81 and .96, respectively.

2.3.5. Peer Deviance Scale

The scale was developed by Kaner in 1998 with a sample of 1648 students to investigate adolescent's peer relations according to Social Control Theory and Social Learning Theory. Question items include behaviors of young people that are considered as a crime or that will incite them to crime, and participants answer the items by thinking of their close friends. The scale consists of 14 items, rated on a 6-point Likert type scale ranging from 1 "hiçbiri" to 6 "hepsi". Higher scores indicate that the participant has more deviant friends. Sample items are as follows: "hırsızlık yapmak", "yalan söylemek", "uyuşturucu kullanmak", "polisle başı derde girmek".

The Cronbach's alpha coefficients for the total was .90 (Kaner, 1998). The Cronbach's alpha coefficients for the total scale was .94 in the current thesis.

2.3.6. Drug Use Disorders Identification Test (DUDIT)

The Drug Use Disorders Identification Test was developed by Berman, Bergman, Palmstierna and Schlyter in 2003. The scale has 11 items assessing an individual's illicit drug use and related consequences over the past year. The first nine questions are scored on 5-point Likert scales ranging from 0 to 4, and the last two are scored on 3-point Likert scales with values 0, 2 and 4. Thus, total scores range from 0 to 44 (11 x 4), higher scores suggesting a more serious drug problem. Sample items are as follows: "How often do you use drugs other than alcohol?", "How many times do you take drugs on a typical day when you use drugs?", "Has it happened, over the past year, that you have not been able to stop taking drugs once you started?", "How often over the past year have you had guilt feelings or a bad conscience because you used drugs?".

Turkish adaptation of the scale was carried out by Evren, Ovalı, Karabulut and Çetingök (2014) with a sample of 100 adolescents with substance use disorder in a substance abuse treatment program for adolescents, 123 adult heroin-addicted patients in an inpatient substance abuse treatment program, and 35 patients with alcohol addiction who did not report substance abuse problems from the same clinic. The internal consistency value was found to be .93. In addition, when the cut-off score was taken as 10 and above, the sensitivity and specificity scores were found to be .96 and .94, respectively. The scale is also said to have a good differential validity to differentiate patients with substance use problem from patients with alcohol problems (Evren, Ovalı, Karabulut & Çetingök, 2014). The Cronbach's alpha coefficients for the total scale was .92 in the current thesis.

2.3.7. University Form of Risk Behaviors Scale

The University Form of Risky Behaviors Scale (RDÖUF) was developed by Gençtanırım based on the Risky Behaviors Scale developed by Gençtanırım-Kuru (2010) for high school students in 2014. The scale consists of 60 items and 7 dimensions such as; antisocial behaviors, smoking, alcohol use, substance use, suicide tendency, eating habits and school dropout. Sample items are as follows: "Eğlence olsun diye arkadaşlarımın canını acıtmaktan hoşlanırım", "Bir kutlamada

alkol almadan eğlenmeyeceğimi düşünürüm", "Sigara içmek istediğimde kendime engel olamam", "Sorunlarım karşısında kendimi çaresiz hissederim", "Yediklerimin bende oluşturabileceği sağlık sorunlarını önemsemem", "İyi bir iş bulduğumda okulu bırakmaktan çekinmem", "Yaşadığım olumsuzlukları unutmak için madde kullandığım olur". It is scored on a 5-point Likert scale ranging from 1 "hiçbir zaman" to 5 "her zaman". There is no reversed item in the scale. Since the dimensions of the scale are not related to each other, the scale does not give total points, and the scores obtained from each dimension are evaluated separately. Higher scores in each dimension indicate that the risk level in that dimension is higher.

As a result of the exploratory factor analysis, it was determined that the total variance explained was 52%. As a result of the confirmatory factor analysis, it was determined that the factor loads of the items in the scale varied between .37 and .91 and the model belonging to the scale had a good fit. The internal consistency reliability (Cronbach's alpha) of the scale was between .64 and .92, and the test-retest reliability was between .74 and .98. The Cronbach's alpha coefficients of the scale in the current thesis were found to be ranging from .61 and .94.

2.4. Procedure

Ethical approval was obtained from the TEDU Human Research Ethics Committee before any procedure was applied. Later, research permission was obtained from the Ministry of Health to collect data at the Ministry of Health Treatment Center (AMATEM). After obtaining permission, the responsible doctor of the treatment center was contacted and data collection began. Visits were made once or twice a week to collect data. Each week, the list of patients who were newly admitted to the inpatient treatment section of the treatment center and met the criteria for the study was obtained from the responsible doctor. Then the rooms of these individuals were visited, verbal information about the study and written consent forms were given and asked whether they would participate. A questionnaire was given to those who volunteered to participate in the study.

Except for the participants treated at AMATEM, the participants were reached in two different ways. First, the questionnaire battery was distributed in hard copy format. These participants were reached with the snowball sampling technique. Informed consent was given to those who met the inclusion criteria, and a hard copy of the questionnaire set was given to those who volunteered to participate in the

study. Afterwards, the social networks of these participants who were using substances was targeted. Accordingnly, individuals using substances referred the researchers to the others with substance abuse problem, and volunteers were included in the study.

On the other hand, instruments were uploaded to an online data management program (i.e., QUALTRICS) to facilitate the participation process when collecting data, and a call for participation was shared via various social media platforms. The participation link was shared for those who wanted to participate voluntarily, and those who met the inclusion criteria were included in the study. Therefore, the instruments were distributed to the participants either online or through hard copy format. Firstly, all participants were required to read and sign an informed consent that briefly explained the research process and the participants' ethical rights (eg anonymity, confidentiality, right to withdraw from the study). Afterwards, participants were expected to fill in the seven aforementioned instruments as self-reports. The completion of survey was approximately 35-45 minutes. Participants who completed the questionnaire were given a debriefing form and an information form with the contact addresses of the treatment centers was given to the participants who wanted to.

2.5. Data Analysis

All analyzes (ie, preliminary and main analyzes) were conducted using the Statistical Package for Social Sciences (SPSS), version 22.0 (2013). Descriptive statistics formed the first step of data analysis. Then, two different one-way multivariate analyzes of variance (MANOVA) were performed to determine the differences between high and low substance use severity and the differences between clinical sample and non-clinical sample in terms of dependent variables. Then, multiple regression analysis was performed to observe the relationships between study variables.

Before starting the statistical analysis, missing data analyzes were made. Questionnaires were administered to 189 participants. 29 participants left the surveys unfinished. 160 participants were included in the analyses.

After that, the data was checked for possible mistakes in the data entry and the data scanning process was completed to ensure its accuracy. In addition, the frequencies, minimum and maximum values and ranges of the variables were checked to determine whether there were any mistakes. Then, all items of the warmth

/ affection subscale the Parental Acceptance-Rejection Questionnaire (PARQ) (items 1, 5, 8, 12, 15, 19, 22, 26, 29, 33, 36, 40, 43, 47, 50, 54, 55, 57, 58, 60) and seven items of the indifference / neglect subscale of the PARQ (items 7, 14, 21, 28, 35, 42, 49) and nine items of the Brief Self-Control Scale (items 2, 3, 4, 5, 7, 9, 10, 12, 13) are reverse coded.

CHAPTER 3

RESULTS

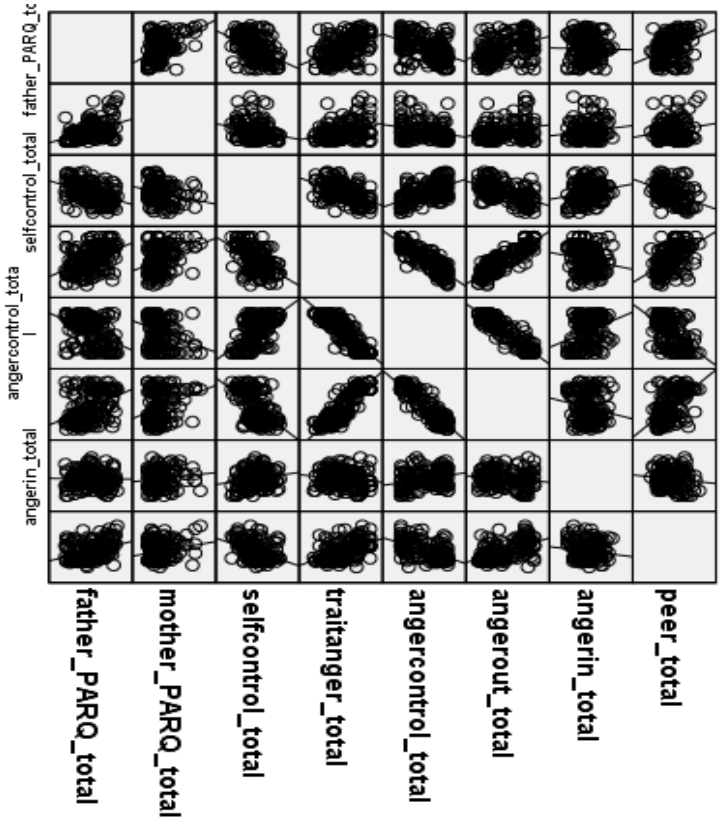
In this part of the study, the analysis results for the statistical operations made in line with the research hypotheses and questions are given in five main sections. First, preliminary analyzes are given. Then, the descriptive statistics of the variables and bivariate correlations between variables are presented. In the third part, the results of one-way MANOVA and discriminant analysis are given to compare the variables in terms of substance use severity. In the forth chapter, the results of one-way MANOVA and discriminant analysis are given for the comparison of variables in terms of clinical/non-clinical sunbstance use status. In the last section, simultaneous multiple regression analysis used for substance use is presented.

3.1. Preliminary Analyses of the Study

Normality estimation was tested. As seen in Table 3.1, there are extreme z scores of skewness and kurtosis values that should be between -2 and +2 (George & Mallery, 2010) so the normality assumption was violated. On the other hand, to test linearity assumption for MANOVA analysis and multiple regression analysis, the linearity between father rejection, mother rejection, self-control, trait anger, anger control, anger-out expression, anger-in expression and peer deviance variables was examined and Scatterplot matrix which showed any important non-linearity of the variables were checked. Therefore, linearity between variables is generally provided.

Figure 3.1

Scatterplot Matrix of the Variables



Some researchers suggest data transformation when the normal distribution cannot be observed, but it is often not recommended due to the difficulty of interpretation and discussion of the transformed results (Ribeiro-Oliveira et al., 2018; Tabachnick & Fidell, 2007). Bootstrap confidence intervals and significance values were used when assumptions were not provided, as they are not based on assumptions of normality or homoscedasticity and therefore give an accurate estimate of the true population value of b for each estimator. For this reason bias-corrected bootstrap confidence interval calculated based on 2.000 bootstrap was performed in MANOVAs and in multiple regression analysis, since assumptions could not be provided in this study.

3.2. Descriptive Statistics and Bivariate Correlations

Before the main analysis, the means, standard deviations, and minimum maximum values of the variables were calculated. The results are shown in Table 3.1 above.

Table 3.1.

Descriptive Statistics of Predictor and Criterion Variables

Variables	N	Mean	SD	Min	Max	Z scores of Skewness	Z scores of Kurtosis
Father PARQ	160	146.47	47.92	63.00	240.00	.68	-2.57
Father Warmth	160	52.77	17.35	20.00	80.00	-.52	-2.92
Father Hostility	160	31.98	12.99	15.00	60.00	2.21	-2.86
Father Neglect	160	37.30	12.14	15.00	60.00	.10	-2.84
Father Undif. Rejection	160	24.37	9.37	10.00	40.00	1.47	-3.02
Mother PARQ	160	102.00	35.47	60.00	240.00	8.68	8.00
Mother Warmth	160	35.73	14.21	20.00	80.00	6.52	2.42
Mother Hostility	160	23.26	8.70	15.00	60.00	9.21	8.71
Mother Neglect	160	25.41	10.57	15.00	60.00	7.68	4.78
Mother Undif. Rejection	160	17.72	6.47	10.00	40.00	7.21	5.63
Self-control	160	33.13	9.42	13.00	54.00	.31	-1.31
Trait Anger	160	26.05	7.49	11.00	40.00	.84	-2.39
Anger Control	160	21.14	8.35	8.00	32.00	-1.94	-3.60
Anger-out	160	18.20	6.00	10.00	29.00	1.63	-3.68
Anger-in	160	18.20	5.00	8.00	31.00	.63	-1.18
Peer Deviance	160	43.23	14.45	18.00	84.00	3.47	-1.23
Drug Use (DUDIT)	160	22.72	12.75	4.00	44.00	1.05	-3.21

Note. PARQ: Parental Acceptance Rejection Questionnaire; Undif. rejection: Undifferentiated rejection; Anger-out: Anger out expression style; Anger-in: Anger in expression style; DUDIT: Drug Use Disorders Identification Test

Pearson Product Moment Correlations Coefficients between all variables are presented in Table 3.2. As shown in Table 3.2., the Father and Mother Parental Acceptance Rejection Questionnaire, warmth / affection subscale, hostility/aggression subscale, indifference/neglect subscale and undifferentiated

rejection subscale of the scale, self-control, trait anger, anger control, anger-out, anger-in and peer deviance were generally significantly correlated with each other.

Table 3.2

Bivariate Correlations Between Criterion and Predictor Variables (n = 160)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1.Father PARQ total	-	.95**	.88**	.91**	.92**	.45**	.40**	.44**	.33**	.46**	-.42**	.45**	-.45**	.40**	-.01	.36**
2.Father warmth		-	.74**	.93**	.79**	.41**	.43**	.30**	.35**	.34**	-.44**	.39**	-.37**	.32**	.02	.28**
3.Father hostility			-	.65**	.93**	.39**	.26**	.55**	.18*	.52**	-.35**	.47**	-.52**	.48**	-.08	.42**
4.Father neglect				-	.74**	.47**	.47**	.32**	.45**	.38**	-.37**	.35**	-.30**	.26**	.06	.27**
5.Father undif.					-	.38**	.27**	.49**	.20**	.51**	-.36**	.47**	-.49**	.44**	-.10	.38**
6.Mother PARQ total						-	.93**	.79**	.91**	.85**	-.23**	.32**	-.28**	.27**	.13	.20*
7.Mother warmth							-	.58**	.92**	.66**	-.23**	.26**	-.19*	.17*	.14	.10
8.Mother hostility								-	.53**	.87**	-.23**	.35**	-.39**	.40**	.02	.36**
9.Mother neglect									-	.64**	-.13	.21**	-.13	.13	.20*	.08
10.Mother undif.										-	-.23**	.38**	-.36**	.36**	.06	.25**
11.Self-control											-	-.51**	.58**	-.55**	.19*	-.40**
12.Trait anger												-	-.87**	.89**	-.16*	.51**
13.Anger control													-	-.91**	.29**	-.56**
14.Anger-out														-	-.16*	.57**
15.Anger-in															-	-.13
16.Peer deviance																-

Note. PARQ: Parental Acceptance Rejection Questionnaire; Undif: Undifferentiated rejection; Anger-out: Anger out expression style; Anger-in: Anger in expression style.

3.3. Results Regarding Substance Use Severity

Participants completed the Drug Use Disorders Identification Test by self-report. Then, according to the answers given by the participants, the mean of the scores was calculated as 22.72 and the standard deviation as 12.75, and 22.75±12.75 was calculated; those with a score of 35 and above were determined as the "high severity substance use group", and those with a score of 9 and below were determined as the "low severity substance use group". The quasi-experimental designs were used and a one-way Multivariate Analysis of Variance (MANOVA) and discriminant analyses were run in order to find out whether father's total rejection score, warmth, hostility, neglect and undifferentiated rejection, mother's total rejection score, warmth, hostility, neglect and undifferentiated rejection, youths' self-control, trait anger, anger control, anger-out and anger-in expression and peer deviance were different in terms of their substance use severity. MANOVA is an analysis to test the difference of two or more groups in terms of dependent variables (Field, 2013).

When starting MANOVA, assumptions of sample size, normality, univariate and multivariate outliers, linearity, multicollinearity, singularity, homogeneity of variance, and covariance matrices were tested (Pallant, 2016). The sample size for the analyzes was 68, meeting the criterion that the number of participants should be greater than the number of dependent variables of the analysis. As for normality and outliers, histograms and Mahalanobis Distances were checked and there were no significant violations of these assumptions (Barnett & Lewis's, 1978).

As shown in Table 3.2., bivariate correlation of the variables were generally meet assumptions of no multicollinearity and singularity. However, there were some correlations between the variables were not meet the assumptions. Additionally, there was homogeneity of variance-covariances matrices, as assessed by Box's M Test of Equality of Covariance Matrices (p = .002).

Finally, via Levene's Test of Equality of Error Variances, assumption of variance equality was checked. Levene's Test significance value needs to be greater than .05 to meet assumption (Cohen et al., 2003). As seen in Table 3.3., the variables of father PARQ total, father warmth, father neglect, mother PARQ total, mother hostility, mother undif rejection, trait anger, peer deviance did not meet the assumption. The analysis continued despite the fact that normality assumptions could

not be met, since the creation of purposive sampling by limiting the participants within the framework of a psychopathology and filling the questionnaire with the self-report method increased the possibility of a biased and social desirability response. Therefore in case of violation of the assumptions, 95% bias-corrected confidence interval (BCCI) calculated based on 2.000 bootstrap was performed in MANOVA.

Table 3.3

Levene's Test of Equality of Error Variances for Substance Use Severity

	F	df1	df2	Sig.
Father PARQ total	10.81	1	66	.00*
Father warmth	6.59	1	66	.01*
Father hostility	3.70	1	66	.05
Father neglect	11.25	1	66	.00*
Father undif rejection	2.52	1	66	.11
Mother PARQ total	4.23	1	66	.04*
Mother warmth	1.26	1	66	.26
Mother hostility	4.51	1	66	.03*
Mother neglect	3.00	1	66	.08
Mother undif rejection	6.34	1	66	.01*
Self-control	.08	1	66	.76
Trait anger	5.92	1	66	.01*
Anger control	1.04	1	66	.31
Anger-out	1.82	1	66	.18
Anger-in	.00	1	66	.96
Peer deviance	6.61	1	66	.01*

Note. *$p < .05$

PARQ: Parental Acceptance Rejection Questionnaire; Undif. rejection: Undifferentiated rejection; Anger-out: Anger out expression style; Anger-in: Anger in expression style.

The MANOVA results revealed a significant difference between high substance use severity and low substance use severity, F (15, 52) = 4,915, $p < .001$; Wilks' $\Lambda = .414$; partial $\eta 2 = .586$.

As seen in Table 3.4., considering substance use severity, MANOVA results showed that, youths with high substance use severity and youths with low substance use severity significantly differed in terms of mother hostility/aggression [F (1, 66) = 5.419, $p < .05$; partial η2 = .076], mother undifferentiated rejection [F (1, 66) = 5.322, $p < .05$; partial η2 = .075], self-control [F (1, 66) = 20.794, $p < .001$; partial η2 = .240], trait anger [F (1, 66) = 20.784, $p < .001$; partial η2 = .239], anger control [F (1, 66) = 18,930, $p < .001$; partial η2 = .223], anger-out expression [F (1, 66) = 25.486, $p < .001$; partial η2 = .279] and peer deviance [F (1, 66) = 52.940, $p < .001$; partial η2 = .445]. On the other side, no significant differences was found between high or low level of substance use severity in terms of father rejection [F (1, 66) = 1.394, $p > .05$; partial η2 = .021], father warmth/affection [F (1, 66) = .255, $p > .05$; partial η2 = .004], father hostility/aggression [F (1, 66) = 2.780, $p > .05$; partial η2 = .040], father indifference/neglect [F (1, 66) = .510, $p > .05$; partial η2 = .008], father undifferentiated rejection [F (1, 66) = 3.529, $p > .05$; partial η2 = .051], mother rejection [F (1, 66) = 1.929, $p > .05$; partial η2 = .028], mother warmth/affection [F (1, 66) = .455, $p > .05$; partial η2 = .007], mother indifference/neglect [F (1, 66) = 247, $p > .05$; partial η2 = .004], and anger-in expression [F (1, 66) = .978, $p > .05$; partial η2 = .015].

Table 3.4.

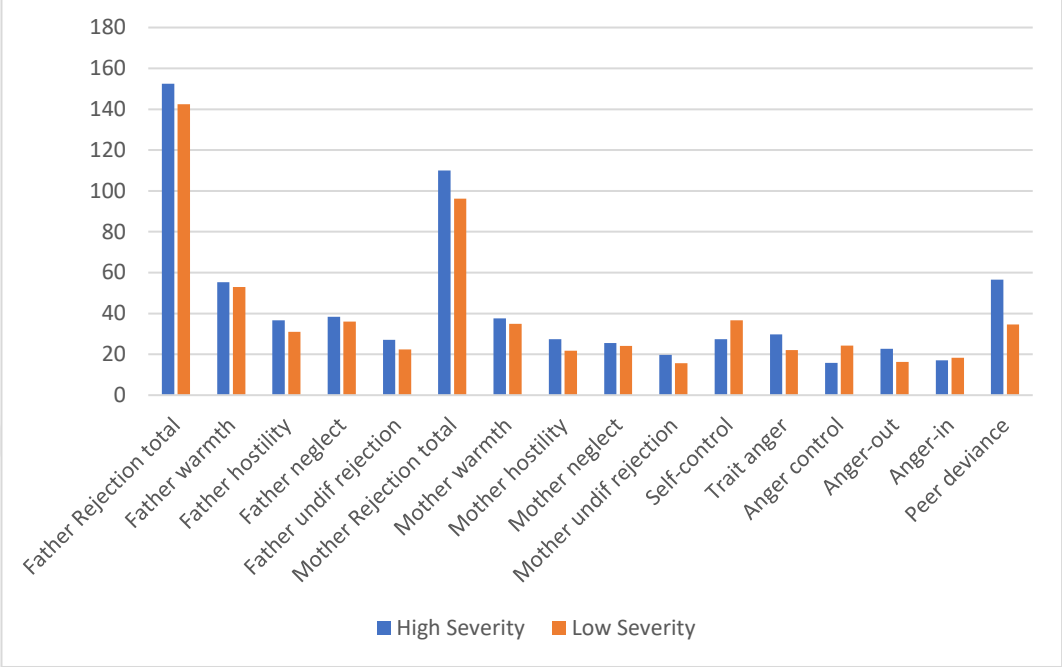
Univariate Test Results for Substance Use Severity with Means and Standard Deviations

					ANOVA		
Variables	Substance Use Severity	*N*	*M*	*SD*	Type III SS	F	*p*
Father PARQ total	High	37	157.48	60.64	3829.26	1.39	.24
	Low	31	142.41	40.38			
Father warmth	High	37	55.35	21.23	90.71	.25	.61
	Low	31	53.03	15.56			
Father hostility	High	37	36.64	15.00	538.20	2.78	.10
	Low	31	31.00	12.48			
Father neglect	High	37	38.43	15.56	94.57	.51	.47
	Low	31	36.06	10.83			
Father undif rejection	High	37	27.05	11.23	377.61	3.52	.06
	Low	31	22.32	9.16			
Mother PARQ total	High	37	110.02	48.56	3212.84	1.92	.16
	Low	31	96.22	28.86			
Mother warmth	High	37	37.54	17.90	120.20	.45	.50
	Low	31	34.87	14.02			
Mother hostility	High	37	27.43	11.64	552.41	5.41	.02*
	Low	31	21.70	7.84			
Mother neglect	High	37	25.51	13.69	35.41	.24	.62
	Low	31	24.06	9.52			
Mother undif rejection	High	37	19.70	8.55	282.13	5.32	.02*
	Low	31	15.61	5.37			
Self-control	High	37	27.35	8.93	1477.23	20.79	.00*
	Low	31	36.70	7.77			
Trait anger	High	37	29.83	7.85	1010.77	20.78	.00*
	Low	31	22.09	5.74			
Anger control	High	37	15.83	8.46	1214.31	18.93	.00*
	Low	31	24.32	7.42			
Anger-out	High	37	22.70	5.55	693.57	25.48	.00*
	Low	31	16.29	4.77			
Anger-in	High	37	17.02	5.27	28.31	.97	.32
	Low	31	18.32	5.50			
Peer deviance	High	37	56.62	14.58	8170.41	52.94	.00*
	Low	31	34.61	9.18			

Note. *p<.05. Type III SS: tests the presence of one main effect after the other main effect and interaction in significant interactions.
PARQ: Parental Acceptance Rejection Questionnaire; Undif. rejection: Undifferentiated rejection; Anger-out: Anger out expression style; Anger-in: Anger in expression style.

Figure 3.2.

Means of Substance Use Severity Groups



Note. PARQ: Parental Acceptance Rejection Questionnaire; Undif. rejection: Undifferentiated rejection; Anger-out: Anger out expression style; Anger-in: Anger in expression style.

The MANOVA was followed up with discriminant analysis, which revealed one discriminant functions which explain 100% of the variance, canonical R^2 = .57. The discriminant function significantly differentiates the substance use severity groups, L = 0.43, $\chi 2(1)$ = 50.13, p = .000. The correlations between outcomes and the discriminant function revealed that peer deviance (r = .77), anger-out expression (r = .53), self-control (r = -.48), trait anger (r = .48), anger control (r = -.46) loaded highly onto the function. Additionally, mother hostility (r = .25), mother undifferentiated rejection (r = .22) loaded moderately onto the function. The discriminant function plot showed that the function discriminated the high substance use severity group from the low substance use severity group.

3.4. Results Regarding Being Clinical Sample

The sample of the study consisted of both patients who were diagnosed with substance use disorder and received inpatient treatment in the Ministry of Health Treatment Centers (AMATEM) with the permission of the Ministry of Health, and people who could live outside, were not diagnosed and used low-dose drugs (mostly

cannabis only). Therefore, the data consists of both clinical sample and non-clinical sample. The quasi-experimental designs were used and a one-way Multivariate Analysis of Variance (MANOVA) and discriminant analyses were run in order to find out whether father total rejection score, warmth, hostility, neglect and undifferentiated rejection, mother's total rejection score, warmth, hostility, neglect and undifferentiated rejection, youths' self-control, trait anger, anger control, anger-out and anger-in expression and peer deviance were different in terms of being clinical sample or non-clinical sample.

When starting MANOVA, assumptions of sample size, normality, univariate and multivariate outliers, linearity, multicollinearity, singularity, homogeneity of variance, and covariance matrices were tested (Pallant, 2016). For linearity assumption, Scatterplot matrix which showed any important non-linearity of the variables were checked (see Figure 3.1). As shown in Table 3.2., bivariate correlation of the variables were generally meet assumptions of no multicollinearity and singularity. However, there were some correlations between the variables were not meet the assumptions.

Different from the previous MANOVA, the sample size for the analyzes was 160, meeting the criterion that the number of participants should be greater than the number of dependent variables of the analysis. As for normality and outliers, histograms and Mahalanobis Distances were checked and there were some violations of these assumptions.

Additionally, there was no homogeneity of variance-covariances matrices, as assessed by Box's M Test of Equality of Covariance Matrices (p = .000). Finally, according to Levene's Test of Equality of Error Variances, assumption of variance equality was checked. As seen in Table 3.5., the variables of father rejection, father warmth/affection, father hostility/aggression, father indifferance/neglect, father undifferentiated rejection, mother rejection, mother warmth/affection, mother hostility/aggression, mother indifferance/neglect, mother undifferentiated rejection, trait anger, anger control, anger-out expression, peer deviance did not meet the assumption. In case of violation of the assumptions, 95% bias-corrected confidence interval (BCCI) calculated based on 2.000 bootstrap was performed in MANOVA.

Table 3.5.

Levene's Test of Equality of Error Variances for Being Clinical Sample

	F	df1	df2	Sig.
Father PARQ total	13.05	1	158	.00*
Father warmth	7.73	1	158	.00*
Father hostility	8.92	1	158	,00*
Father neglect	15.90	1	158	,00*
Father undif rejection	8.67	1	158	,00*
Mother PARQ total	21.29	1	158	,00*
Mother warmth	12.10	1	158	,00*
Mother hostility	14.66	1	158	,00*
Mother neglect	15.90	1	158	,00*
Mother undif rejection	26.22	1	158	,00*
Self-control	2.08	1	158	.15
Trait anger	4.84	1	158	.02*
Anger control	6.23	1	158	.01*
Anger-out	5.11	1	158	.02*
Anger-in	2.67	1	158	.10
Peer deviance	11.39	1	158	,00*

Note. *$p < .05$

PARQ: Parental Acceptance Rejection Questionnaire; Undif. rejection: Undifferentiated rejection; Anger-out: Anger out expression style; Anger-in: Anger in expression style.

The MANOVA results revealed a significant difference between clinical sample and non-clinical sample, F (16, 143) = 5,225, $p < .001$; Wilks' $\Lambda = .631$; partial $\eta 2 = .369$. At this point, it is known that Pillai's Trace criterion is more robust when group sizes are not equal (Tabachnick & Fidell, 2007). The results were also found to be significant with this criterion, F (16, 143) = 5,225, $p < .001$, Pillai's Trace = .369, partial $\eta 2 = .369$.

As seen in Table 3.6, considering difference between clinical and non-clinical sample, MANOVA results showed that, clinical sample and non-clinical sample significantly differed in terms of father hostility/aggression [F (1,158) = 7.357, $p <$

.001; partial η2 = .044], father undifferentiated rejection [*F* (1, 158) = 4.207, *p* < .05; partial η2 = .026], mother hostility/aggression [*F* (1, 158) = 12.209, *p* < .001; partial η2 = .072], mother undifferentiated rejection [*F* (1, 158) = 4.669, *p* < .05; partial η2 = .029], trait anger [*F* (1, 158) = 17.654, *p* < .001; partial η2 = .101], anger control [*F* (1, 158) = 21.231, *p* < .001; partial η2 = .118], anger-out expression [*F* (1, 158) = 32.642, *p* < .001; partial η2 = .171] and peer deviance [*F* (1,158) = 51812, *p* < .001; partial η2 = .247]. On the other side, no significant differences was found between clinical sample and non-clinical sample in terms of father rejection [*F* (1, 158) = 1.122, *p* > .05; partial η2 = .007], father warmth/affection [*F* (1, 158) = .002, *p* > .05; partial η2 = .000], father indifference/neglect [*F* (1, 158) = .074, *p* > .05; partial η2 = .000], mother rejection [*F* (1, 158) = 1.313, *p* > .05; partial η2 = .008], mother warmth/affection [*F* (1, 158) = .006, *p* > .05; partial η2 = .000], mother indifference/neglect [*F* (1, 158) = .142, *p* > .05; partial η2 = .001], self control [*F* (1, 158) = 2.466, *p* > .05; partial η2 = .015] and anger-in expression [*F* (1, 158) = .059, *p* > .05; partial η2 = .000].

Table 3.6.

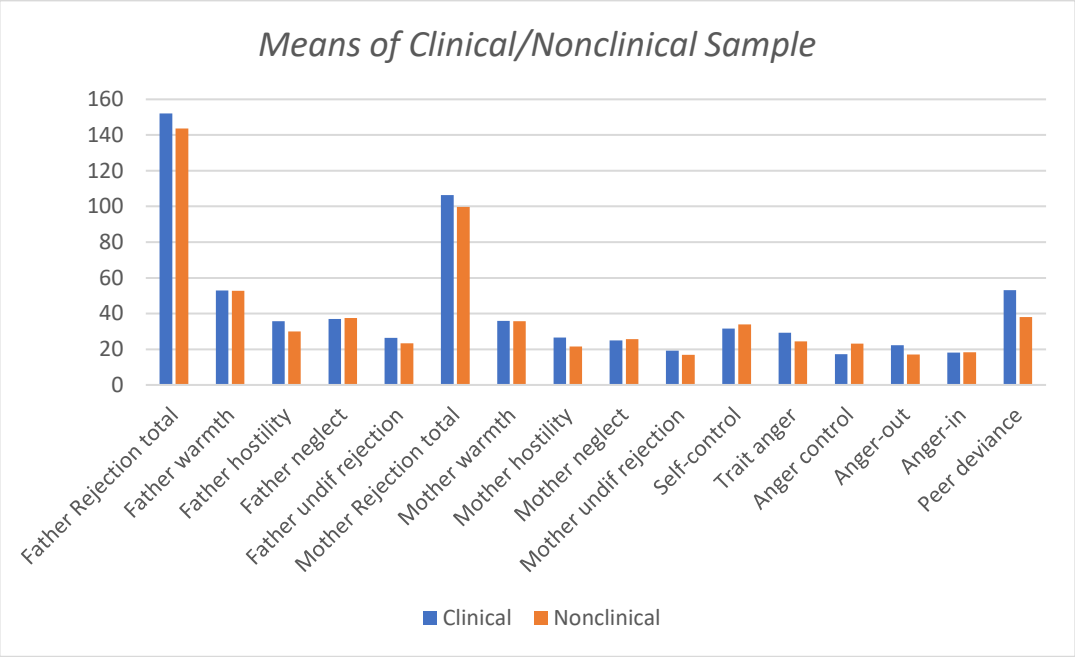
Univariate Test Results for Being Clinical Sample with Means and Standard Deviations

					ANOVA		
Variables	Being Clinical Sample	*N*	*M*	*SD*	Type III SS	F	*p*
Father PARQ total	Clinical	55	152.01	57.21	2575.20	1.12	.29
	Nonclinical	105	143.57	42.26			
Father warmth	Clinical	55	52.85	19.76	.53	.00	.96
	Nonclinical	105	52.73	16.05			
Father hostility	Clinical	55	35.76	14.53	1195.05	7.35	.00*
	Nonclinical	105	30.00	11.70			
Father neglect	Clinical	55	36.94	14.68	10.91	.07	.78
	Nonclinical	105	37.49	10.65			
Father undif rejection	Clinical	55	26.45	10.69	362,43	4.20	.04*
	Nonclinical	105	23.28	8.45			
Mother PARQ total	Clinical	55	106.43	48.84	1649.48	1.31	.25
	Nonclinical	105	99.67	25.87			
Mother warmth	Clinical	55	35.85	17.97	1.14	.00	.94
	Nonclinical	105	35.67	11.87			
Mother hostility	Clinical	55	26.47	11.12	863.70	12.20	.00*
	Nonclinical	105	21.58	6.57			
Mother neglect	Clinical	55	24.98	14.01	16.00	.14	.70
	Nonclinical	105	25.64	8.29			
Mother undif rejection	Clinical	55	19.23	8.66	191.43	4.66	.03*
	Nonclinical	105	16.93	4.83			
Self-control	Clinical	55	31.52	10.56	217.30	2.46	.11
	Nonclinical	105	33.98	8.71			
Trait anger	Clinical	55	29.32	7.85	896.72	17.65	.00*
	Nonclinical	105	24.34	6.71			
Anger control	Clinical	55	17.18	8.79	1315.55	21.23	.00*
	Nonclinical	105	23.21	7.34			
Anger-out	Clinical	55	22.20	6.01	983.13	32.64	.00*
	Nonclinical	105	16.98	5.19			
Anger-in	Clinical	55	18.07	5.64	1.49	.05	.80
	Nonclinical	105	18.27	4.65			
Peer deviance	Clinical	55	53.12	15.82	8207.57	51.81	.00*
	Nonclinical	105	38.04	10.51			

Note. *p<.05. Type III SS: tests the presence of one main effect after the other main effect and interaction in significant interactions.
PARQ: Parental Acceptance Rejection Questionnaire; Undif. rejection: Undifferentiated rejection; Anger-out: Anger-out expression style; Anger-in: Anger-in expression style.

Figure 3.3.

Means of Clinical/Non-clinical Sample Groups



Note. PARQ: Parental Acceptance Rejection Questionnaire; Undif. rejection: Undifferentiated rejection; Anger-out: Anger-out expression style; Anger-in: Anger-in expression style.

The MANOVA was followed up with discriminant analysis, which revealed one discriminant functions which explain 100% of the variance, canonical R^2 =.35. The discriminant function significantly differentiates the clinical/non-clinical sample groups, L = 0.64, $\chi 2(1) = 66.14$, p = .000. The correlations between outcomes and the discriminant function revealed that peer deviance (r = .77), anger-out expression (r = .61), anger control (r = -.49), trait anger (r = .45), mother hostility (r = .37), father hostility (r = .29) loaded highly onto the function. Additionally, mother undifferentiated rejection (r = .23), father undifferentiated rejection (r = .21) loaded moderately onto the function. The discriminant function plot showed that the function discriminated clinical sample group from the non-clinical sample group.

3.5. Results Regarding Multiple Regression Analysis

Multiple regression analysis was performed to examine whether variables (father rejection, father warmth/affection, father hostility/aggression, father indifference/neglect, father undifferentiated rejection, mother rejection, mother warmth/affection, mother hostility/aggression, mother indifference/neglect, mother undifferentiated rejection, self control, trait anger, anger control, anger-out and

anger-in expression nd peer deviance) successfully predicted individuals' substance use status. Before the main analysis, assumptions such as outliers, multicollinearity and singularity, linearity, normality, covariance and independence of residuals were checked and bias-corrected bootstrap confidence interval calculated based on 2.000 bootstrap for unconfirmed assumptions. Multiple regression analysis is a model in which more than two independent variables are considered simultaneously and their role on the dependent variable is examined (Field, 2013).

Table 3.7.

Results of Multiple Regression Analysis Concerning Substance Use

					Boostrap BCa 95% Confidence Interval			
	B	SE	Beta	t	p (two-tailed)	Lower	Upper	R^2	Adjusted R^2
Model 1								.437	.379
(Constant)	-5.71	13.37		-.41	.68	-31.293	17.958		
Father warmth	-.20	.17	-.27	-1.17	.24	-.818	.042		
Father hostility	-.39	.20	-.40	-1.96	.05	-.538	.128		
Father neglect	-.08	.23	-.08	-.40	.72	-.588	.399		
Father undif rejection	.76	.29	.56	2.49	.01*	.114	1.424		
Mother rejection	-.57	1.38	-1.58	-.90	.35	-4.581	.037		
Mother_warmth	.78	1.37	.87	1.26	.22	.255	5.023		
Mother_hostility	.46	1.43	.31	.67	.52	-.586	5.411		
Mother_neglect	.39	1.39	.33	.57	.56	-.701	4.939		
Mother undif rejection	.76	1.42	.39	1.09	.35	-.413	5.310		
Self-control	-.17	.10	-.12	-1.48	.10	-.379	.043		
Trait anger	-.21	.26	-.12	-.79	.41	-.791	.391		
Anger control	.29	.29	.19	1.03	.32	-.286	.888		
Anger-out	.77	.39	.36	1.89	.04*	-.016	1.519		
Anger-in	.07	.19	.02	.39	.71	-.318	.485		
Peer deviance	.48	.08	.55	6.74	.00*	.331	.669		

Note. *$p < .05$ *Note.* PARQ: Parental Acceptance Rejection Questionnaire; Undif. rejection: Undifferentiated rejection; Anger-out: Anger out expression style; Anger-in: Anger in expression style.

Firstly, the model predicted substance use ($R^2 = .437$, F (15, 144) = 7.461, p = .000). In other words, all the variables explained 43.7% of the variance in substance use.

As shown in Table 3.7, substance use was predicted significantly by father undifferentiated rejection ($B = .763$, $SE = .299$, $t = 2.493$, $p = .015$) and by peer deviance ($B = .489$, $SE = .082$, $t = 6.749$, $p = .001$). As expected, the findings suggest that the higher paternal undifferentiated rejection, the greater substance use level. When paternal undifferentiated rejection scores increase 1-point, it is expected that

substance use increase as .763 point. Also, there is a positive relationship between score of peer deviance and substance use. While peer deviance scores increase 1-point, substance use score rise .489 point.

On the other hand, father warmth (*B* = -.204, *SE* = .171, *t* = -1.175, *p* > .05), father hostility (*B* = -.398, *SE* = .208, *t* = -1.960, *p* = .05), father neglect (*B* = -.085, *SE* = .234, *t* = -.402, *p* > .05), mother rejection (*B* = -.570, *SE* = 1.380, *t* = -.903, *p* > .05), mother warmth (*B* = .786, *SE* = 1.373, *t* = 1.265, *p* > .05), mother hostility (*B* = .466, *SE* = 1.436, *t* = .676, *p* > .05), mother neglect (*B* = .398, *SE* = 1.399, *t* = .570, *p* > .05), mother undifferentiated rejection (*B* = .769, *SE* = 1.427, *t* = 1.093, *p* > .05), self-control (*B* = -.173, *SE* = .104, *t* = -1.487, *p* > .05), trait anger (*B* = -.216, *SE* = .264, *t* = -.793, *p* > .05), anger control (*B* = .292, *SE* = .290, *t* = 1.033, *p* > .05), anger-out expression (*B* = .779, *SE* = .390, *t* = 1.899, *p* = .043) and anger-in expression (*B* = .074, *SE* = .198, *t* = .399, *p* > .05) did not significantly predict substance use.

CHAPTER 4

DISCUSSION

This study aimed to investigate substance use problem among late adolescents in terms of its relationship with parental acceptance-rejection, self-control, anger, and peer deviance. Although there are studies examining the personal and environmental level factors seperately in the literature, only a handful of studies have investigated the familial, environmental and psychological aspects of substance use in young people from a multifaceted perspective, especially in Turkey. Thereof, in this study, substance use in late adolescents was inspected in terms of (1) parental acceptance rejection and its sub-dimensions, (2) self-control, (3) anger and its sub-dimensions, and (4) peer deviation. In the following sections, the obtained results were discussed with respect to existing literature. Next, clinical implications were presented, and finally, limitations and recommendations for future studies were provided.

4.1. The Difference between High Substance Use and Low Substance Use Severity Group in terms of Parental Acceptance-rejection, Self-control, Anger and Peer Deviance

The results of one-way MANOVA analysis, which was conducted to understand whether there was a difference between individuals with high and low severity of substance use in terms of parental acceptance-rejection, self-control, anger and peer deviance, were discussed in this section.

Our results indicated that, in contrast to paternal rejection and its sub-dimensions, maternal hostility and maternal undifferentiated rejection made a significant difference between individuals with high-severity and low-severity substance use. Although no significant difference was obtained with regard to father acceptance-rejection in total and its subdimensions, it was noted that paternal hostility and paternal undifferentiated rejection scores were higher for the high risk severity group. In fact, many studies in the existing literature have yielded that both maternal and paternal rejection together are associated with substance use problem among adolescents (Furstenberg & Weiss, 2000; Rohner & Britner, 2002; Rohner & Veneziano, 2001; Söderström & Skårderud, 2013; Veneziano, 2000; 2003).

Nevertheless, those studies either considered impacts of mothers and fathers together, or only focused on the role of maternal rejection on the severity of substance abuse (Baron et al., 2010; Glavak et al., 2003; Hay, 2001; Rohner & Veneziano 2001; Veneziano 2000; 2003; Yang et al., 2019). By contrast, research inspecting the association between father rejection and substance use are relatively scarce (Rai, 2008). In that respect, our results gave support to the existing literature once again highlighting the importance of maternal acceptance-rejection on offspring risk-taking behavior (Ju et al., 2020; Yang et al., 2019). Maternal rejection has been long known to be influencing behavioral and emotional symptoms of the affected offspring (e.g., depression, anxiety, substance use etc.) through emotion regulation skills, dysfunctional beliefs and coping strategies (Rohner, 2015; Yang et al. 2019). Thereof, it would be theoretically sensible to assume that children with higher maternal rejection had greater propensity to engage in risk taking behaviors including substance misuse, particularly when exposed to environmental risk factors (e.g., poor neighborhood, peer deviance etc.) more pertaining to substance misuse (Cano-Lozano et al., 2020; Fergusson & Horwood, 1999; Simons & Robertson, 1989).

In contrast to our expectations, no significant difference was found between high and low severity group with regard to paternal rejection scores. In recent study, only paternal rejection was found to be associated with substance use among girls, while the same relation was not obtained for the male using substances indicating a possible interaction between offspring and parents' gender (Yang et al., 2019). By contrast, maternal rejection was reported as a potent risk factor for substance misuse for both genders. Accordingly, girls are more likely to be influenced by deviant peers when their relationship with their fathers are troubled as they were seeking for an authority figure as a role model (Farrell & White, 1998; Hoeve et al., 2011). Yet, the same tendency was not observed for the male adolescents. Consistent with these findings, only maternal hostility and undifferentiated rejection created a significant difference between high and low severity groups in our study as well, considering that all participants of the current study were male. In that respect, the aforementioned gender effect might have explained the non-significant relation between male substance misuse and paternal rejection for the present study. Thereof, it is utmost importance for future studies to examine the relation between paternal rejection and substance use considering the possible impacts of offspring and parent

genders. Besides, other father related factors might have more over-riding impacts on adolescents' risk-taking behaviors (e.g., father antisocial personality characteristics, paternal criminal history etc.) over paternal parenting styles, considering the multifaceted nature of substance use problem among youth (Fals-Stewart et al., 2004; Moss et al., 2001; Ohannessian et al., 2005). Additionally, all participants of the current study were substance users and we did not have a control group to make comparisons with regard to parental acceptance-rejection scores as a baseline.

Our results also indicated significant differences between high severity and low severity substance use groups in terms of self-control, trait anger, anger control, anger-out expression, and peer deviance. However, there was no significant difference between two groups with regard to anger-in expression. More specifically, the high severity substance use group had higher mean scores for trait anger, anger-out expression, and peer deviance, while their self-control and anger control scores were lower than the low severity substance use group. In fact, these results are almost perfectly fitting with the existing empirical findings and related theoretical explanations in agreement with the results of previous studies. Accordingly, individuals with lower self-control are more likely to start abusing substances, and usually consume higher doses of psychoactive drugs (e.g. marijuhana, alcohol consumption etc.) (Colder & Stice, 1998; Donoghue, 2001; Jones et al., 2011; Malouf et al., 2012; Winstanley et al., 2010; Winters et al., 2009). A possible explanation for this result might be closely related with the emotion regulation difficulties of the individuals with poorer self-control. According to Self-Control Theory, low self control is characterized by the temptation to display impulsive acts because of an inability to delay gratification for long-term commitments (Gottfredson and Hirschi 1990; Paschke et al., 2016). Individuals with lower self-control are more likely to adopt dysfunctional emotion regulation strategies in an attempt to ease aversive emotional states. In that respect, abusing substances might be one regulatory strategy employed by individuals with poor self control to achieve immediate relief. Our results also provided support for the reported relationship between anger and substance abuse among adolescents. Accordingly, those with higher levels of trait anger and who express anger externally are more likely to abuse substances (Baharvand & Malekshahi, 2019; Cautin et al., 2001; Cole, 2008; Eftekhari et al., 2004; Hofvander et al., 2011; Khakbaz et al., 2014; Nichols et al.,

2008). By contrast, people who can control and regulate their anger less likely to start using psychoactive drugs (Avcı et al., 2017; Baharvand & Malekshahi, 2019). In fact, these results are in accordance with the emotion regulation difficulties underlined for the low self-control individuals. Accordingly, problems in regulating and expressing anger might result in employment of poor decision making strategies which might explain the well-established relation between trait anger, outward anger expression and substance misuse (Colder & Stice, 1998; Eftekhari et al., 2004; Gambetti & Giusberti, 2009).

Last but not least, we obtained a significant difference between high severity and low severity substance use groups in terms of peer deviance, providing further support for the theoretical assumptions of Social Learning Theory. In fact,peer deviance is an important environmental factor having the most potent relationship with adolescents' substance misuse (Barnes et al., 2006; Mohasoa, 2010; Mudavanhu, 2013; Ramirez et al., 2012; Tucker et al., 2011). Adolescence is a transition period during which formation and maintenance of peer relations are of utmost importance for identity development (Santrock, 2016). In that respect, adolescents who identify with marginalized peer groups are at greater risk of abusing substances particularly when other risk factors (e.g., poor neighbor, availability of drugs, parental psychopathology etc.) have also been present (Ramirez et al., 2012; Tucker et al., 2011).

4.2. Difference between Clinical and Non-clinical Sample in terms of Parental Acceptance-rejection, Self-control, Anger and Peer Deviance

The participants of this study consisted of both a clinical sample (who were officially diagnosed and hospitalized in the Ministry of Health Treatment Center), and a non-clinical sample (who were undiagnosed yet using soft substances on a regular basis). Therefore, the participants were divided into two different groups in terms of their diagnostic status and the type, dose, range and number of substances they used. In the current study, one-way MANOVA analysis was performed to find out whether there was a difference between clinical and non-clinical group in terms of parental acceptance-rejection, self-control, anger and peer deviance.

According to the obtained results, there was a significant difference between clinical and non-clinical group in terms of paternal hostility, paternal undifferentiated

rejection, maternal hostility and maternal undifferentiated rejection. In contrast to the non-significant difference between high severity and low severity group, significant differences were obtained for the paternal hostility and undifferentiated rejection scores between clinical and non-clinical group, consistent with our expectations. In fact, majority of the studies highlighted the contribution of maternal rejection on adolescents' risk taking behaviors (Baron et al., 2010; Glavak et al., 2003; Yang et al, 2019) since mothers are still perceived as the primary caregivers due to deeply rooted gender-role assignments (Rothbaum & Weisz, 1994). Nevertheless, it would be risky to ignore the role of paternal rejection in the development of substance use problems considering the other well-established paternal factors (e.g., father anti-social behavior, paternal criminal history, paternal psychopathology) increasing risk for adolescents' substance misuse (Fals-Stewart et al., 2004; Moss et al., 2001; Ohannessian et al., 2005). Besides, the significant differences with regard to parental hostility was also notable since levels of trait anger and anger-out expressions had also differed across two groups in the present study. Accordingly, parental hostility might also predispose offspring for the anger-regulation problems, which in turn, might increase the risk for substance misuse problems, as well. Also, no significant associations were obtained with regard to maternal and paternal rejection total scores although hostility and undifferentiated rejection dimensions differed significantly across two groups. This specifity in rejection domain may be related with the fact that clinical sample in our study might have remembered more concrete aspects of mother and father rejection such as hostility while disregarding more implicit negative parenting attitudes like neglect.

Consistent with our findings for the high severity group, the clinical group obtained higher mean scores for trait anger, anger-out expression, and peer deviance, and lower scores for anger-control when compared with the non-clinical group. In the present study, the clinical in-patient group (i.e., using more than one hard-drug with greater intensity, frequency, dosage) had lower levels of anger-control when compared with the non-clinical soft-drug users (i.e., only using cannabis without an official diagnosis), providing further support for the previous studies, individuals with greater anger control skills are less likely to abuse substances particularly due to employment of functional emotional regulation strategies (Avcı et al., 2017; Baharvand & Malekshahi, 2019). Likewise, the fact that people in the clinical sample

expressed more trait anger and outward anger is also consistent with the existing findings suggesting a positive relationship between substance use and trait anger and outward anger expression (Cole, 2008; Eftekhari et al., 2004; Hofvander et al., 2011; Khakbaz et al., 2014; Nichols et al., 2008). Last but not least, those in the clinical sample reported more deviant behaviors from their friends. Again, this finding is in line with the Social Learning Theory, which proves a strong positive relationship between peer deviance and substance use among youth (Miller et al., 2011; Pratt et al. 2010).

4.3. Parental Acceptance-rejection, Self-control, Anger and Peer Deviance Components in Substance Use

In the present study, a multiple regression analysis was also conducted to understand to what extend the paternal and maternal acceptance-rejection, self-control, anger and peer deviance predicted substance use among late adolescents. Accordingly, the proposed model significantly predicted substance misuse, and all the study variables together explained 43.7% of the variance in late adolescents' substance use scores. In fact, our results once again highlighted the importance of assessing and treating substance use problem from a biopsychosocial perspective. According to Biopsychosocial Model of Addiction, no single factor is sufficient to explain development and maintenance of youth's substance abuse problem. Instead, biological (e.g., genetic predisposition, familial substance abuse history etc.), familial (e.g., parental psychopatology, parenting, parental criminal behavior etc.), psychological (e.g., impulsivity, low harm avoidance, low self-control) and environmental (e.g., poor neighborhood, peer relations) factors intreact with each other giving pavement to different forms of addiction (Briones, et al., 2006; Galizio & Maisto, 1985; Marlatt, 1992; Smith, 2020). Thereof, our study provided evidence for the contribution of different level factors in explaining and addressing youths' substance misuse problem.

When the predictors were analyzed separately, it was found that paternal undifferentiated rejection and peer deviance significantly predicted substance use. As expected, the findings suggested that higher father undifferentiated rejection was associated with levels of substance use problem. Also, there was a positive relationship between scores of peer deviance and substance use. Accordingly, peer

deviance is one of the two most important predictors of substance use, and these findings were consistent with many previous studies examining the relationship between substance use and peer relationships (Gray et al., 2015; HeavyRunner-Rioux & Hollist, 2010; Miller et al., 2008; Norman & Ford, 2015; Schaefer et al., 2015a; Schaefer et al., 2015b; Whaley et al., 2011; Yun & Kim, 2015).

In addition, the fact that only the father's undifferentiated rejection among the parental acceptance-rejection factors was a significant predictor of substance use supported the previous studies emphasizing the importance of the father related factors in substance use (Hay, 2001; Rai, 2008; Rohner & Veneziano 2001; Veneziano, 2003). Except for paternal undifferentiated rejection, none of the perceived parental acceptance-rejection dimensions in childhood significantly predicted substance use. One of the reasons for this may be related with the current parental acceptance-rejection levels of our participants. In a previous study, less perceived parental rejection in the present was found to have a buffering effect on the relationship between perceived parental rejection in childhood and psychological problems (Rohner et al., 2005). In other words, when people who perceived to be rejected by their parents in childhood have higher current perceived parental acceptance, this may be a protective factor against substance use problem. In the current study, the relationship between the participants' perceptions of parental acceptance-rejection in childhood and their current substance use was examined without measuring their current parental acceptance-rejection perceptions. Therefore, current parental acceptance-rejection perceptions may have affected the participants' perception and reporting of childhood parental rejection in this study and this may have affected our results.

Moreover, self-control did not significantly predict substance use among all other variables, contrasting with our expectations. This non-significant result might be explained by the effects of self-control on different types of deviant behaviors among youth. For example, Vazsonyi et al. (2017), in their study, examined the relationship of low self-control with deviant behavior, reporting that low self-control had the weakest association with was substance use when compared with other types of marginalized behavior. Besides, rather than the general self-control construct, specific dimensions such as impulsiveness and impaired emotion regulation might be measured in the future studies in order to delineate the association betweens self-

control and substance misuse. Another explanation comes from a recent study conducted in Saudi Arabia (Beaver et al., 2016). Accordingly, higher level of self-control was found to increase the likelihood of substance use, and the researchers stated that the opposite result of the self-control literature could be attributed to the cultural differences or the self-control scale was not working properly in their home country. Perhaps the reason why self-control was not one of the predictors of substance use in the current study may be the effort of individuals to show themselves as having more self-control than they are due to social desirability reasons, as well.

4.4. Clinical Implications

As mentioned earlier, according to reciprocal determinism, human behavior is determined by the relationship between personal factors, the external environment, and the behavior itself. When evaluated in terms of reciprocal determinism, substance use can be seen as a chronically developing biopsychosocial behavior that encompasses both internal and external dimensions of the individual (Bandura, 1977; Smith, 2020). Therefore, it is known that biological, psychological and social factors have an important place in explaining substance use. Although biological risk factors were not within the scope of the current thesis, psychological and social factors have been found as important factors affecting substance use among adolescents. Thereof, intervention and prevention strategies developed for substance misuse among youth should employ a multicomponent approach targeting both familial, individual and environmental level risk factors.

According to our results, parental hostility and undifferentiated rejection perceived by the person in childhood are important familial factors in substance use providing preliminary evidence for the intervention and prevention programs targeting parenting behaviors for adolescents' risk taking behavior. In addition, peer deviance has emerged as an important social factor in this study. In addition to the social factors emphasized as parents and peers, it has been seen that anger expression style, anger control status and self-control skills are also important psychological factors affecting substance use. Hence, this study emphasizes that substance use is not just an individual problem, but rather emerges as a result of multiple environmental and parental factors. Therefore, in the treatment and rehabilitation

process, the person using the substance should not be only subjected to medical treatment focusing on quitting the drug. Instead, a multicomponent model can be applied targeting different level components, including the Strenghthening Family program and Life Skills Training program (Spoth et al., 2002).

The Strengthening Families Program based on the biopsychosocial model can be used to reduce familial and parental risk factors, enhance protective factors and empower young people. The model targets families to contribute more to the protective processes associated with young people's problematic behaviors. Therefore, the program includes seven coping and life skills training: the ability to restore self-esteem, emotional management skills, interpersonal social skills, problem-solving ability, reflective skills, academic and work skills, and planning skills. The long-term goal of the program is to reduce youth substance use and other risky behaviors. The program includes both simultaneous parent training and children's skills training, and family skills training, where parents and young people jointly apply the skills they have earned in separate sessions (Kumpfer et al., 1996; Spoth et al., 2001). This model supports the familial risk-focused and youth resilience approaches for reducing or preventing familial behavioral antecedents and substance use problems in adolescents. Strategies also help adolescents develop protective coping skills through positive rather than negative behaviors. In this context, some of the topics to be studied throughout the program are supportive family involvement, age-appropriate parental expectations, positive discipline, family cohesiveness, positive future orientation, consistent parenting style, family discipline; meaningful family conflict, clear parental expectations regarding substance use, interpersonal social skills, peer refusal skills (Molgaard et al., 2000; Spoth et al., 2002).

On the other hand, the Life Skills Training program based on Social Learning Theory is implemented to encourage skill development such as social resilience, self-control skills, general social skills, and to provide information that encourages substance use avoidance. Adolescents are trained in this program in the various skills domains through the use of interactive teaching techniques, including couching, role modeling, feedback and reinforcement, homework exercises and out-of-class behavioral rehearsal. The main purpose of the program is to teach coping with social factors that encourage substance use, to facilitate the development of basic life skills

and the development of personal competence. The program includes cognitive-behavioral techniques aimed at emphasizing the consequences of substance use, making decisions, reducing the social effects that lead to substance use, developing self-control skills, coping with anxiety and anger, anger management skills, communication skills, and general interpersonal skills (Botvin, 1996, 2000; Spoth et al., 2002).

4.5. Limitations and Future Directions

Still, the present study is not without limitations. First, the data are cross-sectional preventing to establish a chronological order and causality. In this respect, the collection of longitudinal data in the future studies will be of great benefit to delineate robust risk factors for adolescents' substance abuse problems. Secondly, this study is a quantitative study and data was collected through self-reports. This might overshadow the possibility of participants to make a reliable assessment because the issues evaluated in this study (e.g., parental rejection, substance use), are highligy subjected to issues of social desirability. In addition, especially the people in the clinical sample, that is, substance addicts receiving inpatient treatment at the treatment center, were less likely to understand, perceive and answer the questions reliably because they suffered from withdrawal symptoms, and were under the influence of heavy medical drugs used for therapeutic purposes. As a result, reaching similar individuals using substances and conducting a qualitative study on this subject might enable both the participants to express themselves better and researchers to work more deeply on the determined issues. Another limitation is the absence of a control group. The creation of a control group that does not use substances and the application of the study to these individuals would have provided a more concrete examination of the relationship between the psychosocial factors and substance use.

In the current study, although participants were instructed to remember parental rejection in their childhood, perceptions of parenting may differ between different stages of development, and thus participants' perceptions of parenting may also change over time (Yang et al., 2019). Therefore, the results could only have reflected the influence of the overall perception of parental rejection, rather than focusing only on the childhood experiences. Another limitation is that we did not

examine current parental acceptance rejection. As mentioned before, it was shown in a study that current perceived parental acceptance has a buffering effect on the relationship between perceived parental rejection in childhood and current psychological problems (Rohner et al., 2005). Hence, current levels of parental acceptance/rejection might have been examined in the future studies as family's attitudes might have undergone several changes due to treatment process

Another suggestion for future studies is to consider resilience while studying the factors associated with substance use. Resilience is a functional and protective psychological mechanism by which people can recover from stressors and avoid being physically or emotionally dysfunctional (Bonanno, 2004; Rutter, 2012). In this study, the resilience of the participants was not controlled, but it is not possible for anyone with similar parental acceptance rejection, self-control, anger, or deviant peers to start or use drugs in the same way. Therefore, while some people with the same conditions tend to use substances, others do not. One of the important factors that can explain this difference may be the person's level of resilience. Also, only male participants were included in this study, eliminating the possibility of examining parent-child gender impacts on adolescents' drug use problems. Finally, a hard-to-reach sample has been sampled in the present thesis. Since it is a difficult process to reach people using substances, and to get them to participate voluntarily in the study, the number of participants were relatively small limiting the generalizability of our results.

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APPENDICES

Appentix A: Informed Consent for Participation

Sayın Katılımcı,

Bu araştırma TED Üniversitesi Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Yüksek Lisans Programı öğrencisi Psk. Ezgi Koşar tarafından, Dr. Öğr. Üyesi Yağmur Ar-Karcı ve Dr. Öğr. Üyesi Emrah Keser danışmanlığında yürütülmektedir. Araştırmanın amacı, algılanan baba-çocuk ilişkisinin madde kullanımı üzerindeki etkilerini incelemektir. Bu araştırma kapsamında 18-25 yaşlarındaki gençlerden bazı anket sorularına yanıt vermeleri istenecektir. Çalışmanın etik ilkelere uygunluğu, TED Üniversitesi İnsan Araştırmaları Etik Kurulu tarafından değerlendirilmiş ve onaylanmıştır. Çalışma kapsamında sizden yaklaşık 30 dk. sürecek bazı anket sorularına yanıt vermeniz beklenecektir.

Bu anket birden fazla psikolojik test içermektedir. Lütfen her testin başındaki yönergeyi dikkatli okuyunuz ve size en uygun şekilde cevaplayınız. Araştırmadan sağlıklı sonuçlar elde edebilmek için soruları içten bir şekilde ve eksiksiz doldurmanız önemlidir. **Soruların DOĞRU ya da YANLIŞ cevapları yoktur.** Çalışma süresince sizden herhangi bir kişisel bilgi istenmeyecektir. Vermiş olduğunuz bilgiler yalnızca bilimsel amaçlar için kullanılacak ve diğer katılımcıların bilgileriyle bütün olarak değerlendirilecektir. Bu çalışma kapsamında elde edilecek olan bilimsel bilgiler sadece araştırmacılar tarafından yapılan bilimsel yayınlarda, sunumlarda ve eğitim amaçlı çevrimiçi bir ortamda paylaşılacaktır.Tüm bilgiler araştırmacının bilgisayarında katılımcının ismi belirtilmeksizin tutulup, şifreli bir program aracılığı ile korunacaktır.

Bu çalışmaya katılım gönüllük esasına dayalıdır. Araştırmada yer alan sorular kişisel rahatsızlık verecek nitelikte değildir. Ancak herhangi bir nedenden ötürü kendinizi rahatsız hissederseniz, nedenini açıklamaksızın araştırmadan ayrılabilirsiniz. Çalışmaya katıldığınız için şimdiden teşekkür ederiz.

Araştırmaya yönelik soru ve önerileriniz için Psk. Ezgi Koşar (ezgi.kosar@tedu.edu.tr), Dr. Öğr. Üyesi Yağmur Ar-Karcı (e-posta: yagmur.ar@tedu.edu.tr) ve Dr. Öğr. Üyesi Emrah Keser (emrah.keser@tedu.edu.tr) ile iletişime geçebilirsiniz. Değerli katkılarınız için teşekkür ederiz.

Araştırmacı tarafından bu araştırma ile ilgili yeteri kadar bilgilendirildim. Bu çalışmaya tamamen gönüllü olarak katılıyorum ve istediğim zaman sebep göstermeksizin araştırmadan ayrılabileceğimi biliyorum. Verdiğim bilgilerin bilimsel amaçlı yayınlarda kullanılmasını kabul ediyorum. Araştırmada verdiğim bilgilerin bilimsel makaleler, akademik sunumlar ve çevrimiçi bir eğitim ortamı dışında kesinlikle kullanılmayacağını biliyorum.

☐ Onaylıyorum ☐ Onaylamıyorum

Ad Soyad:

İmza:

Tarih:

Araştırmaya katılımınız ve haklarınızın korunmasına yönelik sorularınız varsa ya da herhangi bir şekilde risk altında olduğunuza veya strese maruz kalacağına inanıyorsanız TED Üniversitesi İnsan Araştırmaları Etik Kurulu'na (0312 585 00 05) telefon numarasından veya iaek@tedu.edu.tr *eposta adresinden ulaşabilirsiniz.*

Appendix B: Demographic Information Form

Doğum Tarihi: ...../...../.....

Cinsiyetiniz:

☐ Kadın ☐ Erkek ☐ LGBTI+ ☐ Belirtmek istemiyorum

Eğitim Durumunuz:

☐ Okur/yazar ☐ İlkokul ☐ Ortaokul ☐ Lise ☐ Lisans ☐Lisansüstü

Mesleğiniz:

Aylık Geliriniz:

☐ 1000 TL ve altı

☐ 1001 TL- 2000 TL

☐ 2001 TL- 3000 TL

☐ 3001TL -5000 TL

☐ 5001 TL ve üzeri

Yaşamınızın büyük bölümünü geçirdiğiniz yeri işaretleyiniz:

☐ Büyükşehir ☐ İl ☐ İlçe ☐ Kasaba ☐ Köy

Şu an yaşadığınız yer:

☐ Yurt ☐ Tek başıma, evde ☐ Arkadaşlarımla, evde

☐ Romantik partnerimle, evde ☐ Ailemin yanında ☐ Akraba yanında ☐ Diğer

Medeni durumunuz:

☐ Bekar ☐ Evli ☐ Boşanmış ☐ Diğer

Geçmişte doktor veya psikiyatrist tarafından tanı koyulan bir sağlık sorununuz oldu mu?

☐ Evet ☐ Hayır

Evet ise:

Hangi sorunları yaşadınız? .....

Hangi ilaçları kullandınız? .....

Şu an devam eden fiziksel veya psikolojik herhangi bir sağlık sorununuz var mı?

☐ Evet ☐ Hayır

Evet ise:

Hangi sorunları yaşadınız? .....

Güncel olarak kullandığınız bir ilaç var mı? .....

Bağımlılık yapıcı herhangi bir madde kullanıyor musunuz?

☐ Evet ☐ Hayır ☐ Belirtmek istemiyorum

Evet ise;

Kullandığınız madde nedir? (Birden fazla seçenek işaretleyebilirsiniz)

☐ Tütün ürünü

☐ Alkol

☐ Diğer (Belirtiniz) ……..

Tütün ve alkol dışında bir maddeyi işaretlediyseniz lütfen bu maddeyi ne kadar süredir kullandığınızı belirtiniz. (Lütfen ortalama yıl olarak belirtiniz) ……..

Lütfen bu sayfadaki diğer soruları tütün ve alkol dışında kullandığınızı belirttiğiniz maddeyi düşünerek yanıtlayınız.

Ne sıklıkla kullanıyorsunuz?
☐ Her gün
☐ İki-üç günde bir
☐ Her hafta
☐ Bulursam içerim
☐ İçmeden duramam

Madde kullanmaya kaç yaşında başladınız? ……

Madde kullanmaya nasıl başladınız? (Birden fazla işaretleme yapabilirsiniz.)

☐ Arkadaş ortamında başladım
☐ Okuldaki sorunlarım yüzünden başladım
☐ Ailedeki problemlerimiz yüzünden başladım
☐ Merak ettim
☐ Arkadaşlarımda madde kullananlar vardı
☐ Ailemde madde kullananlar var
☐ Diğer belirtiniz ……..

Babanızın doğum yılı:.....

Babanız hayatta mı? ☐ Evet ☐ Hayır

Babanızın medeni durumu:

☐ Bekar, hiç evlenmemiş
☐ Annenizle evli
☐ Boşanmış,ayrı yaşıyor
☐ Boşanmış, birlikte yaşıyor
☐ Yeniden evlenmiş
☐ Diğer; Açıklayınız.....

Babanızın eğitim durumu:

☐ Okur/yazar ☐ İlkokul ☐ Ortaokul ☐ Lise ☐ Lisans ☐ Lisansüstü

Babanızın mesleği:.....

Babanıza uygun seçeneği işaretleyiniz:

☐ Yarı zamanlı çalışıyor ☐ Tam zamanlı çalışıyor ☐Emekli
☐Çalışmıyor ☐İşsiz

Şu an babanızın devam eden fiziksel veya psikolojik herhangi bir sağlık sorunu var mı?

☐ Evet ☐ Hayır

Evet ise:

Hangi sorunları yaşadı? .....

Güncel olarak kullandığı bir ilaç var mı? .....

Babanız bağımlılık yapıcı herhangi bir madde kullanıyor mu?

☐ Evet ☐ Hayır ☐ Belirtmek istemiyorum

Evet ise;

Kullandığı madde nedir? (Birden fazla seçenek işaretleyebilirsiniz)

☐ Tütün ürünü

☐ Alkol

☐ Diğer ……..

Lütfen babanızın söz konusu maddeyi/maddeleri ne kadar süredir kullandığını yıl olarak belirtiniz. Eğer birden fazla madde kullanıyorsa lütfen her bir maddenin kullanım süresini **AYRI** olarak yazınız (Örn., alkol: 3 yıl; sigara: 15 yıl vb.) ……..

Babanızın geçmişte kullanıp bıraktığı herhangi bir bağımlılık yapıcı madde var mı?

☐ Evet ☐ Hayır ☐ Belirtmek istemiyorum

Evet ise;

Kullandığı madde nedir? (Birden fazla seçenek işaretleyebilirsiniz)

☐ Tütün ürünü

☐ Alkol

☐ Diğer ……..

Lütfen babanızın söz konusu maddeyi/maddeleri ne kadar süre kullandığını yıl olarak belirtiniz. Eğer birden fazla kullanıp bıraktığı madde varsa lütfen her bir maddenin kullanım süresini **AYRI** olarak yazınız (Örn., alkol: 3 yıl; bonsai: 10 yıl vb.) ……..

Lütfen babanızın söz konusu maddeyi/maddeleri kaç yıl önce bıraktığını belirtiniz. Eğer birden fazla kullanıp bıraktığı madde varsa lütfen her bir maddeyi kaç yıl önce bıraktığını **AYRI** olarak yazınız (Örn., alkol: 3 yıl önce; esrar: 10 yıl önce vb.) ……..

Annenizin doğum yılı:.....

Anneniz hayatta mı? ☐ Evet ☐ Hayır

Annenizin medeni durumu:

☐ Bekar, hiç evlenmemiş
☐ Babanızla evli
☐ Boşanmış,ayrı yaşıyor
☐ Boşanmış, birlikte yaşıyor
☐ Yeniden evlenmiş
☐ Diğer; Açıklayınız.....

Annenizin eğitim durumu:

☐ Okur/yazar ☐ İlkokul ☐ Ortaokul ☐ Lise ☐ Lisans ☐ Lisansüstü

Annenizin mesleği:.....

Annenize uygun seçeneği işaretleyiniz:

☐ Yarı zamanlı çalışıyor ☐ Tam zamanlı çalışıyor ☐Emekli
☐Çalışmıyor ☐İşsiz

Şu an annenizin devam eden fiziksel veya psikolojik herhangi bir sağlık sorunu var mı?

☐ Evet ☐ Hayır

Evet ise:

Hangi sorunları yaşadı? .....

Güncel olarak kullandığı bir ilaç var mı? .....

Anneniz bağımlılık yapıcı herhangi bir madde kullanıyor mu?

☐ Evet ☐ Hayır ☐ Belirtmek istemiyorum

Evet ise;

Kullandığı madde nedir? (Birden fazla seçenek işaretleyebilirsiniz)

☐ Tütün ürünü

☐ Alkol

☐ Diğer ……..

Lütfen annenizin söz konusu maddeyi/maddeleri ne kadar süredir kullandığını yıl olarak belirtiniz. Eğer birden fazla madde kullanıyorsa lütfen her bir maddenin kullanım süresini **AYRI** olarak yazınız (Örn., alkol: 3 yıl; sigara: 15 yıl vb.) ……..

Annenizin geçmişte kullanıp bıraktığı herhangi bir bağımlılık yapıcı madde var mı?

☐ Evet ☐ Hayır ☐ Belirtmek istemiyorum

Evet ise;

Kullandığı madde nedir? (Birden fazla seçenek işaretleyebilirsiniz)

☐ Tütün ürünü

☐ Alkol

☐ Diğer ……..

Lütfen annenizin söz konusu maddeyi/maddeleri ne kadar süre kullandığını yıl olarak belirtiniz. Eğer birden fazla kullanıp bıraktığı madde varsa lütfen her bir maddenin kullanım süresini **AYRI** olarak yazınız (Örn., alkol: 3 yıl; bonsai: 10 yıl vb.) ……..

Lütfen annenizin söz konusu maddeyi/maddeleri kaç yıl önce bıraktığını belirtiniz. Eğer birden fazla kullanıp bıraktığı madde varsa lütfen her bir maddeyi kaç yıl önce bıraktığını **AYRI** olarak yazınız (Örn., alkol: 3 yıl önce; esrar: 10 yıl önce vb.) ……..

Appendix C: Adult Parental Acceptance - Rejection Questionnaire

Yetişkin Ebeveyn Kabul-Red Ölçeği: Baba

Aşağıda babaların çocuklarına karşı sergiledikleri davranışlarla ilgili bazı cümleler var. Her cümleyi dikkatlice okuyun ve okuduğunuz cümlenin, **siz çocukken babanızın** size karşı göstermiş olduğu davranışları ne kadar iyi anlattığını düşünün. Her cümlenin yanında 4 adet kutu var:

BABANIZIN size çocukluğunuzda **hemen hemen her zaman** okuduğunuz cümledeki gibi davrandığını düşünürseniz, **"Hemen Hemen Her Zaman Doğru"** kutusunu işaretleyin,

BABANIZIN size **bazen** böyle davrandığını düşünürseniz **"Bazen Doğru"** kutusunu işaretleyin,

BABANIZIN size **nadiren** böyle davrandığını düşünürseniz, **"Nadiren Doğru" kutusunu** işaretleyin,

BABANIZIN size **hiçbir zaman** böyle davranmadığını düşünürseniz, **"Hiçbir Zaman Doğru Değil" kutusunu** işaretleyin.

Cevaplarınızı, çocukken babanızdan beklediğiniz davranışlara göre değil, **babanızın size gerçekte gösterdiği davranışlara göre verin**. **Lütfen her soruyu cevaplayın**.

BABAM,	Hemen Hemen Her Zaman Doğru	Bazen Doğru	Nadiren Doğru	Hiçbir Zaman Doğru Değil
1. Benim hakkımda güzel şeyler söylerdi.				
2. Kötü davrandığımda bana söylenir veya beni azarlardı.				
3. Sanki ben hiç yokmuşum gibi davranırdı.				
4. Beni gerçekten sevmezdi.				
5. Planlarımız hakkında benimle konuşur ve benim söyleyeceklerimi de dinlerdi.				
6. Onun sözünü dinlemediğim zaman beni başkalarına şikâyet ederdi.				

7. Benimle yakından ilgilenirdi.				
8. Arkadaşlarımı eve çağırmam için beni cesaretlendirir ve onların güzel vakit geçirmesi için elinden geleni yapardı.				
9. Benimle alay eder ve dalga geçerdi.				
10. Onu rahatsız etmediğim sürece benimle ilgilenmezdi.				
11. Kızdığı zaman bana bağırırdı.				
12. Benim için önemli olan şeyleri ona anlatabilmemi kolaylaştırırdı.				
13. Bana karşı sert davranırdı.				
14. Onun etrafında olmamdan hoşlanırdı.				
15. Bir şeyi iyi yaptığımda, kendimle gurur duymamı sağlardı.				
16. Hak etmediğim zaman bile bana vururdu.				
17. Benim için yapması gereken şeyleri unuturdu.				
18. Beni büyük bir baş belası olarak görürdü.				
19. Beni başkalarına överdi.				
20. Kızdığı zaman beni çok kötü cezalandırırdı.				
21. Sağlıklı ve doğru şeyleri yememe çok dikkat ederdi.				
22. Benimle sıcak ve sevgi dolu bir şekilde konuşurdu.				
23. Bana hemen kızardı.				

24. Sorularımı cevaplayamayacak kadar meşguldü.				
25. Benden hoşlanmıyor gibiydi.				
26. Hak ettiğim zaman bana güzel şeyler söylerdi.				
27. Çabuk parlar ve öfkesini benden çıkarırdı.				
28. Arkadaşlarımın kim olduğuyla yakından ilgilenirdi.				
29. Yaptığım şeylerle gerçekten ilgilenirdi.				
30. Bana bir sürü kırıcı şey söylerdi.				
31. Ondan yardım istediğimde benimle ilgilenmezdi.				
32. Başım derde girdiğinde, hatanın bende olduğunu düşünürdü.				
33. Bana istenilen ve ihtiyaç duyulan biri olduğumu hissettirirdi.				
34. Onun sinirine dokunduğumu söylerdi.				
35. Bana çok ilgi gösterirdi.				
36. İyi davrandığım zaman benimle ne kadar gurur duyduğunu söylerdi.				
37. Beni kırmak için elinden geleni yapardı.				
38. Hatırlaması gerekir diye düşündüğüm önemli şeyleri unuturdu.				
39. Şayet kötü davranırsam, beni artık sevmediğini hissettirirdi.				
40. Bana yaptığım şeylerin önemli olduğunu hissettirirdi.				
41. Yanlış bir şey yaptığımda beni korkutur veya tehdit ederdi.				

42. Benimle zaman geçirmekten hoşlanırdı.				
43. Korktuğumda ya da bir şeye canım sıkıldığında, bana yardım etmeye çalışırdı.				
44. Kötü davrandığım zaman beni arkadaşlarımın önünde utandırırdı.				
45. Benden uzak durmaya çalışırdı.				
46. Benden şikâyet ederdi.				
47. Benim ne düşündüğüme önem verir ve düşündüklerim hakkında konuşmamdan hoşlanırdı.				
48. Ne yaparsam yapayım, diğer çocukların benden daha iyi olduğunu düşünürdü.				
49. Bir plan yaparken benim de ne istediğime önem verirdi.				
50. Benim için önemli olan şeyleri, kendisine zorluk çıkarsa da yapmama izin verirdi.				
51. Diğer çocukların benden daha akıllı ve uslu olduğunu düşünürdü.				
52. Bakmaları için beni hep başkalarına bırakırdı.				
53. Bana istenmediğimi belli ederdi.				
54. Yaptığım şeylerle ilgilenirdi.				
55. Canım yandığında veya hasta olduğumda kendimi daha iyi hissetmem için elinden geleni yapardı.				
56. Kötü davrandığım zaman benden ne kadar utandığını söylerdi.				
57. Beni sevdiğini belli ederdi.				
58. Bana karşı yumuşak ve iyi kalpliydi.				

59. Kötü davrandığım zaman beni utandırır veya suçlu hissettirirdi.				
60. Beni mutlu etmeye çalışırdı.				

Yetişkin Ebeveyn Kabul-Red Ölçeği: Anne

Aşağıda annelerin çocuklarına karşı sergiledikleri davranışlarla ilgili bazı cümleler var. Her cümleyi dikkatlice okuyun ve okuduğunuz cümlenin, **siz çocukken annenizin** size karşı göstermiş olduğu davranışları ne kadar iyi anlattığını düşünün. Her cümlenin yanında 4 adet kutu var:

ANNENİZİN size çocukluğunuzda **hemen hemen her zaman** okuduğunuz cümledeki gibi davrandığını düşünürseniz, **"Hemen Hemen Her Zaman Doğru"** kutusunu işaretleyin,

ANNENİZİN size **bazen** böyle davrandığını düşünürseniz **"Bazen Doğru"** kutusunu işaretleyin,

ANNENİZİN size **nadiren** böyle davrandığını düşünürseniz, **"Nadiren Doğru" kutusunu** işaretleyin,

ANNENİZİN size **hiçbir zaman** böyle davranmadığını düşünürseniz, **"Hiçbir Zaman Doğru Değil" kutusunu** işaretleyin.

Cevaplarınızı, çocukken annenizden beklediğiniz davranışlara göre değil, **annenizin size gerçekte gösterdiği davranışlara göre verin**. **Lütfen her soruyu cevaplayın**.

ANNEM,	Hemen Hemen Her Zaman Doğru	Bazen Doğru	Nadiren Doğru	Hiçbir Zaman Doğru Değil
1. Benim hakkımda güzel şeyler söylerdi.				
2. Kötü davrandığımda bana söylenir veya beni azarlardı.				
3. Sanki ben hiç yokmuşum gibi davranırdı.				

4. Beni gerçekten sevmezdi.				
5. Planlarımız hakkında benimle konuşur ve benim söyleyeceklerimi de dinlerdi.				
6. Onun sözünü dinlemediğim zaman beni başkalarına şikâyet ederdi.				
7. Benimle yakından ilgilenirdi.				
8. Arkadaşlarımı eve çağırmam için beni cesaretlendirir ve onların güzel vakit geçirmesi için elinden geleni yapardı.				
9. Benimle alay eder ve dalga geçerdi.				
10. Onu rahatsız etmediğim sürece benimle ilgilenmezdi.				
11. Kızdığı zaman bana bağırırdı.				
12. Benim için önemli olan şeyleri ona anlatabilmemi kolaylaştırırdı.				
13. Bana karşı sert davranırdı.				
14. Onun etrafında olmamdan hoşlanırdı.				
15. Bir şeyi iyi yaptığımda, kendimle gurur duymamı sağlardı.				
16. Hak etmediğim zaman bile bana vururdu.				
17. Benim için yapması gereken şeyleri unuturdu.				
18. Beni büyük bir baş belası olarak görürdü.				
19. Beni başkalarına överdi.				
20. Kızdığı zaman beni çok kötü cezalandırırdı.				

21. Sağlıklı ve doğru şeyleri yememe çok dikkat ederdi.				
22. Benimle sıcak ve sevgi dolu bir şekilde konuşurdu.				
23. Bana hemen kızardı.				
24. Sorularımı cevaplayamayacak kadar meşguldü.				
25. Benden hoşlanmıyor gibiydi.				
26. Hak ettiğim zaman bana güzel şeyler söylerdi.				
27. Çabuk parlar ve öfkesini benden çıkarırdı.				
28. Arkadaşlarımın kim olduğuyla yakından ilgilenirdi.				
29. Yaptığım şeylerle gerçekten ilgilenirdi.				
30. Bana bir sürü kırıcı şey söylerdi.				
31. Ondan yardım istediğimde benimle ilgilenmezdi.				
32. Başım derde girdiğinde, hatanın bende olduğunu düşünürdü.				
33. Bana istenilen ve ihtiyaç duyulan biri olduğumu hissettirirdi.				
34. Onun sinirine dokunduğumu söylerdi.				
35. Bana çok ilgi gösterirdi.				
36. İyi davrandığım zaman benimle ne kadar gurur duyduğunu söylerdi.				
37. Beni kırmak için elinden geleni yapardı.				
38. Hatırlaması gerekir diye düşündüğüm önemli şeyleri unuturdu.				

39. Şayet kötü davranırsam, beni artık sevmediğini hissettirirdi.				
40. Bana yaptığım şeylerin önemli olduğunu hissettirirdi.				
41. Yanlış bir şey yaptığımda beni korkutur veya tehdit ederdi.				
42. Benimle zaman geçirmekten hoşlanırdı.				
43. Korktuğumda ya da bir şeye canım sıkıldığında, bana yardım etmeye çalışırdı.				
44. Kötü davrandığım zaman beni arkadaşlarımın önünde utandırırdı.				
45. Benden uzak durmaya çalışırdı.				
46. Benden şikâyet ederdi.				
47. Benim ne düşündüğüme önem verir ve düşündüklerim hakkında konuşmamdan hoşlanırdı.				
48. Ne yaparsam yapayım, diğer çocukların benden daha iyi olduğunu düşünürdü.				
49. Bir plan yaparken benim de ne istediğime önem verirdi.				
50. Benim için önemli olan şeyleri, kendisine zorluk çıkarsa da yapmama izin verirdi.				
51. Diğer çocukların benden daha akıllı ve uslu olduğunu düşünürdü.				
52. Bakmaları için beni hep başkalarına bırakırdı.				
53. Bana istenmediğimi belli ederdi.				
54. Yaptığım şeylerle ilgilenirdi.				
55. Canım yandığında veya hasta olduğumda kendimi daha iyi hissetmem için elinden geleni yapardı.				

56. Kötü davrandığım zaman benden ne kadar utandığını söylerdi.				
57. Beni sevdiğini belli ederdi.				
58. Bana karşı yumuşak ve iyi kalpliydi.				
59. Kötü davrandığım zaman beni utandırır veya suçlu hissettirirdi.				
60. Beni mutlu etmeye çalışırdı.				

Appendix D: Brief Self-Control Scale

1 den 5'e kadar olan seçeneklerden sizi en iyi tanımlayan şıkkı seçiniz. Lütfen her soruyu cevaplayınız.

Derecelendirme:

1- Tamamen Yanlış
2- Oldukça Yanlış
3- Kararsızım
4- Oldukça Uygun
5- Tamamen Uygun

Lütfen aşağıdaki ifadeleri okuduktan sonra kendinizi değerlendirip sizin için en uygun seçeneği işaretleyiniz.		Tamamen Yanlış	Oldukça Yanlış	Kararsızım	Oldukça Uygun	Tamamen Uygun
1.	İnsanların beni kötülüğe yönlendirmesine karşı koymada başarılıyımdır.	1	2	3	4	5
2.	Kötü alışkanlıklarımı terk etmekte zorlanırım.	1	2	3	4	5
3.	Tembel biriyim.	1	2	3	4	5
4.	Uygun olmayan şeyler söylerim.	1	2	3	4	5
5.	Eğlenceli olmaları durumunda benim için kötü olan bazı şeyleri yaparım.	1	2	3	4	5
6.	Benim için kötü olan şeyleri redderim.	1	2	3	4	5
7.	Daha fazla öz-disipline sahip olmayı isterdim.	1	2	3	4	5
8.	İnsanlar güçlü bir öz-disipline sahip olduğumu ifade ederler.	1	2	3	4	5
9.	Zevkli ve eğlenceli şeyler, yapacağım işten beni alıkoyar.	1	2	3	4	5
10.	Konsantrasyon sorunum var.	1	2	3	4	5

11.	Uzun vadeli amaçlarıma ulaşmak için verimli biçimde çalışabilirim.	1	2	3	4	5
12.	Bazen yanlış olduğunu bilsem de bazı şeyleri yapmaktan kendimi alamam.	1	2	3	4	5
13.	Sıklıkla bütün seçenekler üzerinde düşünmeden hareket ederim.	1	2	3	4	5

Appendix E: Trait Anger – Anger Expression Inventory

Aşağıda kişilerin kendilerine ait duygularını anlatırken kullandıkları birtakım ifadeler verilmiştir. Her ifadeyi okuyun. Sonra genel olarak nasıl hissettiğinizi düşünün ve ifadelerin sağ tarafındaki sayılar arasında sizi en iyi tanımlayanı seçerek üzerine (x) işareti koyun. Doğru ya da yanlış cevap yoktur. Herhangi bir ifadenin üzerinde fazla zaman sarf etmeksizin, genel olarak nasıl hissettiğinizi gösteren cevabı işaretleyin. Aşağıdaki ifadeler sizi ne kadar tanımlıyor?

	İFADELER	**Hiç (1)**	**Biraz (2)**	**Oldukça (3)**	**Tümüyle (4)**
1.	Çabuk parlarım.	**( )**	**( )**	**( )**	**( )**
2.	Kızgın mizaçlıyımdır.	**( )**	**( )**	**( )**	**( )**
3.	Öfkesi burnunda birisiyimdir.	**( )**	**( )**	**( )**	**( )**
4.	Başkalarının hataları, yaptığım işi yavaşlatınca kızarım.	**( )**	**( )**	**( )**	**( )**
5.	Yaptığım iyi bir işten sonra takdir edilmemek canımı sıkar.	**( )**	**( )**	**( )**	**( )**
6.	Öfkelenince kontrolümü kaybederim.	**( )**	**( )**	**( )**	**( )**
7.	Öfkelendiğimde ağzıma geleni söylerim.	**( )**	**( )**	**( )**	**( )**
8.	Başkalarının önünde eleştirilmek beni çok hiddetlendirir.	**( )**	**( )**	**( )**	**( )**
9.	Engellendiğimde içimden birilerine vurmak gelir.	**( )**	**( )**	**( )**	**( )**
10.	Yaptığım iyi bir iş kötü değerlendirildiğinde çılgına dönerim.	**( )**	**( )**	**( )**	**( )**
11.	Öfkemi kontrol ederim.	**( )**	**( )**	**( )**	**( )**
12.	Kızgınlığımı gösteririm.	**( )**	**( )**	**( )**	**( )**
13.	Öfkemi içime atarım.	**( )**	**( )**	**( )**	**( )**
14.	Başkalarına karşı sabırlıyımdır.	**( )**	**( )**	**( )**	**( )**

15.	Somurtur ya da surat asarım.	**( )**	**( )**	**( )**	**( )**
16.	İnsanlardan uzak dururum.	**( )**	**( )**	**( )**	**( )**
17.	Başkalarına iğneli sözler söylerim.	**( )**	**( )**	**( )**	**( )**
18.	Soğukkanlılığımı korurum.	**( )**	**( )**	**( )**	**( )**
19.	Kapıları çarpmak gibi şeyler yaparım.	**( )**	**( )**	**( )**	**( )**
20.	İçin için köpürürüm ama göstermem.	**( )**	**( )**	**( )**	**( )**
21.	Davranışlarımı kontrol ederim.	**( )**	**( )**	**( )**	**( )**
22.	Başkalarıyla tartışırım.	**( )**	**( )**	**( )**	**( )**
23.	İçimde kimseye söyleyemediğim kinler beslerim.	**( )**	**( )**	**( )**	**( )**
24.	Beni çileden çıkaran her neyse saldırırım.	**( )**	**( )**	**( )**	**( )**
25.	Öfkem kontrolden çıkmadan kendimi durdurabilirim.	**( )**	**( )**	**( )**	**( )**
26.	Gizliden gizliye insanları epeyce eleştiririm.	**( )**	**( )**	**( )**	**( )**
27.	Belli ettiğimden daha öfkeliyimdir.	**( )**	**( )**	**( )**	**( )**
28.	Çoğu kimseye kıyasla daha çabuk sakinleşirim.	**( )**	**( )**	**( )**	**( )**
29.	Kötü şeyler söylerim.	**( )**	**( )**	**( )**	**( )**
30.	Hoşgörülü ve anlayışlı olmaya çalışırım.	**( )**	**( )**	**( )**	**( )**
31.	İçimden, insanların farkettiğinden daha fazla sinirlenirim.	**( )**	**( )**	**( )**	**( )**
32.	Sinirlerime hâkim olamam.	**( )**	**( )**	**( )**	**( )**
33.	Beni sinirlendirene, ne hissettiğimi söyleyemem.	**( )**	**( )**	**( )**	**( )**
34.	Duygularımı kontrol ederim.	**( )**	**( )**	**( )**	**( )**

Appendix F: Peer Deviance Scale

Gençlik döneminde, geçici olarak istenmeyen ve onaylanmayan bazı davranışlar görülebilir. Bu bölümde yakın arkadaşlarınızdan kaçının bu tür davranışlarda bulunduğunu belirtmeniz beklenmektedir.

Örnek: Yakın arkadaşlarınızdan hiçbiri okula/işe devamsızlık etmiyorsa "hiçbiri", birkaç tanesi devamsızlık gösteriyorsa "birkaçı", yaklaşık yarısı gösteriyorsa "yaklaşık yarısı", yarından fazlası gösteriyorsa "yarıdan fazlası", çoğu gösteriyorsa "çoğu", hepsi gösteriyorsa "hepsi", bu soru sizin için uygun değilse "uygun değil" seçeneklerini işaretleyiniz.

Lütfen her ifadeyi cevaplayınız. Cevaplarınızı iyice düşünerek ve içtenlikle veriniz.

Aşağıdaki soruları yakın arkadaşlarınızı düşünerek yanıtlayınız. Yakın arkadaşlarınızın kaçı aşağıdaki davranışları son 6 ay içerisinde göstermektedir.

		Hiçbiri	Birkaçı	Yaklaşık Yarısı	Yarıdan Fazlası	Çoğu	Hepsi	Uygun Değil
1.	Okula/işe devamsızlık	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**
2.	Kopya çekmek ya da birinin emeğini kendi emeği gibi göstermek	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**
3.	Hırsızlık yapmak	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**
4.	Yalan söylemek	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**
5.	Evi terk etmek	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**
6.	Uyuşturucu satmak	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**
7.	Uyuşturucu kullanmak	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**
8.	Kuralları sık sık ihlal etmek	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**
9.	Polisle başı derde girmek	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**
10.	Polis tarafından	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**

	yakalanmak							
11.	Kendinden üst konumdaki biriyle (örn., öğretmeniyle/ patronuyla/müdürü yle) kavga etmek	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**
12.	İşi/okulu aksatmak	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**
13.	Alkol kullanmak	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**
14.	Sigara içmek	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**	**( )**

Appendix G: Drug Use Disorders Identification Test (DUDIT)

Burada kişide fiziksel ve psikolojik bağımlılık yaratabilecek maddeler hakkında bazı genel sorular yer almaktadır. Lütfen mümkün olduğunca içten bir şekilde sizin için hangi cevabın doğru olduğunu belirterek cevaplayın.

☐ **Erkek** ☐ **Kadın**				**Yaş:**	
1. Alkol/sigara dışındaki diğer maddeleri ne sıklıkta kullanıyorsunuz? (Arka taraftaki madde listesine bakın.)	Asla ☐	Ayda bir ya da daha az sıklıkta ☐	Ayda 2 ila 4 kez ☐	Haftada 2 ila 3 kez ☐	Haftada 4 ya da daha sık ☐
2. Bir çeşitten fazla maddeyi aynı anda kullanıyor musunuz?	Asla ☐	Ayda bir ya da daha az sıklıkta ☐	Ayda 2 ila 4 kez ☐	Haftada 2 ila 3 kez ☐	Haftada 4 ya da daha sık ☐
3. Madde kullandığınız zaman tipi bir günde kaç defa madde alıyorsunuz?	0 ☐	1-2 ☐	3-4 ☐	5-6 ☐	7 veya daha fazla ☐
4. Maddeden ne sıklıkta aşırı derecede etkileniyorsunuz?	Asla ☐	Ayda birden daha az sıklıkta ☐	Her ay ☐	Her hafta ☐	Her gün veya hemen hemen her gün ☐
5. Geçen yıl süresince, maddeye karşı duyduğunuz isteğin, karşı koyamayacak kadar kuvvetli olduğunu hissettiniz mi?	Asla ☐	Ayda birden daha az sıklıkta ☐	Her ay ☐	Her hafta ☐	Her gün veya hemen hemen her gün ☐
6. Geçen yıl süresince, maddeleri kullanmaya başladığınızda almayı	Asla	Ayda birden daha az	Her ay	Her hafta	Her gün veya hemen hemen her

durduramadığınız oldu mu?	☐	sıklıkla ☐	☐	☐	gün ☐
7. Geçen yıl süresince, ne sıklıkla madde alıp daha sonra yapmanız gereken bir şeyi ihmal ettiniz?	Asla ☐	Ayda birden daha az sıklıkta ☐	Her ay ☐	Her hafta ☐	Her gün veya hemen hemen her gün ☐
8. Geçen yıl süresince, aşırı derecede madde kullandığınız bir günden sonraki sabah madde almaya ne sıklıkta ihtiyacınız oldu?	Asla ☐	Ayda birden daha az sıklıkta ☐	Her ay ☐	Her hafta ☐	Her gün veya hemen hemen her gün ☐
9. Geçen yıl süresince madde kullandığınız için ne sıklıkta suçluluk duygularınız oldu ya da vicdan azabı çektiniz?	Asla ☐	Ayda birden daha az sıklıkta ☐	Her ay ☐	Her hafta ☐	Her gün veya hemen hemen her gün ☐
10. Madde kullandığınız için siz ya da bir başkası zarar gördü mü (ruhsal ya da fiziksel olarak)?	Hayır ☐		Evet, fakat geçen yıl içinde değil ☐		Evet, geçen yıl içinde ☐
11. Bir akraba ya da arkadaş, bir doktor ya da hemşire, ya da herhangi birinin madde kullanımınız konusunda endişelendiği ya da madde kullanmayı durdurmanız gerektiğini söylediği oldu mu?	Hayır ☐		Evet, fakat geçen yıl içinde değil ☐		Evet, geçen yıl içinde ☐

Maddelerin listesini görmek için sayfayı çevirin →

MADDELERİN LİSTESİ

(Dikkat! Alkol değil!)

Esrar	Amfetaminler	Kokain	Opiatlar	Halusinojenler	Uçucular/ İnhalantlar	Diğerleri
Marijuana Kannabis Joint Kubar Ot Haşiş Bonzai	Khat Concerta® Ritalin® (Metilfenidat) Dekstroamfetamin Metamfetamin Captagon® (Fenetilin) Dexedrine® Modiodal® (Modafinil)	Taş (Crack) Freebase	Koreks Eroin Opium Haşhaş Afyon sakızı Morfin Kodein	Ecstasy (MDMA) LSD (Liserjik Asit) Meskalin (Kaktüs) PCP (Melek Tozu) (Fensiklidin) Psilosibin (Sihirli Mantar) Ketamin Ketalar® DMT (Dimetiltriptamin)	Tiner Soğutucu sprey (Trikloretilen) Benzin/petrol Gaz Bally LPG (Çakmak gazı)	GHB (Gama Hidroksi Bütürat) Anabolik steroidler Gülme gazı (Halotan) Amil nitrat (Poppers) Antikolinerjikler Akineton (Biperiden) Maraş otu Boru otu (Güzel avrat otu)

Haplar eğer doktor tarafından reçete edildiyse ve reçetelendirilen dozda kullandıysanız madde olarak SAYILMAZ

Haplar madde olarak sayılır

- Fazla aldığınızsa ya da doktorun sizin için reçete ettiğinden daha sık aldığınızda,
- Hapları eğlenmek, iyi hissetmek, "kafayı bulmak" istediğiniz ya da sizde nasıl bir etki yapacaklarını merak ettiğiniz için aldığınızda,
- Akraba ya da arkadaştan aldığınız haplar,
- "Kara borsa"dan ya da çalınmış haplar satın aldığınızda

UYKU HAPLARI/ SEDATİFLER		AĞRI KESİCİLER	
Alprazolam	Klordiazepoksid	Buprenorfin	Jurnista®
Xanax®	Klorazepat Dipotasyum	Suboxone®	Petidin
Diazepam	Fenobarbital	Temgesic®	Aldolan®
Diazem®	Luminal®	Fentanil	Profenid
Nervium®	Difenhidramin	Durogesic®	
Zopiklon	Hidroksizin	Benzidamin	
Imovane®	Atarax®	Actiq®	Tantum®
Meprobamate	Flunitrazepam	Kodein	
Danitrin®	Rohypnol (Roş)	Dekstrometorfan	
Zopiklon	Ativan®	Tramadol	
Klonazepam		Contramal®	
Rivotril®		Parasetamol	
Lorazepam		Hidromorfon	

Appendix H: University Form of Risk Behaviors Scale

Yönerge: İnsanlar farklı durumlarda gösterdiği düşünce ve davranışları ile birbirlerinden ayrılırlar. Bu test bazı durumlarda nasıl düşündüğünüzü ve davrandığınızı ölçen bir testtir.

		Hiçbir zaman	Nadiren	Bazen	Genellikle	Her zaman
1.	Ağız kavgası yaptığım olur.	1	2	3	4	5
2.	Küfürlü konuştuğum olur.	1	2	3	4	5
3.	Başkalarına ait eşyalarını izinsiz olarak aldığım olur.	1	2	3	4	5
4.	Eğlence olsun diye arkadaşlarımın canını acıtmaktan hoşlanırım.	1	2	3	4	5
5.	Hakkımı kavga ederek savunurum.	1	2	3	4	5
6.	Biriyle tartıştığımda ağzıma geleni söylerim.	1	2	3	4	5
7.	Arkadaşlarıma zorla bir şeyler ısmarlatırım.	1	2	3	4	5
8.	İnsanların kusurlarını yüzlerine vurmaktan çekinmem.	1	2	3	4	5
9.	Etrafımdakilere verdiğim zararı umursamam.	1	2	3	4	5
10.	İnsanları sinirlendirmek hoşuma gider.	1	2	3	4	5
11.	Alkol kullandığımda rahatladığımı hissederim.	1	2	3	4	5
12.	Cesaretimi toplamak için alkol aldığım olur.	1	2	3	4	5
13.	Eğlence mekânlarına gidip alkol alırım.	1	2	3	4	5
14.	Bir kutlamada alkol almadan eğlenmeyeceğimi düşünürüm.	1	2	3	4	5
15.	Çevremdeki kişiler onaylamasa da alkol kullanmaktan çekinmem.	1	2	3	4	5
16.	Alkol almak için para bulurum.	1	2	3	4	5
17.	Alkol teklif edildiğinde hayır diyemem.	1	2	3	4	5
18.	Arkadaşlarıma uymak için alkol kullanırım.	1	2	3	4	5

19.	Kontrolümü kaybedecek kadar alkol aldığım olur.	1	2	3	4	5
20.	Sigara kullanıyorum.	1	2	3	4	5
21.	Yakın arkadaşlarımın bir kısmı sigara içer.	1	2	3	4	5
22.	Sigara içmek istediğimde kendime engel olamam.	1	2	3	4	5
23.	Sigara almak için param vardır.	1	2	3	4	5
24.	Bir sorunla karşılaştığımda hemen sigara içmek isterim.	1	2	3	4	5
25.	Nargile içmekten keyif alırım.	1	2	3	4	5
26.	Yasak olmasına rağmen kapalı bir ortamda sigara içebilirim.	1	2	3	4	5
27.	Canım sıkıldığında sigara içerek rahatlarım.	1	2	3	4	5
28.	Kendimi değersiz hissederim.	1	2	3	4	5
29.	Kendime güvenim yoktur.	1	2	3	4	5
30.	Sabahları mutsuz bir şekilde uyanırım.	1	2	3	4	5
31.	Sorunlarım karşısında kendimi çaresiz hissederim.	1	2	3	4	5
32.	Yaptığım hiçbir şeyden keyif almam.	1	2	3	4	5
33.	Kendimi yalnız hissederim.	1	2	3	4	5
34.	Hayattan bıkmış durumdayım.	1	2	3	4	5
35.	Karamsar biri olduğumu düşünürüm.	1	2	3	4	5
36.	Geleceğe ilişkin hedeflerimi gerçekleştiremeyeceğimi düşünüyorum.	1	2	3	4	5
37.	Hayatın bana vereceği hiçbir şey olmadığını düşünürüm.	1	2	3	4	5
38.	Beni hayatta tutmaya yetecek değerlere sahip değilim.	1	2	3	4	5
39.	Kendimi bu dünyaya ait hissetmediğim olur.	1	2	3	4	5
40.	Satın aldığım yiyeceklerin sağlıklı olmalarından çok lezzetli olmalarına önem veririm.	1	2	3	4	5

41.	Zararlı olmasına rağmen gazlı içecekleri içerim.	1	2	3	4	5
42.	Fast-food yiyecekler tüketmeyi tercih ederim.	1	2	3	4	5
43.	Abur cubur yemekten hoşlanırım.	1	2	3	4	5
44.	Çoğunlukla ev dışında yemek yerim.	1	2	3	4	5
45.	Yediklerimin bende oluşturabileceği sağlık sorunlarını önemsemem.	1	2	3	4	5
46.	Sağlıklı beslenme konusunda yeterli bilgiye sahip değilim.	1	2	3	4	5
47.	Yediklerimin besin ve sağlık değerlerini dikkate almam.	1	2	3	4	5
48.	Derinlemesine düşünmeden okulu/işi bırakabilirim.	1	2	3	4	5
49.	Arkadaşlarımın birçoğu yükseköğretime devam etmezler.	1	2	3	4	5
50.	Okuldan ayrılıp bir an önce bir işte çalışmaya başlamak istediğim olur.	1	2	3	4	5
51.	İyi bir iş bulduğumda okulu bırakmaktan çekinmem.	1	2	3	4	5
52.	Esrar ya da benzeri bir maddeyi kullanırım.	1	2	3	4	5
53.	Rahatlamak için bağımlılık yapıcı maddeleri kullanırım.	1	2	3	4	5
54.	Bugüne kadar bağımlılık yapan maddeleri kullandığım olur.	1	2	3	4	5
55.	Yakın arkadaşlarım arasında uyuşturucu madde kullananlar var.	1	2	3	4	5
56.	Uyuşturucu maddeler kullanılan ortamlara rahatlıkla girerim.	1	2	3	4	5
57.	Yaşadığım olumsuzlukları unutmak için madde kullandığım olur.	1	2	3	4	5
58.	Sadece heyecan yaşamak için uyuşturucu madde kullanırım.	1	2	3	4	5
59.	Arkadaş grubum madde kullanmama karşı çıkmaz.	1	2	3	4	5
60.	Merakımı gidermek için uyuşturucu madde kullandığım olur.	1	2	3	4	5

Appendix I: Debriefing Form

Sayın Katılımcı,

Bu araştırma, daha önce de belirtildiği gibi, TED Üniversitesi Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Yüksek Lisans Programı öğrencisi Psk. Ezgi Koşar tarafından, Dr. Öğr. Üyesi Yağmur Ar-Karcı ve Dr. Öğr. Üyesi Emrah Keser danışmanlığında yürütülmektedir. Araştırmanın amacı, algılanan baba-çocuk ilişkisinin madde kullanımı üzerindeki etkilerini incelemektir. Literatüre göre, algılanan baba-çocuk ilişkisi, kişinin öz-düzenleme becerileri ve öfke ifade tarzı madde kullanım davranışını etkilemektedir. (Avcı, Tarı-Selçuk & Doğan, 2017; Becona, Martinez, Calafat, Juan, Fernandez- Hermida ve Secades-Villa, 2012; King, Lengua ve Monahan, 2013). Ayrıca madde kullanımının kişinin arkadaş çevresiyle ilişkili olabileceği de bilinmektedir (Tibbs & Parry, 1994). Tüm bu bilgiler çerçevesinde, bu araştırma kapsamında 18-25 yaşlarındaki gençlerden bazı anket sorularına yanıt vermeleri istenmiştir. Bu anket; algılanan ebeveyn-çocuk ilişkisini, öz-düzenleme düzeyini, öfke ifade tarzını, arkadaş çevresini, madde kullanım davranışını ve riskli davranışları ölçen birden fazla psikolojik test içermektedir.

Vermiş olduğunuz bilgiler yalnızca bilimsel amaçlar için kullanılacak ve diğer katılımcıların bilgileriyle bütün olarak değerlendirilecektir. Bu çalışma kapsamında elde edilecek olan bilimsel bilgiler sadece araştırmacılar tarafından yapılan bilimsel yayınlarda, sunumlarda ve eğitim amaçlı çevrimiçi bir ortamda paylaşılacaktır. Tüm bilgiler araştırmacının bilgisayarında katılımcının ismi belirtilmeksizin tutulup, şifreli bir program aracılığı ile korunacaktır.

Bu çalışmadaki ön verilerin Eylül 2021 sonunda elde edilmesi hedeflenmektedir. Araştırmaya yönelik soru ve önerileriniz için Psk. Ezgi Koşar (ezgi.kosar@tedu.edu.tr), Dr. Öğr. Üyesi Yağmur Ar-Karcı (e-posta: yagmur.ar@tedu.edu.tr) ve Dr. Öğr. Üyesi Emrah Keser (emrah.keser@tedu.edu.tr) ile iletişime geçebilirsiniz.

Değerli katkılarınız için teşekkür ederiz.