WELLNESS AND ITS' CORRELATES AMONG UNIVERSITY STUDENTS: RELATIONSHIP STATUS, GENDER, PLACE OF RESIDENCE, AND GPA

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ABSTRACT

WELLNESS AND ITS' CORRELATES AMONG UNIVERSITY STUDENTS: RELATIONSHIP STATUS, GENDER, PLACE OF RESİDENCE, AND GPA

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The purpose of this study was to investigate the relationship among wellness relationship status, gender, place of residence, and GPA among university prep-school students. The study was carried out on a sample of 506 prep-school students from Başkent University. The students were asked to fill out Wellness Inventory and the demographic data sheet. In order to investigate the differences between wellness sub-scales' scores (Relational Self, Social Interest and Empathy, Self Consistency, Mastery Orientation, Physical Wellness, Humor, Love, and Environmental Sensitivity) of the subjects with respect to gender, relationship status, place of residence, and GPA; four separate MANOVA's were conducted.

The results of this study revealed significant gender differences in self-consistency, love, environmental sensitivity sub-scales' scores in favor of male students, but in social interest and empathy sub-scales in favor of female students. The findings also showed that students who were in a committed relationship scored significantly higher in love sub-scale, whereas students who were not in a committed relationship scored significantly higher in physical wellness sub-scale. Results indicated no significant differences in terms of the place of residence. The results also revealed that students, whose GPA ranged between 90-100, scored significantly higher on mastery orientation sub-scale of Wellness Inventory than students, whose GPA level ranged between 50-70 and below 50.

Keywords; Wellness, relationship status, gender, place of residence, GPA, university students

ÖZ

ÜNİVERSİTE ÖĞRENCİLERİNİN İYİLİK HALİ VE İLGİLİ OLDUĞU DEĞİŞKENLER: DUYGUSAL İLİŞKİ STATÜSÜ, CİNSİYET, KALINAN YER VE GENEL AKADEMİK NOT ORTALAMASI

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Bu araştırmanın amacı; cinsiyet, duygusal ilişki statüsü, kalınan yer, akademik not ortalaması ile üniversite öğrencilerinin iyilik hali arasında ilişkiyi incelemektir.

Çalışmanın örneklemini Başkent Üniversitesi hazırlık okulunda okuyan 506 öğrenci oluşturmuştur. Veriler, İyilik Hali Envanteri ve Demografik Bilgi Formu kullanılarak toplanmıştır.

İyilik Hali Envanterinin alt ölçeklerinden (ilişkisel benlik, sosyal ilgi ve empati, iç tutarlılık, başarı oryantosyonu, fiziksel iyilik hali, mizah, sevgi ve çevresel duyarlılık) alınan puanların cinsiyet, duygusal ilişki statüsü, kalınan yer ve akademik not ortalamasına göre değişip değişmediğini incelemek için dört ayrı tek yönlü MANOVA yapılmıştır.

Bulgular, iç tutarlılık, sevgi ve çevresel duyarlılık alt ölçeklerinde erkek öğrenciler lehine, sosyal ilgi ve empati alt ölçeğinde ise kız öğrenciler lehine anlamlı farklılıklar olduğunu göstermiştir. Bulgular, aynı zamanda duygusal ilişki içinde olan öğrencilerin sevgi alt ölçeğinden olmayanlara göre daha yüksek puan aldıklarını göstermiştir. Duygusal ilişki içinde olmayan öğrenciler ise fiziksel iyilik hali alt ölçeğinde olanlara göre daha yüksek puanlar almışlardır. Araştırma sonuçları kalınan yerin İyilik Hali açısından etkili olmadığını göstermektedir. Bunun yanın sıra bulgular, akademik not ortalaması 90 ile 100 arasında olan öğrencilerin başarma oryantasyonu alt ölçeğinden akademik ortalaması 50 ile 70 arasında ve 50'den düşük olanlara göre daha yüksek puan aldıklarına işaret etmektedir.

Anahtar Kelimeler: İyilik hali, cinsiyet, duygusal ilişki statüsü, kalınan yer, akademik not ortalaması, üniversite öğrencileri

To my mother, Raziye Ersoy

for her unbelievable love

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I here by declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

Date: Signature

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CHAPTER I

INTRODUCTION

1.1. Background of the Study

As we began the new century, life has become more complicated economically, politically, socially, and psychologically with a growing amount of change in every aspects of human life. Changes in social roles, technology, the availability of resources, and the social structure negatively affect the psychological and physiological well-being of human beings. The challenges of modern life touch all individuals at one time or another, and pull most of them in choosing unhealthy life styles such as eating, smoking, and drinking to struggle with life stresses. Such unhealthy life-styles block striving for self-development and achieving optimum human functioning (Cowen & Kilmer, 2002).

Unhealthy life-styles have been found to be strongly related with numerous physical and mental disorders, deviant behaviours, diminished self-esteem, excessive anxiety, increased heart disease, strokes, and cancer (Omizo & Omizo, 1992). During the last half of 20^{th} century, data from medical profession indicated that more than halves of the deaths in the world are due to lifestyle factors that could be modified (Koçoğlu, 1998). Moreover, most of the top killers by age 40 are reported as the result of lifestyle choices

(Hettler, 1984). With the increase in the amount of such data, it has been recognised that absence of positive health habits has tremendous impact on virtually all aspects of an individual's life (Romano, 1984). This awareness has resulted in an increased attention from professionals in a variety of health and social service disciplines to the definition of health (Cowen, 1991).

As early as 1947 the World Health Organization had defined health as "absence of illness". However, in 1964, the World Health Organization has changed the definition of health and provided a definition of optimal health as "physical, mental, and social well-being, not merely the absence of disease or infirmity" (as cited in Witmer & Sweeney, 1992). Similarly in 1974, the Surgeon General of the United States facilitated a major paradigm shift by changing its orientation from illness to wellness (Myers, Sweeney & Witmer, 2000).

Along with these attempts, a new age in mental health field began. The underlying rule of this age is the use of scientific knowledge for not only treating illnesses but also enhancing health and promoting individual growth (Granello, 2001). In the recent years it is widely understood that, fighting illnesses or counterattacks to disorders don't adequately help individuals to live a healthy life. Thus, it is essential to teach individuals how to build health (Cowen, 1998). Such an understanding caused the entire health care system shift from the traditional medical model of disease, which is exemplified by a "fix it when it's not right" approach, toward a more protective and preventive approach that empowers the individual to make choices in the direction of his or her growth (Cowen, 2000; Donagy, 1995).

A new paradigm of wellness which incorporates the principles of positive psychology has emerged in the last decade as an alternative to traditional, illness-based medical model for treatment of mental and physical disorders (Hatfield & Hatfield, 1992). According to this approach, health does not only include physical domain but also emotional, spiritual and intellectual domains, which altogether support a balanced life. With a holistic focus, wellness approach necessitates the best possible physical, psychological, and social functioning of individuals throughout the totality of the life span versus the more medical definition of remaining free of disease. (Myers, Sweney & Witmer, 2000). This approach also focuses on prevention, development, and positive functioning (Lightsey, 1996).

As a profession, counseling is based on the premise that people can change and grow in positive ways. The fundamental function of counselors is to stimulate an individual's level of personal growth and assist persons to maintain a healthy mind, body, and spirit (Witmer & Young, 1996). Omizo and Omizo (1992) suggested that the wellness approach and counseling are two sides of the same coin in many ways. Both view individuals holistically and emphasize the importance of moving in a preventive and proactive direction.

Furthermore, development has been as a core and an integral concept of counseling (Ivey, 1986). The counseling profession adheres to the importance of developmental, gender and age differences in order to understand individual strengths, problems, coping patterns, adaptive abilities, and potential for growth and change. Since wellness paradigm also incorporates a developmental emphasis stressing prevention, the

phenomenon of choice, and the optimisation of human functioning, wellness is directly related with skills of the professionals coming from counseling field (Myers, 1992).

During the past two decades, there have been increasing attempts by researchers from various areas to identify the benefits of wellness and explore variables associated with overall wellness. Research supporting the benefits of wellness is well-documented (Myers et al., 2000; Omizo & Omizo, 1992; Witmer & Sweney, 1992). A major benefit of wellness is that it enables people to make choices that are increasingly in their own best interest. Healthy individuals tend to make healthy choices and decisions that enhance their life circumstances (Myers, 1992). Having recognized the need to identify factors or conditions that advance or restrict wellness, several different wellness models have been proposed from various fields of study, such as medicine (Hettler, 1984; Ardell, 2001; Zimpfer, 1992), general systems theory (Crose & Nicholas, 1992), and counseling (Myers et al., 2000; Sweeney & Witmer, 1991). Different wellness training programs based on these models have also been developed (Witmer & Sweeney, 1992).

Hettler (1984), in describing a holistic wellness philosophy, indicated that wellness is a proactive approach in which individuals enhance the quality of their lives through progressively responsible choices for self-care. The goal of counseling is also to help a client become more self-sufficient and experience a sense of empowerment to not only cope with life more effectively but also to choose and maintain more healthy life-styles. This includes helping people achieve a high level of wellness (Dunn, 1977).

Sweney and Witmer (1992), and Myers et al. (2000), coming from counseling field, proposed a holistic, multidimensional, and developmental model of wellness based on Adlerian counseling theory (1956) and incorporating concepts from the fields of psychology, anthropology, sociology, religion, and education. In this model, wellness is viewed as a life-long process of striving to achieve optimal human functioning. The model, named the “Wheel of Wellness”, can be visualised as a wheel with spokes that are interrelated and interconnected (Myers et al., 2000). They concluded that people, who tend to demonstrate high levels of wellness, demonstrate higher levels of spirituality, sense of worth, sense of control, realistic beliefs, emotional responsiveness, intellectual stimulation, sense of humor, nutrition, exercise, self-care, stress management, gender identity, satisfaction with work, leisure, connection through friendship and connection through love. Myers et al. (2000) also provided a four-step strategy for using the Wheel model in counseling to help clients achieve overall wellness. Recently, Myers (2003) suggested their model as an alternative one with the potential for empowering caregivers and helping them develop healthier lifestyles. She stated that marriage and family counselors could use this approach to enhance wellness in caregivers and their families.

Myers (1992) suggested that in order to provide competent services to clients, counselor education programs should provide training and supervision in wellness area. More recently, there have been similar calls for integrating wellness into counselor education (Chandler, Holden & Kolander, 1992; Matthews, 1998; Myers & Williard, 2003; Witmer & Young, 1996). According to Witmer and Young (1996), wellness models have some

common dimensions including spiritual, intellectual, emotional, physical, occupational, and social components, which could be useful for establishing a wellness philosophy in counselor education programs. Such programs would be beneficial both for curriculum knowledge and faculty and students' personal development (Myers & Williard, 2003).

As life becomes more complicated by several factors, many university students who experience numerous psychological, physiological, and social difficulties, develop several unhealthy lifestyle choices like, smoking, alcohol, eating too much that are often used for coping or as an avoidance to struggle with life stresses (Walker & Fraizer, 1993).

There have been reports of wellness programs or models targeting students that have been overwhelmed by number of wellness issues (Hybertson, Hulme & Holton, 1992). As McClanahan (1993) concluded such wellness programs equip students with necessary information about self-direction; nutrition, exercise, and self-care and enhance student wellness.

In line with McClanahan, several authors have suggested ways to integrate wellness into student personnel and counseling services (Archer, 2001; Davies, Davies & Heacock, 2003; McDonald & Davidson, 2000; Walker & Fraizer, 1993; Welle & Kittleson, 1994). In recent years, many institutions of higher education in the United States have developed multidisciplinary programs that have been integrated into student services to support individual efforts and choices in promoting health, well-being, and a balanced life-style based on wellness construct.

Reviewing the literature about wellness among college students, wellness was found to be positively correlated with religiosity (Oleckno &

Blacconiere, 1991), effective problem solving (Elliot & Marmarosh, 1994), physical self-esteem (Bezner, Adams & Steinhardt, 1997), self-regulation (Hermon & Hazler, 1999), positive thoughts and optimism (Adams & Bezner, 2000; Lightsey, 1996), perceived social support (Granello, 2001), age (Hybertson, Hulme, Smith & Holton, 1992; Oleckno & Blacconiere, 1991), spirituality (Adams & Bezner, 2000) and negatively correlated with depression (Brylinsky & Hoadley, 1991).

Depken (1994) indicated that, it is essential to be aware of gender differences and their impact on wellness to better understand how a person can move toward wellness. While recent research points out to gender differences in almost every aspect of health and health care, gender differences in wellness are just beginning to be investigated (Sackney, Noonan & Miller, 2000).

To further the understanding of wellness in the university setting, investigating the effects of several constructs and certain background variables deemed to be important (Granello, 1999). Because as concluded by Oleckno and Blacconiere (1991), in spite of increasing interest in wellness on college campuses, little empirical research has been done to determine the psychological, sociological and demographic factors that contribute to student wellness. At present in Turkey, there exists no published study that investigated the wellness construct and factors related to wellness among different age groups. However, there are some studies which investigated variables related to wellness such as empathy (Bozkurt, 1997) irrational beliefs (Yurtal, 1999) and well-being (Aydın, 1999) among university students.

1.1. Purpose of the Study

The purpose of the present study is to investigate the relationship between wellness and gender, relationship status, place of residence, and GPA among university students.

1.2. Significance of the Study

Wellness is imperative during adolescence if individuals are to live healthy and well across their life spans. Because habits and attitudes developed during adolescence are often difficult to break, and are continued in adulthood (Omizo & Omizo, 1992). College years are the years of late adolescence and the early adulthood. During these years, college students change on a broad line of, attitudinal, social, physiological, moral, and value dimensions, in an integrated way with the change in one area appearing as a pattern of change in another area. This period of life is indeed not only a time of crucial change but also a time of exploration when students make significance gains in factual knowledge, and make many lifestyle decisions (Barnes, 1996). In addition, they are in the process of discovering whom they are and what they want to do (Fenske, 1989).

Besides, the transition to the university environment often demands students to balance the conflicting roles of student, worker, roommate, homemaker, and spouse/lover. The first year of college life requires students to make many adjustments, including adjustments to increases in academic demands, changes in the source and amount of social support, increases in individual responsibility and decision-making regarding career direction, finances, and management of schedules. Freshmen experience more

adjustment problems than other classes, including more appetite disturbances, feelings of worthlessness, concentration problems, depression, and suicidal thoughts (Kashani & Priesmeyer, 1993). Furthermore, freshmen also reports experiencing loneliness, lower self-esteem than seniors (Marron & Kayson, 1984). As a result the first year of university can be a very stressful period for many students.

Without adequate coping skills, students are often overwhelmed by the stresses. In response to this situation, they do engage in unhealthy life-styles such as avoidance drinking, drugs, eating and sleeping (McClanahan, 1993). Grace (1997) indicated that nearly two out of three college women and one out of two college men suffer from depression at one point in their college career; and 1 out of 10 college students thought of injuring themselves or taking their own lives.

Along with increasing amount of such data, improving the quality of student life has long been a concern for university educators, administrators, and counselors. Because the purpose of education in all levels that is to help the student to enhance not only their intellectual development but also emotional, social, spiritual development. Wellness training during college years can lead to healthy development of physical, cognitive, social and emotional wellness in adulthood. In other words, to the degree that the college student attains maturity in all aspects of wellness, the adult role will enable him/her to most fully express his/her potential and achieve optimum functioning (Davies, Davies & Heacock, 2002).

Recognising the relationship between health and quality in life, many institutions of higher education in United States have recently assumed a

wellness philosophy. This has resulted the inclusion of wellness courses in the college curriculum (McClanahan, 1993). Omizo and Omizo (1992) and Hettler (1984) encouraged the development of wellness programs in schools and universities to encourage lifestyle improvement efforts. However, in order to develop such programs and help university students to facilitate optimal human functioning, empirical data is needed about causes and correlates of wellness among university students (McConatha, 1990).

Searching for the studies conducted in Turkey, no research study that investigated wellness and factors that contribute to wellness was found. However, there are studies carried out to investigate the psychological problems and concerns of the university students. These studies revealed findings about the dimensions such as future anxiety; finding a job after graduation; social and leisure time activities; health (alcohol and drug use); quality of life and education; relations with parents, friends, and opposite sex; religious beliefs and moral values (Özdemir, 1985). Thus, the purpose of this study is to fill in this gap and to investigate the relationship between wellness, relationship status, gender, place of residence, and GPA among university students.

Findings of the present study might provide some important cues for both counselors and university staff about relevant variables that enhance student wellness. Furthermore, the results of the present study might contribute to further studies that aim at developing wellness programs to help students achieve optimal functioning.

In the following chapter, the review of the literature on wellness definitions and wellness models are presented. In the third chapter, overall

design of the study, research questions, population and sample selection, data collection instruments, data collection procedure and data analysis are presented. The results of the data are presented in the fourth chapter. Finally, in the fifth chapter conclusions and implications that were drawn from the study are presented.

1.3. Definitions of Terms

Wellness represents a way of life oriented toward optimal health and well-being in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community (Myers, Sweeney & Witmer, 2000).

CHAPTER II

REVIEW OF LITERATURE

In this chapter, the research literature deemed by the author to be most relevant to the purpose of this study is summarized. The first section presents the definitons and models of wellness. The second section presents the factors that contribute to wellness. Finally the third section presents the studies concerning wellness among college students.

2.1. Definitions and Models of Wellness

2.1.1. Definitions of Wellness

The term wellness is new, but the basic concept is not. The term “arete” in ancient Greek referred to the noblest state of human functioning which includes a merging of body, mind, and spirit (Archer, Probert & Cage, 1987). There is long heritage in psychological theory of viewing the individual as a "whole" seeking “reciprocal actions of the mind on the body, for both of them are parts of the whole with which we should be concerned” (Adler, 1956, p. 255). Jung (1958) and particularly Maslow (1954, 1970) who argued that striving toward self-actualisation, growth, and excellence is a universal human tendency and overarching life purpose developed this integration further.

Archer et al. (1987) and Myers et al. (2000) identified Adler's writings of individual psychology and the purpose of the psychic life, Maslow's description of self-actualisation, Rogers' opinion of the fully-functioning person, and Jung's observation of the human psyche as modern forerunners to the current wellness movement.

Wellness was first coined in 1961 by Dunn, who is widely credited as being the "architect" of the modern wellness movement. He defined wellness as "an integrated method of functioning which is oriented toward maximising the potential of which the individual is capable" (as cited in Myers & Williard, 2003).

Hettler (1984) viewed wellness as a process of becoming aware of toward a more successful existence. Ardell's (1996) view of wellness is similar to Hettler's definition. He defines wellness as a proactive approach to life that optimizes one's potential (Ardell, 2003). Archer, Probert and Gage (1987) defined wellness as "the process and a state of a quest for maximum human functioning that involves the mind, body, and spirit" (p. 311). According to Hatfield and Hatfield (1992), wellness is "a process that involves the striving for balance and integration in one's life, adding and refining skills, rethinking previous beliefs and stances toward issues as appropriate" (p. 164).

More recently, Myers, Sweeney and Witmer (2000) defined wellness as:

> A way of life oriented toward optimal health and well-being in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving. (p. 252)

All the definitions of wellness presented here are similar in that wellness is conceptualized as a multidimensional, dynamic, and proactive philosophy (Myers, 1991). This philosophy has been operationalized in models of wellness and many attempts have been done to propose a wellness model in order to explain the factors that enhance healthy functioning. The most frequently cited models in the literature were developed by Hettler (1984), Sleet and Dane (1985, cited in Sweeney & Witmer, 1991), Ardell (1985), Sweeney and Witmer (1991), and Myers, Sweeney and Witmer (2000).

2.1.2. Models of Wellness

Ardell (1977) was the first person who developed a model of wellness. His model was “The Original Wellness Model”. This model emphasized self-responsibility and stress management through five broad dimensions in a simple circle: (1) self-responsibility, (2) nutritional awareness, (3) stress awareness and management, (4) physical fitness, and (5) environmental sensitivity. Self-responsibility is in the center of that circle, bordered by the other dimensions (as cited in Ardell, 2001).

In 1982, Ardell revised his model and named this new model as The Revised and Expanded Wellness Model. This model, which is more inclusive, includes dimensions of (1) self-responsibility, (2) nutritional awareness and physical fitness, (3) meaning and purpose, (4) relationship dynamics, and (5) emotional intelligence. Along with these dimensions are eight areas of behavioural change: (1) psychological and spiritual, (2) physical fitness, (3)

job satisfaction, (4) relationships, (5) family life, (6) nutrition, (7) leisure time, and (8) stress management.

In 2001, Ardell modified this model and developed his third and last model, in which there are 3 domains of self-management, which are explained in the context of the challenge of aging well. Within these three domains, there are total of 14 skill areas: (1) Physical Domain (Exercise and Fitness, Nutrition, Appearance, Adaptations / Challenges), (2) Mental Domain (Emotional Intelligence, Effective Decisions, Stress Management, Factual Knowledge, and Mental Health), (3) Meaning and Purpose (Meaning and Purpose, Relationships, Humor, Play).

Hettler (1984), a public health physician and medical educator, described a hexagon model including six dimensions of healthy functioning; (1) social, (2) occupational, (3) spiritual, (4) physical, (5) intellectual, and (6) emotional components. Social dimension involves the development of social intimacy with family, friend and coworkers. The dimension also includes the type of environment in which the individual lives. Occupational and career dimension includes the past and present vocational experiences and skills acquired, a level of satisfaction attained during the period of employment, and salary level attained. Physical dimension refers to behaviours and factors that directly and indirectly affect physical health such as types and levels of exercise, nutrition, alcohol, stress levels, sexual activity, body esteem, and amount of sleep. Intellectual dimension involves formal and informal means toward knowledge and enlightenment. Emotional dimension includes the ability to own and express one's emotions in a healthy manner. This model is the basis for two assessment instruments, Testwell (National Wellness

Institute, 1988) and the Lifestyle Assessment Questionnaire (LAQ) (National Wellness Institute, 1983).

Smilarly, Travis and Ryan (1988), coming from medical profession, offered a wellness model, which they named as “The Wellness Energy System”. They argued that this model is an alternative to the usual piecemeal way of looking at health. They described their model as an integrated overview of all human life functions, seeing them as various forms of energy. According to them these life functions are: Breathing, sensing, eating, moving, feeling, thinking, working, communicating, sex, finding meaning, and transcending. They stated that the more harmonious balancing of life functions, the more good results in health and well-being.

Other wellness researchers have proposed similar models with varying numbers of components. However these models are developed with specific populations in mind, such as cancer patients, battered women, high school students, college students. For example, Sleet and Dane (1985, cited in Sweeney & Witmer, 1991) provided a model for wellness with a focus on the development of healthy adolescents. According to this model, wellness is divided into three components: physical health, social health, and emotional health. Physical health includes nutrition-related characteristics, personal-body-care characteristics, substance use and misuse, and safety-related behaviours. Social health includes maintaining healthy relationships in the home, school, and community. Finally, emotional health includes values, attitudes, and beliefs, stress and stress management, and emotional and sexual maturity.

Zimpfer (1992) proposed a wellness model based on his treatment of cancer patients. His model includes seven areas of treatment, which are important for client wellness: (1) medical health, (2) immune function, (3) life-style management, (4) spiritual beliefs and attitudes, (5) psychodynamics, (6) energy forces, and (7) interpersonal relations. He indicated that the broad outline of the model is described as applicable, with appropriate modifications, beyond cancer to other diseases, including especially the autoimmune system malfunctioning.

Donagy (1995) adopted Hettler's (1984) hexagon model for applying wellness interventions in battered women's shelters. He addressed how the six dimension of this model (social, occupational, spiritual, physical, intellectual, and emotional) can be effectively applied in women shelters and described ways in which shelter personnel can use multidimensional wellness interventions to empower women to adopt choices toward enhancing their health. He indicated that by adopting the wellness paradigm, shelter staff is able to assist battered women in breaking the hiearchal pattern of patriarchal power and control that characterizes their past treatment by their abusers.

Although most of models explained above have their foundation in physical health profession, they place primary emphasis on psychological development (Myers & Williard, 2003). The difficulty with these models for counseling-oriented professions is that a) each has a firm basis in health care rather than psychological development b) many models of wellness include prevention and strengths-based perspectives, they fail to recognize the influence of gender and they are not based in counseling c) most of these

models give emphasis on present functioning, not on the development over time (Hartwing & Myers, 2003).

On the other hand, wellness models have some common dimensions that provide a basis for establishing a general wellness philosophy. These are spiritual component, intellectual component, emotional component, physical component, occupational component, and social component (Witmer & Young, 1996).

Beside these models, there are two other models focused on especially spiritual wellness. Two separate researchers, Howden (1992; as cited in Briggs, 2001) who is from nursing field, and Westgate (1996) coming from the counseling field, independently formulated similar models to explain spiritual wellness. After completing a review of literature in philosophy, psychology, sociology, theology and nursing, Howden (1992) identified meaning or purpose in life, transcendence, and unifying interconnectedness as the four conceptual components of spiritual wellness. From this model, she developed the Spirituality Assessment Scale (as cited in Briggs, 2001).

Similarly, Westgate (1996) reviewed counseling, psychology, and medical wellness literature, and proposed four dimension of spiritual wellness as a result of this review. The dimensions are sense of meaning in life, transcendent perspective, instruct value system, and sense of belonging to a spiritual community of shared values and support. He also mentioned the negative correlation between depression and spirituality. With this perspective he additionally suggested that in order to provide competent services to clients, especially to depressed clients, counselors education programs should provide training and supervision in this area.

In contrast to earlier models, there is only one current holistic model based on counseling theory. The “Wheel of Wellness” model was first introduced in early 1990s (Sweeney & Witmer 1991; Witmer & Sweeney, 1992) and later modified to incorporate new findings relative to issues of diversity and self direction (Myers, Sweeney & Witmer, 2000). The most important difference of this model to earlier ones is not only its basis on counseling profession but also it concentrates on life span development. Plus, it attends to various influential factors such as gender differences, and the effects of external forces upon health and well-being. This holistic model of wellness incorporates research and theoretical concepts from a variety of disciplines including anthropology, counseling, education, medicine, psychology, religion, sociology, and psychoneuroimmunology. The authors summarized a broad array of literature from multiple disciplines and identified a number of characteristics that correlated positively with healthy living, quality of life, and longevity.

Sweeney and Witmer (1991) proposed the original Wheel of Wellness model, a holistic model of wellness and prevention over the life span, having both a multidisciplinary focus and theoretical grounding in theories of human growth and behaviour. They proposed this model based on the writings of Adler, Jung and Maslow who studied characteristics of healthy persons. Adler (1956), in writing about individual psychology noted the importance of holism in understanding the individual. Jung (1958) also observed that the human psyche actively moves toward a state of integration, based on an instinctual drive toward health and wholeness. Maslow (1970), in studying characteristics of healthy persons, concluded that a striving toward self-

actualization, growth, and excellence is a universal human tendency and overarching life purpose.

The Wheel of Wellness model is based largely on the psychology of Alfred Alder (Witmer & Sweeney, 1992). Because the characteristics that they identified were organized using Adler's proposed three major life tasks, work, friendship, and love, and two additional tasks of self and spirit which Dreikurs an Mosak (1987) described as integral to understanding Adlerian theory. Adler (1956) believed that health was more than the absence of disease and pain. His theory suggested that an individual's physical, emotional, intellectual, and spiritual growths are interconnected: "The style of life and corresponding emotional disposition exert a continuous influence on the development of the body" (Adler, 1956, p. 226).

The original Wheel model included five major life tasks, which are interrelated and interconnected, as central to understanding healthy people. These tasks include (1) spirituality, (2) work and leisure, (3) friendship, (4) love, and (5) self-regulation with 7 sub-tasks. Several years of clinical and empirical studies led to a revision of their original Wheel of Wellness model (Myers et al., 2000). The life task of work was subdivided into the two tasks of work and leisure and the life task self-regulation was renamed "self-direction", and new subtasks of self-direction were added, bringing the total to 12. These subtasks are as follows: (1) sense of worth, (2) sense of control, (3) realistic beliefs, (4) emotional awareness and coping, (5) problem solving and creativity, (6) sense of humor, (7) nutrition, (8) exercise, (9) self-care, (10) stress management, (11) gender identity, and (12) cultural identity. These life tasks interact dynamically with various life forces, including but not

limited to family, community, religion, education, government, media, and industry (Myers et al., 2000).

Furthermore, Myers, Sweeney and Witmer (2001) indicated that they use the Wheel of Wellness model in different contexts such as workshops with counselors and other professionals; classes with undergraduate and graduate in counseling and other fields; and in clinical work with individuals, couples and groups. They revealed that in each context, the Wheel of Wellness model was useful. Flowing from that point, they illustrated how this model can be practically integrated into wellness-based treatment through four phases: (1) Introduction of the Wheel of Wellness model, (2) Formal or informal assessment, (3) Intentional interventions to enhance wellness, (4) Evaluation and follow-up. Based on research, an assessment instrument was developed from the model (the Wellness Evaluation of Lifestyle, or WEL) (Myers, et al., 2001).

The Wheel of Wellness model was hypothesized as circumflex, with spirituality as the core, most central, and hierarchically most important component of wellness which provides a firm foundation for the rest of components of the wellness. The tasks of self-direction were seen as functioning much like the spokes in a wheel, and providing the self-management necessary to meet successfully Adler's three main life tasks of work, friendship, and love. As long as the spokes are strong, the wheel can roll along solidly through time and space. Surrounding the individual in the Wheel are life forces that impact personal wellness: family, religion, education, business, media, government, and community. As mentioned before, The Wheel of Wellness model evolved from an examination of the

existing knowledge base relative to components of wellness. Some of this scientific knowledge is also given while describing the dimensions (Myers et al., 2001).

Spirituality, the first life task in the Wheel of Wellness model, refers to a sense of wholeness and connectedness to the universe. It incorporates one's existential meaning, hopefulness, and purpose toward life (Myers et al., 2001) and was defined as "personal beliefs and behaviours practiced as part of the recognition that we are more than the material aspects of mind and body" (Myers et al., 2000, p 8). A distinction is made between spirituality and religiosity. Spirituality is a broad concept representing beliefs and values, where as religiosity is a concept that refers to behaviours (Chandler, Holden & Kolander, 1992; Ingersoll, 1994). Religion is a part of spirituality, however does not comprise the total meaning of the broader concept (Myers & Williard, 2003; Savolaine & Granello, 2002).

Spirituality is conceptualised as the core characteristic of healthy persons and as the source of all other dimensions of wellness. Chandler, Holden and Kolander (1992) suggested that spiritual health should not be conceptualised as just one of dimensions of wellness. Similarly, Myers and Williard (2003) indicated that spirituality is the capacity and tendency present in all human beings to construct meaning about life and to move toward personal growth, responsibility, and relationship with others. They added that it is the integrating force that motivates and shapes the physical, psychological and emotional functioning of all human beings.

Self-direction, the second life task in the Wheel of Wellness model, is the process by which an individual regulates, disciplines, and directs the self

not only in daily activities but also in pursuit of long-range goals. It is concerned with a sense of mindfulness in covering the major tasks of life. The patterns of behaviour and methods of adjustment to life that make up self-direction are sometimes referred to as a positive personality trait that makes an individual a stress-resistant person (Myers et al., 2001).

Self-direction is represented through (a) sense of worth, (b) sense of control, (c) realistic beliefs, (d) spontaneity and emotional responsiveness, (e) intellectual stimulation, problem solving, and creativity, (f) sense of humor, (g) nutrition, (h) exercise, (i) and self-care, (j) stress management, (k) gender identity, and (l) cultural identity. Because of functioning as the infrastructure of the self that provides balance and stability to understanding, predicting, and managing one's external, social life tasks, the 12 tasks of self-direction may be seen as the spokes of the Wheel of Wellness. Each spoke forms an area of competence that contributes to well-being and healthy functioning (Myers et al., 2001).

a) Sense of worth, the first subdimension of self-direction, is frequently cited in the literature as self-esteem. Self–esteem is known as the greatest single factor that affects individual growth and behaviour. Accepting oneself as a person of worth and having a sense of control corresponds to Adler's emphasis on striving for superiority or significance (Witmer & Sweeney, 1992).

b) Sense of control, the second subdimension of self-direction, is variously referred in the literature as sense of competence, locus of control, or self-efficacy (Sweeney & Witmer, 1991).

c) Third subdimension of self-direction is realistic beliefs. Maslow (1954) noted that healthy people are able to perceive reality as it is, not as they desire it to be. They recognize not only which is rational and logical but also which is distorted. Maslow (1970) also indicated that people who have realistic beliefs understand and accept themselves as imperfect, and they understand that they may make mistakes.

d) The fourth subdimension of self-direction is emotional responsiveness and management. To experience and manage a full range of emotions, both positive and negative, is one index of healthy functioning (Myers et al., 2000). It is similar to the characteristics of Maslow's (1970) "self-actualizing" people who are relatively spontaneous in behaviour and far more spontaneous than others in their inner life, thoughts, impulses, emotions, desires, and opinions. They experience and share their emotions with others in a spontaneous way. They are free of defensiveness and deceptiveness in their relationships. They have a childlike simplicity and authenticity in their responsiveness to events.

e) The fifth subdimension of self-direction is intellectual stimulation, problem solving, and creativity. The task of intellectual stimulation, problem solving, and creativity necessitates that one be open-minded, creative, curious, and able to problem solve in an effective way (Myers et al., 2000). Intellectual stimulation, involving problem solving, and creativity, is essential for healthy brain functioning and for this reason necessary for enriching quality of life across the life span (Pelletier, 1994).

f) Sense of humor, the sixth subdimension of self-direction, is combined of the ability both to appreciate humor and to create humor. Humor

appreciation entails not only the capacity to comprehend but also to enjoy humorous material. Hence, humor is both a cognitive and emotional process (Freheit & Overholser, 1998).

Humor, especially when accompanied by laughter, has a positive physiological impact. During laughter there is complex system of exchanges between physiological and psychological process. Fry (1982) reported that hearth rate, respiration and oxygen exchange are increased during laughter. Laughing also massages the vital organs, stimulates circulation, and releases chemicals into brain that enhance a sense of well-being (Erdman, 1991). This state of arousal is incompatible with most common physiological symptoms of depression (Frey, 1995).

g) The seventh subdimension of self-direction is nutrition. Nutrition style of an individual is another important factor that affects his/her health. Nutritional research has demonstrated that there is a clear relationship between what we eat and our health, our moods, and our performance (Benson & Stuart, 1992).

Eating habits have ethnic, religious, and cultural roots. Eating habits are established early in life. That's why it is difficult to change one's eating habits and food preferences as age increases. Obesity and high cholesterol forming in the early childhood lead to serious health problems in the following years. Heart attacks and cancer are the diseases that have dietary components. Nutrition composed of low fat and cholesterol, more loafs, cereals, fruit and vegetables decreases the risk of getting chronic illnesses such as hearth diseases, cancer, paralysis and diabetes (Travis & Ryan, 1988).

Unhealthy nutrition leads to not only physical diseases but also psychological problems such as stress. In order to come over unhealthy nutrition, the first step is to improve consciousness for healthy eating habits and this can be achieved by education and health institutions (Corbin, Lindsey & Welk, 2000).

h) The eight subdimension of self-direction is exercise. Exercise has been defined as regular, patterned, leisure time activity pursued to achieve desirable outcomes, such as improved level of general health. (Myers et al., 2000). Mental functioning and mood can be improved by regular, proper exercise. Regular exercise is defined as a minimum of 20-30 minutes, 2-3 times per week. Regular physical activity is viewed as essential in the prevention of disease and improvement of general health (Ardell, 1992; Greenberg & Dintiman 1997).

i) The ninth subdimension of self-direction is self-care. The life task self-care refers to the process of taking responsibility for one's health through personal habits of preventive behaviour (Myers et al., 2000). Three aspects of self-care are included into this dimension: (1) safety habits that we learn to protect ourselves from injury or death, such as wearing seat belts, (2) periodical medical check-ups, (3) avoidance of harmful substances, such as illegal drugs and toxic substances in the environment (Myers et al., 2000). Success in engaging in these preventive health habits improves the quality of one's life and positive mental health, where as failure to engage in them leads to decline in physical functioning (Broman, 1993).

j) The tenth subdimenson of self-direction is stress management. Stress management has been defined as the ability to identify stresses in

one's life and to minimize stress by participating in one or more programs of stress reduction (Charleswort & Nathan, 1982).

k) Gender identity, the elevent subdimension of self-direction, is the individual's internal perception of being male or female. In other words, it is the awareness and acceptance of one's biological nature as a male or a female. Gender role identity is the outward expression of maleness or femaleness (Conger, 1991).

l) The last subdimension of self-direction is cultural identity. Cultural identity is defined as the subjective sense of belonging to a culture (Dalal, 1999). It is an integral part of an individual's self and it may affect social and individual functioning of individuals leading to mental distress (Bhugra, 1999)

The third life task in the "Wheel of Wellness" model is work and leisure. Work and leisure involves satisfaction with one's work and time spent in recreation and leisure.

Work is one of the most fundamental life tasks that provide economic, psychological, and social benefits to the well-being of the individual and to others. It is well known that those who are unable to engage in work activities struggle psychological and economical problems to go on living (Myers et al., 2000)

In the Wheel of Wellness model, the major components of work life task are;

(a) Perception of adequacy of financial resources

(b) Job satisfaction

(c) Feeling that one's skills are used

(d) Perception of work overload

(e) Role conflict, role ambiguity

(f) Non-participation in decision making

(g) Satisfaction with relationships in the job setting

Leisure is defined in the Wheel of Wellness as “self-determined activities and experiences (engaged in) for mostly intrinsic satisfaction that are available due to having discretionary income and time” (Witmer & Sweeney, 1996, p. 91).

Major components of leisure include;

(a) Satisfaction with one’s leisure activities

(b) Importance of leisure

(c) Positive feelings associated with leisure

(d) Having at least one activity in which “I lose myself and time stands still”

(e) Ability to approach tasks from a playful point of view

(f) Ability to put work aside for leisure without feeling guilty

The fourth life task in the Wheel of Wellness model is friendship. Friendship incorporates all of an individual’s social relationships involving a sense of connection with others in a non-sexual manner. In the Wheel of Wellness model, life task friendship includes;

(a) Filial love- friendship, brotherly love

(b) Having social support when needed

(c) Being able to give social support

(d) Not feeling lonely due to lack of friends

(e) Sense of comfort in social situations

The fifth life task in the Wheel of Wellness model is love. Life task Love refers specifically to innate relationships with spouses or partners, family and extended family, and close friends. Love includes an intimate, trusting, self-disclosing, cooperative, and long-term relationship and often sexual relations with another person (Myers et al., 2000; Sweeney & Witmer, 1991; Witmer & Sweeney, 1992). The major components of life task love in the Wheel of Wellness are:

(a) Having faith that one's well-being will be respected and reciprocating by respecting the well-being of another

(b) Ability to be intimate, trusting, self-disclosing with another person

(c) Ability to receive as well as express affection with a significant other

(d) Capacity to experience or convey non-possessive caring that respects the uniqueness of another

(e) Presence of enduring, stable intimate relationship

(f) Act of concern for the nurturance and growth of others

(g) Recognize that others have concern for one's growth

(h) Physical satisfaction with sexual life/ needs for touch are being met

In addition, life task love involves having a family or family-like support system that provides following characteristics: shared coping and problem-solving skills, commitment to the family, good communication, encouragement of individuals, expression of appreciation, shared religious/spiritual orientation, social connectedness, clear roles, and shared interests, values and time (Myers et al., 2001). Myers et al. (2000) indicated

that coping successfully with the life task love is not only important but also necessary for life satisfaction, good health, and longevity, to conclude, for wellness.

These life tasks interact with and are affected by a variety of life forces, including government, business and industry, and the media, as well as global events.

2.2. Studies That Investigated the Factors Contributing Wellness

Numerous authors have defined wellness from a number of different perspectives. Several models have been proposed. This has resulted in the development of numerous instruments designed to assess various components of this construct (Palombi, 1992). Therefore, studies related to wellness have been conducted to investigate the factors that enhance wellness in several populations. For example, in their study of investigating the effects of wellness promoting guidance activities among elementary school children, Omizo & Omizo (1992) found that the children who participated in the guidance activities had significantly higher levels of self-esteem and knowledge of wellness information than the children who did not participate in the guidance activities

Abood & Conway (1992) examined the relationship between self-esteem, health values, specific health behaviours, and general practice of wellness behaviours in Navy personnel and found that health values predicted health behaviours and general practice of wellness behaviours. The results also revealed that self-esteem predicted general practice of wellness behaviours.

Epstein, Griffen and Botvin (2002) conducted a study to test whether competence (decision-making skills and self-efficacy) affects psychological wellness and alcohol use among adolescents. On the basis of a longitudinal structural equation model, adolescents who were highly competent reported greater psychological wellness, which was then associated with less drinking.

In their study that explored the self-report influence of initial sexuality information on the lifetime wellness of adolescent to adult males and females, Ansuini and Fiddler-Woite (1996) indicated that accurate sexuality information was extremely important to lifetime wellness, and ignorance was found to have produced guilt and illness in the majority of respondents.

Page (1990) investigated whether shy and super-shy adolescents suffer greater impairment in certain aspects than do those who are not shy. The results indicated that shy adolescents were less physically active, less likely to exercise, more hopeless, and more likely to maintain tendencies toward an eating disorder than those who are not shy.

Degges-White, Myers, Adelman and Pastoor (2003) investigated the relationship between wellness and perceived stress in a clinical headache population and found significant negative correlation's between wellness and perceived stress.

Garret (1999), in his study of assessing and comparing the wellness of Native American with Non-Native American high students, found that ethnicity did not have an overall effect on student wellness.

Dice (2002) conducted a study to investigate the relationship between coping resources, wellness, and attached companion animal ownership among older persons. The results indicated that the relationship among

wellness, coping resources, and level of attachment were positive and statistically significant.

2.3. Studies Regarding Wellness among College Students

Recently there has been considerable research into the measurement of college students' wellness because it is well documented that college students typically experience developmental and behaviour-associated threats to health that are unique to this phase in their lives (Adams & Bezner, 2000). There is a considerable amount of study in the literature that propose wellness programs for college students (Archer, 2001; Chandler, 1985; Davies, Davies & Heacock, 2002; Fedorovich & Boyle, 1992; Floater & Kulumpyan, 1998; Kelemen, 2001; Sivik, 1992; Sullivan, 1987; Warner, 1984; Weidel, 1998).

For example, Southern Illinois University at Carbobdale Wellness program was aimed to decrease the risk of disease and health problems related to AIDS, alcohol and drug problems, sexually transmitted diseases, poor nutrition, stress, poor self-esteem of African-American students (Combes-Small, 1991)

Despite, an increase in the number of wellness programs developed for college students, little has been published relative to their effectiveness on increasing student wellness.

For example, Murray and Miller (2000) assessed how college students rated the effect they believe each wellness dimension has on their overall wellness levels, the amount of guidance they believe they need in each dimension, and what they believe their current wellness level is with each

dimension before and after an introductory wellness course. Results indicated that students did recognize that each dimension affects their overall wellness to a moderate to strong degree.

Similarly, Peterson (1996) found that students who participated the wellness program adopted improved health behaviours and exhibited more positive life styles (exercise, nutrition, and self-care).

The earlier descriptive studies on wellness among college students focused on exploring the factors that effect students' level of wellness.

Barnes (1996) conducted a study to demonstrate the applicability of storyboarding technique for identifying the needs and components of wellness as seen by university students. Sixteen graduate students outlined personal habits, and skills useful for enhancing university students' wellness. These were humor, time management, creativity, counseling skills; know health options, appropriate health-seeking behaviours. They also outlined what they expect from wellness services as health assessments, health resources, health referrals, university-wide health promotion services, and improved access to prevent health services and insurance. This study indicated the importance of and the need for university health promotion activities as university members and staff come to view wellness as an integral part of the higher education system.

Oleckno and Blacconiere (1991) investigated the relation between religiosity and several aspects of wellness. The results indicated that religiosity was positively associated with wellness and with a number of health compromising behaviours.

The link between problem solving and wellness (conceptualized as health complaints and health-related expectancies) was examined among college students by Elliot and Marmarosh (1994). Results indicated that effective self-appraised problem solvers reported fewer physical symptoms and had greater internal and lower chance expectancies for health outcomes.

Bezner, Adams and Steinhardt (1997) studied the relationship of body dissatisfaction, restrained eating and core wellness to physical self-esteem. Three samples were used including undergraduate students, corporate employees, and fitness-club members. They assessed body shape perception, restrained eating, self-esteem, physical self-esteem, and overall wellness. The greater physical self-esteem was found to be related to lower body dissatisfaction, higher levels of overall wellness, and lower levels of restrained eating.

Hermon and Hazler (1999) investigated the relationship between college students' adherence to a five-factor (spirituality; work and leisure; self-regulation; friendship; and love) holistic wellness model and their self-reported levels of psychological well-being. Results indicated a significant relationship between the five factors of wellness and both short-term state, and long-term trait components of psychological well-being. Furthermore, results revealed that students' ability to self-regulate, identity with work, and friendships contributed most to their psychological well-being.

Spiritual wellness is an emerging area of interest in counseling, and it is investigated frequently among college students. For example, Lightsey (1996) completed a comprehensive review of the relationship between psychological resources (positive thoughts, hardiness, generalised self-

efficacy, and optimism) and wellness. The results of this study indicated that these psychological resources have been strongly correlated with wellness and resistance to stress. Both positive thoughts and optimism are the components of spirituality, as defined by Myers et al. (2000). The relationship between wellness and optimism was positive, such that persons with a high sense of well-being had a tendency to experience events in a positive manner.

The results of Adams and Bezner (2000) supported these findings. They conducted a study in order to investigate the relationship between measures of spiritual and psychological wellness and perceived wellness in a college student population. The results revealed that higher scores on perceived wellness were significantly related to higher scores on life purpose, optimism, and sense of coherence. However, the effect of life purpose on perceived wellness was found to be mediated by optimism, and sense of coherence. The findings suggested that an optimistic outlook and sense of coherence must be present for life purpose to enhance a sense of overall well-being.

These studies presented above provided support for the importance of spirituality as a core component of wellness.

On the other hand, Briggs (2001) examined the effects of spiritual wellness and its components on depression for older adolescents and for midlife adults. The components of the spiritual wellness were examined as follows; meaning and purpose in life, inner resources, positive interconnectedness, and transcendence. The results of the study showed no significant effects of the four components of spiritual wellness on depression

for either group. However, the four components of spiritual wellness accounted for % 31 of the variance in depression for older adolescents and % 52 of the variance in depression for midlife adults.

The relation between social support and wellness has been a fruitful research area in the literature. For example, Granello (1999) examined wellness, empathic ability, and social support networks of undergraduate students. The results of the study indicated a significant relationship between students' own ratings of wellness and their total wellness scores. Also a significant correlation between social network size, and perceived social support was found. However, the results did not support the assumption that college student's wellness could be significantly predicted by perceived support and emphatic ability. Granello argued that failure of this study to find a significant relationship and wellness may be related to participants age group, which may represent a developmental stage at which perceived social support and wellness are different than for either child or older adult stages.

Later, Granello (2001) studied in two different age groups in order to gain insight into how wellness and social support are affected by adult development. The participants were young adults who are undergraduate students and older adults who are staff at the university faculty. The results of the study indicated several interesting patterns. There were many differences between the younger and older participants in terms of both wellness and social support. The younger group had significantly higher overall wellness and also on nine of the sub-scales, whereas the older group scored higher than younger participants did on only one Self-Care sub-scale.

The other study indicated the effect of age on wellness was conducted by Hybertson, Hulme, Smith and Holton (1992). They examined the differences between wellness levels of traditional-age and non-traditional age students and investigated the personal and environmental factors that have an impact on wellness in both groups. The students ranged in age from 20 to 61 years. Those students whose age was equal or less than 25 were categorised as traditional-age students; whereas the students whose age was greater than 25, were categorised as non-traditional age students. The researchers administered a questionnaire that they developed, consisting three parts. In part I students were asked to rate on a 5-point scale, the importance of Hetler's (1984) dimensions; physical, emotional, spiritual, occupational, social, and intellectual. In part II, students were asked to choose 3 of 30 factors reflecting their life-style, and environment, which they believe the most essential to their personal wellness. In part III, they were asked to evaluate the effect of campus wellness-oriented services on their wellness-oriented life-styles. Significant differences were found between these two groups on the following dimensions; social, intellectual, spiritual, and physical. The non-traditional age students believed that the social dimension affects their wellness more than any other dimension. The environmental factors were found to positively and negatively affect older students' social support systems and social relationships. The results of the study indicated that quality of support systems and interpersonal relationships had an impact on wellness of older students.

Dixon (2002) conducted a study on minority adolescents in order to address minority and non-minority adolescent development. They examined

the relationship among ethnic identity, acculturation, mattering, and six dimensions of wellness (spirituality, self-direction, school-work, leisure, love, and friendship). The subjects of the study were 176 minority and 286 non-minority adolescents. The results indicated no significant differences in the mean scores of ethnic identity, acculturation, mattering, and wellness between the minority and non-minority groups.

Similarly, Supergeon (2002) designed a study to determine the proportion of variance for African American male college students explained by racial identity and self-esteem. The study also investigated the differences among the variables between students from Historically Black Colleges and universities (HBCU) and students from Predominantly White Institutions (PWIs). The results revealed that racial identity and self-esteem did not predict a significant proportion of the variance in wellness. However an analysis of variance indicated that there were significant differences between HBCUs and PWIs on eight of the 17-wellness scales. African American students at HBCUs had higher scores on friendship, love, sense of worth, emotional awareness and control, humor, and gender identity, whereas students attending PWIs scored higher on exercise and nutrition. This study suggested that a variety of variables needed to be considered in evaluating the overall wellness of minority groups.

Myers, Mobley & Booth (2003), in their study of wellness among 263 graduate students in counseling, found that counseling students experienced greater wellness than the general population. Significant within-group variability also existed. Doctoral students reported significantly greater wellness in most areas measured by the Wellness Evaluation of Lifestyle as

compared with new-entry students. Moderate effect resulted for Sense of Control, Intellectual Stimulation, Work, and Total Wellness. Caucasian counseling students reported lower wellness in Cultural Identity than the students who were not Caucasian did.

Brylinsky and Hoadley (1991) found a strong relationship between depression and wellness. They conducted a study in order to determine if there were differences in the wellness scores of college students reporting suicidal attempts and college students with non-suicidal tendencies. The results of descriptive statistics showed that % 16 of total population of this study reported they had seriously considered killing themselves within the past year. The number of students who indicated that they had attempted suicide prior to the testing period was 48 (% 4). 38 (% 79) students were female in the group of 48 suicidal subjects. Descriptive statistics revealed that the “Suicidal” and “At Risk” groups had poorer health risk behaviours than the “Control” group. An analysis of variance also indicated that “Suicide” and “At Risk” groups had significantly lower scores than “control” group on 8 of the 12 wellness inventory items, including physical sub-scales, that are self care, vehicle safety, drug use; emotional sub-scales that are emotional awareness and emotional management; spiritual sub-scale; social environmental sub-scale, and composite score. There were no significant differences between the groups on the scores of sub-scales of physical exercise, nutrition, intellectual wellness, and occupational wellness.

In spite of increasing interest in wellness on college campuses, there is limited empirical research that has been done to determine the effects of

certain background variables on wellness such as gender, relationship status, place of residence, class standing, etc.

Oleckno and Blacconiere (1990; as cited in Briggs, 2001) examined wellness of college students and differences by gender, race, and class standing. They administered the Health-Promoting Lifestyle Profile, which measures self-actualization, health responsibility, exercise, nutrition, interpersonal support, and stress management. The results revealed that women generally occupied higher levels of wellness than men, particularly on health responsibility, nutrition, and interpersonal support; while men didn't show high levels of wellness on any of the sub-scales. White individuals demonstrated higher levels of wellness than People of Colour did in this sample. Moreover, as class standing increased, levels of wellness also increased. In other words freshman were found to be less well compared to seniors.

2.4. Turkish Studies on Wellness

Despite increasing interest to study wellness in The United States, wellness is a new construct in Turkey. Therefore at present no published study that investigates the causes and correlates of wellness exists in Turkey. However there are studies which examined some variables that are related to the dimensions of wellness.

For example, Köknel (1979) conducted a study that investigated the problems of Turkish youth. The results of the study revealed that adolescents have a tendency to use self-defeating coping strategies such as suicide, drug addiction, delinquency, and alcohol when they face with stresses.

Similarly, Şahin, Rugancı, Taş, Kuyucu, and Sezgin (1992) examined the effect of coping strategies on stress symptoms and depression and found that freshman students were found to use helplessness approach more frequently where senior students used optimistic approach.

Some studies examined communication skills, interpersonal relationships, empathy, and loneliness among university students. For example, Demir (1990) found that university students who viewed themselves incompetent in interpersonal relationships felt lonelier than the ones who viewed themselves competent.

Similarly Hamarta (2000) carried out a study to examine the relationship between social skills and loneliness levels of university students. The results revealed that place of residence had a significant effect on social skills and class standing had a significant effect on loneliness levels of university students. The results also indicated a negative correlation between loneliness and social skills.

In her study of investigating the empathy levels of Hacettepe University students, Bozkurt (1997) found that female students had higher empathy scores compared to male students.

There are studies conducted to investigate the amount of irrational thinking among university students. For example, Yurtal (1999), in his study of examining irrational thinking levels of university students with respect to some variables, found that male students scored higher in blaming sub-scale than did females.

Self-esteem is another variable that was investigated with respect to wellness along with several other variables. For example, Maşrabacı (1994)

examined self-esteem of university students with respect to some variables. The results of the study indicated that self-esteem was negatively correlated with depression, physical symptoms, and positively correlated with having an opposite-sex friend, sufficient economic status, and close relationships with fathers.

Similarly, Gürkan (1990) found a negative relationship between self-esteem and depression, and anxiety among university students. Another study investigated the relationship between self-esteem and academic achievement and found a positive relationship between the variables (İnanç, 1997).

There are also studies conducted on problem solving among university students. For example, Basmacı (1998) investigated the problem solving skills of university students with regard to parental attitudes and gender. The results indicated that there was not a significant difference between problem solving skills of males and females. The results of Taylan (1990) were similar. He found that gender did not effect problem solving skills.

Humor is also another variable that was investigated with several other variables. For example, Aydın (1993) carried out a research on the role of humor along with some positive personality characteristics on predicting the physical symptoms of lycee and college students. Results indicated that internal-external locus of control; generalised achievement expectations and sense of humor were the predictors of physical symptoms of students.

In a similar vein, Durmuş (2000) investigated the relationship between sense of humor and coping strategies of college students. In terms of sense

of humor, significant differences were found between those with high and low sense of humor in optimistic and self-confident styles.

Locus of control has been another research area that is, although indirectly related with wellness, in Turkey. For example, Mizrahi (1993) found that people with low trait anxiety; internal orientation of locus of control, low pain intensity and high commitment level reported a high range of self-controlling and cognitive strategies.

Although these studies investigated variables related to wellness and provided valuable data, there is no published study in Turkish literature that investigated wellness in a holistic manner and incorporated all physical, psychological, emotional, intellectual and spiritual domains. Hence, this study aims to investigate the relationship between the factors such as gender, relationship status, place of residence and university students' wellness in Turkey.

CHAPTER III

METHOD

This chapter presents overall design of the study, research questions, hypotheses, description of variables, population and sample selection, data collection instruments, data collection procedure, data analysis methods and limitations of the study.

3.1. Overall Design of the Study

The purpose of this study was four fold: (1) to investigate the relationship between relationship status and wellness among university prep-school students, (2) to determine gender differences in wellness among university prep-school students, (3) to assess the differences in wellness in terms of place of residence of university prep- school students and (4) to determine the relationship between GPA and wellness among university prep-school students. The sample of this study consisted of 506 Başkent University prep-school students. Students were presented with Wellness Inventory and demographic data sheet.

3.2. Research Questions

The research questions were formulated as follows:

1. Are there any significant differences between wellness sub-scales' scores of university prep-school students with respect to relationship status?

2. Are there any significant differences between wellness sub-scales' scores of university prep-school students with respect to gender?

3. Are there significant differences between wellness sub-scales' scores of university prep-school students with respect to place of residence?

4. Are there any significant differences between wellness sub-scales' scores of university prep-school students with respect to GPA?

3.3. Hypotheses

1. There will be no differences between wellness sub-scales' scores of university prep-school students who are in a committed relationship status and who are not in a committed relationship status.

2. There will be no differences between wellness sub-scales' scores of male and female university prep-school students.

3. There will be no differences between wellness sub-scales' scores of university prep-school students with respect to place of residence.

4. There will be no differences between wellness sub-scales' scores of university prep-school students with respect to GPA.

3.4. Description of Variables

Wellness level: Refers to wellness level, measured by Wellness Inventory.

Relationship Status: This variable is a nominated dichotomous variable with categories of (1) Yes and (2) No.

Gender: This variable is a nominated dichotomous variable with categories of (1) Female and (2) Male.

Place of Residence: This variable is presented with categories of (1) With Family, (2) With Relatives, (3) With Friends, (4) Alone and (5) Dormitory.

GPA: This variable is presented with categories of (1) Below 50, (2) 50-70, (3) 70-80, (4) 80-90 and (5) 90-100.

3.5. Population and Sample Selection

The study was carried out on a sample of 506 prep-school students from Başkent University, selected through convinience sampling. The participants were from 22 classes that were eligible among 30 classes of Başkent University Prep-School. The answers of the participants were checked and 389 of 506 were taken into evaluation after elimination of uncompleted and faulty ones.

The mean age of students was 19.72 (SD = 1.84). Fifty five percent were females and 45 % were males. Their ages ranged between 17 and 32. Sixty three percent had not a close relationship with opposite sex and the remaining 37 % had a close relationship with the opposite sex. Nineteen percent's GPA were below 50, 32% had GPA between 50 and 70, 22 % had

GPA between 70 and 80, 18 % had GPA between 80 and 90, and trhe remaining 7 % had GPA between 90 and 100. Fifty-nine percent lived with their families, 6 % lived with relatives, 7 % lived with friends, 4 % lived alone, and the remaining 24 % lived at dormitoy.

3.6. Data Collection Instruments

Wellness Inventory was used in this study. Participants were also given the demographic data sheet.

3.6.1. Wellness Inventory

Wellness Inventory (WI) was developed by Güneri (2003). WI includes 104 items. The items except the diverse ones are rated on a 5-point likert scale ranging from (1) “strongly disagree” to (5) “strongly agree”. The diverse items are rated from (5) “stongly disagree” to (1) “strongly agree”. WI yields a total score. Higher scores indicate having high level of wellness.

To attain evidence for the conctruct validity of WI, a sepetare principal component analysis with varimax rotation followed by the Kaiser normalization procedure was applied to to WI. Results revealed 8 meaningful factors. Those factors and their range of loadings were (1) relational self, .674-.292, (2) social interest and empathy, .525-.310, (3) self-consistency, .510-.297, (4) mastery orientation, .558-.263, (5) physical wellness, .620-.263, (6) humor, .656-.392, (7) love, .715-.375, (8) enviromental sensitvity, .691-.290.

Relational Self consists of 19 items. An example of the items is “I feel comfortable in social settings”. Social Interest and Empathy consists of 11 items. An example of the items is “I am interested in the development and

well-being of others". Self-Consistency consists of 11 items. An example of the items is "I am generally a happy person". Mastery Orientation consists of 29 items. An example of the items is "I am aware of my interests and skills". Physical Wellness consists of 17 items. An example of the items is "I do exercise regularly". Humor consists of 6 items. An example of the items is "I can laugh at myself". Love consists of 4 items. An example of the items is "I am in a committed relationship with a person whom I do trust". Environmental Sensitivity consists of 7 items. An example of the items is "I am interested in things happen in the world". Each sub-scale is scored separately. The higher scores indicate high level of wellness in each sub-scale.

For WI, reliability coefficients were; .94 for the overall scale, .88 for the first sub-scale (Relational self), .76 for the second sub-scale (Social interest and empathy), .80 for the third sub-scale (Self consistency), .91 for the fourth sub-scale (Mastery orientation), .76 for the fifth sub-scale (Physical wellness), .59 for the sixth sub-scale (Humor), .72 for the seventh sub-scale (Love), .77 for the last sub-scale (Environmental sensitivity).

3.7. Data Collection Procedure

The procedure in the present study was completed in five consecutive phases. First, the necessary permission to carry out research was taken from Başkent University. Second, the researcher attended a meeting with the administrators of Başkent University Prep-School. During this meeting the study was explained and the questions of the administrators were answered and their help was asked for the administration of the measures. Third, booklets including a cover letter, demographic data sheet and Wellness

Inventory were given to prep-school's secretary. Fourth, prep- school's administrators asked instructors to obtain booklets from secretary's office and apply them in their classrooms. Fifth, instructors administered the measure and returned them to prep-school secretary. It was reported that questionnaires took approximately thirty minutes to complete.

3.8. Data Analysis Procedures

The answers of the participants were checked and 389 of 506 were taken into evaluation after elimination of uncompleted and faulty ones.

In order to investigate the differences between wellness sub-scale (relational self, social interest and empathy, self-consistency, mastery orientation, physical wellness, humor, love, and environmental sensitivity) scores of subjects with respect to certain background variables (relationship status, gender, place of residence and GPA), four separate one-way MANOVA's were conducted.

All the analysis was carried out by using the relevant subprograms of SPSS, version 10.0.

3.9. Limitations of the Study

In the light of this study, possible limitations should be considered. First, most serious limitation seems to be some parts of the data collection procedure. Due to the absence of the researcher, there is a possibility that students might not read the cover letter during the administration of the measures.

Second, the sample of this study was limited to Başkent University prep-school students. Hence, generalisation of the findings to other populations is limited.

Third limitation might be owing to the self-report nature of the study; the results might not reflect the students' actual wellness levels.

CHAPTER IV

RESULTS

In this chapter, the results of four separate MANOVA's which were carried out to investigate the mean differences between wellness sub-scales' scores with respect to relationship status, gender, place of residence and GPA are presented.

4.1. Results Regarding the Relationship between Relationship Status and Wellness.

The second research question of the present study was "Are there any significant differences between wellness sub-scales' scores of university prep-school students with respect to relationship status?" In order to determine the mean differences between wellness sub-scales' scores with respect to relationship status, a one-way multivariate analysis of variance (MANOVA) was conducted on mean WI sub-scales' scores of students.

Table 4.3 presents the means and standard deviations of the WI sub-scales' scores of the students in relation to relationship status.

Table 4.1. *Means and Standard Deviations of the WI Sub-scales' scores by Relationship Status*

Wellness	Relationship Status	*M*	*SD*	*N*
Relational Self	No	79.24	10.96	242
	Yes	80.82	10.81	140
Social Interest And Empathy	No	42.74	6.33	242
	Yes	42.39	6.12	140
Self-Consistency	No	44.77	8.87	242
	Yes	45.64	8.94	140
Mastery Orientation	No	109.81	14.04	242
	Yes	110.08	16.58	140
Physical Wellness	No	55.50	9.77	242
	Yes	53.12	10.33	140
Humour	No	21.09	3.91	242
	Yes	20.80	3.75	140
Love	No	11.51	3.39	242
	Yes	16.67	3.06	140
Environmental Sensitivity	No	26.35	4.55	242
	Yes	26.17	5.20	140

The one-way multivariate analysis of variance (MANOVA) which was conducted to determine the effect of relationship status on wellness sub-scales' scores indicated significant differences among groups on the dependent measures, Wilks' λ = .59, F [8, *373*] = 31.98, $p < .00$. The multivariate η^2 based on Wilks' λ was satisfactory, .40. Analyses of variances (ANOVA) on each dependent variable was conducted as follow-up tests to MANOVA (See Table 4.3). The ANOVA on physical wellness (F [*1, 380*]= 5.05, η^2 = .013, $p < .05$) and love (F [1, *380*]= 220.57, η^2 = .00, $p < .01$) sub-scales of WI were significant.

Table 4. 2. *The Results of the Analysis of Variance Applied to WI Sub-scales' scores of Students With Respect to Relationship Status.*

Source	Wellness	*df*	*F*	η^2	*p*
Relationship Status	Relational Self	1	1.86	.01	.17
	Social Interest	1	.29	.00	.59
	Self-Consistency	1	.84	.00	.36
	Mastery Orientation	1	.03	.00	.87
	Physical Wellness	1	5.05*	.01	.02
	Humor	1	.50	.00	.48
	Love	1	220.57**	.67	.00
	Environmental Sensitivity	1	.12	.00	.73

* $p < .05$, ** $p < .01$

The results indicated that the students who were in a committed relationship scored higher in love sub-scale (*M*=16.68, *SD*=3.06) than the students who were not (*M*=11.51, *SD*=3.39). On the other hand, the students who were not in a committed relationship scored higher in physical wellness sub-scale (*M*=55.50, *SD*=9.77) than the students who were in committed relationship (*M*=53.12, *SD*=10.33).

4.2. Results Regarding the Relationship between Gender and Wellness

The first research question of the present study was "Are there any significant differences between sub-scales' scores of university prep-school students with respect to gender?" Therefore, to determine the mean differences between wellness sub-scales' scores of male and female students, a one-way multivariate analysis of variance (MANOVA) was conducted on mean WI sub-scales' scores of students.

Table 4.1 presents the means and standard deviations of the WI sub-scales' scores of male and female students.

Table 4.3. *Means and Standard Deviations of the WI Sub-scales' scores of the Students by Gender.*

Wellness	Gender	*M*	*SD*	*N*
Relational Self	Female	80.63	10.45	214
	Male	78.87	11.36	174
Social Interest	Female	43.30	5.46	214
And Empathy	Male	41.86	6.88	174
Self-Consistency	Female	44.05	9.05	214
	Male	46.46	8.57	174
Mastery	Female	108.83	15.43	214
Orientation	Male	111.39	14.24	174
Physical	Female	54.74	10.08	214
Wellness	Male	54.71	9.97	174
Humour	Female	20.88	3.98	214
	Male	21.14	3.68	174
Love	Female	13.00	4.35	214
	Male	13.91	3.72	174
Environmental	Female	25.65	5.02	214
Sensitivity	Male	27.03	4.32	174

The one-way multivariate analysis of variance (MANOVA) which was conducted to determine the effect of gender on wellness sub-scales' scores indicated significant differences among male and female students on the dependent measures, Wilks' λ = .89, F [8, *379*] = 5.96, $p < .001$. The multivariate η^2 based on Wilks' λ was .11. Analyses of variances (ANOVA) on each dependent variable was conducted as follow-up tests to MANOVA (See Table 4.2). The ANOVA on social interest and empathy (F [*1, 386*]= 5.27, η^2 = .013, $p < .05$), self-consistency (F [1, *386*]= 7.19, η^2 = .018, $p <$ .01), love (F [*1, 386*]= 4.70, η^2 = .012, $p < .05$), and environmental sensitivity (F [*1, 386*]= 68.15, η^2 = .021, $p < .01$) sub-scales' scores of WI were significant.

Table 4.4. *The Results of the Analysis of Variance Applied to the WI Sub-scales' scores of Students With Respect to Gender.*

Source	Wellness	*df*	*F*	η^2	*p*
Gender	Relational Self	1	2.50	.01	.11
	Social Interest	1	5.27*	.01	.02
	Self-consistency	1	7.19*	.02	.01
	Mastery Orientation	1	2.84	.01	.09
	Physical Wellness	1	.00	.00	.97
	Humour	1	.44	.00	.51
	Love	1	4.70*	.01	.03
	Environmental Sensitivity	1	8.15**	.02	.00

* $p < .05$, ** $p < .01$

The results indicated that male students scored higher in self-consistency (*M*=46.46, *SD*=8.57), love (*M*=13.90, *SD*=3.72), and environmental sensitivity (*M*=27.03, *SD*=4.32) sub-scales than did the female students (*M*=44.04, *M*=13.00, *M*=25.65; *SD*=9.05, *SD*=4.35, *SD*=5.02, respectively). On the other hand, female students scored higher in social interest and empathy sub-scale (*M*=43.29, *SD*=5.46) than the male students (*M*=41.86, *SD*=6.88).

4.3. Results Regarding the Relationship between Place of Residence and Wellness.

The third research question of the present study was "Are there any significant differences between wellness sub-scales' scores of university prep-school students with respect to place of residence?" To determine the mean differences between wellness sub-scales' scores with respect to place of residence, a one-way multivariate analysis of variance (MANOVA) was conducted on mean WI sub-scales' scores of students.

Table 4.5 presents the means and standard deviations of the WI sub-scales' scores of the students with regard to place of residence.

Table 4. 5. *Means and Standard Deviations of the WI Sub-scales' scores of Students by Place of Residence*

Wellness	Relationship Status	*M*	*SD*	*N*
Relational Self	With Family	79.84	11.14	231
	With Relatives	81.37	10.55	25
	With Friends	82.70	8.10	16
	Alone	77.86	13.87	14
	Dormitory	79.00	10.54	93
Social Interest And Empathy	With Family	42.41	6.18	231
	With Relatives	43.13	5.35	25
	With Friends	43.97	7.28	16
	Alone	42.72	7.04	14
	Dormitory	42.61	6.11	93
Self-Consistency	With Family	45.34	8.99	231
	With Relatives	46.81	8.88	25
	With Friends	45.00	9.98	16
	Alone	47.15	7.80	14
	Dormitory	43.99	8.58	93
Mastery Orientation	With Family	109.67	14.80	231
	With Relatives	112.80	13.09	25
	With Friends	112.74	12.28	16
	Alone	109.93	20.05	14
	Dormitory	109.37	15.70	93
Physical Wellness	With Family	55.91	10.02	231
	With Relatives	54.32	11.59	25
	With Friends	51.62	7.89	16
	Alone	52.93	7.91	14
	Dormitory	52.97	10.06	93
Humor	With Family	21.39	3.60	231
	With Relatives	21.33	4.77	25
	With Friends	21.04	3.59	16
	Alone	20.29	3.94	14
	Dormitory	20.07	4.13	93
Love	With Family	13.56	3.91	231
	With Relatives	12.80	4.50	25
	With Friends	14.50	3.53	16
	Alone	13.79	4.30	14
	Dormitory	12.87	4.54	93
Environmental Sensitivity	With Family	25.10	4.57	231
	With Relatives	26.84	3.90	25
	With Friends	27.85	3.94	16
	Alone	26.86	6.24	14
	Dormitory	26.36	5.42	93

The results of one-way MANOVA did not yield significant effect of place of residence on the mean WI sub-scales' scores of the students. No significant differences were identified between the sub-scales' scores of WI among students with different places of residence, Wilks' λ = .89, F [32, 1391.90] = 1.43, p = .09. The multivariate η^2 based on Wilks'λ was .97.

4.4. Results Regarding the Relationship between GPA and Wellness.

The fourth research question of the present study was "Are there any significant differences between wellness sub-scales' scores of university prep-school students with respect to GPA?" Therefore, to determine the mean differences between wellness sub-scales' scores with respect to GPA, a one-way multivariate analysis of variance (MANOVA) was conducted on mean WI sub-scales' scores of students.

Table 4.6 presents the means and standard deviations of WI sub-scales' scores of the students with respect to GPA.

Table 4. 6. *Means and Standard Deviations of the WI Sub-scales' scores of Students by GPA*

	GPA	*M*	*SD*	*N*
Relational Self	Below 50	79.60	11.39	72
	50-70	79.67	11.11	126
	70-80	81.06	9.14	86
	80-90	78.99	11.04	71
	90-100	82.40	11.45	28
Social Interest	Below 50	43.50	6.61	72
And Empathy	50-70	42.11	7.20	126
	70-80	42.88	4.78	86
	80-90	42.03	5.38	71
	90-100	43.68	6.58	28
Self-Consistency	Below 50	43.81	9.20	72
	50-70	44.36	10.22	126
	70-80	46.41	6.53	86
	80-90	46.55	7.78	71
	90-100	46.72	9.26	28
Mastery	Below 50	106.31	14.71	72
Orientation	50-70	108.28	16.33	126
	70-80	111.63	11.39	86
	80-90	113.02	13.94	71
	90-100	117.58	16.68	28
Physical	Below 50	55.53	9.32	72
Wellness	50-70	54.53	11.36	126
	70-80	54.81	9.18	86
	80-90	54.60	9.81	71
	90-100	53.22	8.63	28
Humour	Below 50	21.24	4.01	72
	50-70	20.85	3.79	126
	70-80	21.76	3.27	86
	80-90	20.34	4.15	71
	90-100	20.68	4.40	28
Love	Below 50	13.42	3.76	72
	50-70	13.37	4.04	126
	70-80	13.68	4.04	86
	80-90	13.53	4.21	71
	90-100	12.86	5.05	28
Environmental	Below 50	26.57	5.55	72
Sensitivity	50-70	26.13	4.78	126
	70-80	26.05	4.16	86
	80-90	26.36	4.46	71
	90-100	27.54	5.24	28

The one-way multivariate analysis of variance (MANOVA) which was conducted to determine the effect of GPA on wellness sub-scales' scores

indicated significant differences were between groups on the dependent measures, Wilks' λ = .85, F [32, 1369.78] = 1.93, $p < .00$. The multivariate η^2 based on Wilks' λ was quite strong, .04. Analyses of variances (ANOVA) on each dependent were conducted as follow-up tests to MANOVA (See Table 4.7). The ANOVA on mastery orientation sub-scale (F [*4, 378*]= 4.46, η^2 = .045, $p < .01$) was significant.

Table 4. 7. *The Results of the Analysis of Variance Applied to WI Sub-scales' scores of Students With Respect to GPA.*

Source	Wellness	*df*	*F*	η^2	*p*
Relationship Status	Relational Self	4	.77	.01	.55
	Social Interest	4	.98	.01	.43
	Self-Consistency	4	1.77	.02	.14
	Mastery Orientation	4	4.47*	.04	.00
	Physical Wellness	4	.29	.00	.89
	Humor	4	1.53	.01	.20
	Love	4	.24	.00	.93
	Environmental Sensitivity	4	.63	.00	.65

* $p < .01$

Post-hoc analysis to the univariate ANOVA for the sub-scales' scores of WI consisted of conducting pairwaise comparisons to find which GPA level affected the WI sub-scales' scores most strongly. To control Type I Error, each pair wise comparison was tested at the .25 level. Results indicated that GPA level 5 (90-100) scored significantly higher on mastery orientation sub-scale of WI than the GPA level 1 (Below 50) and 2 (50-70).

Overall, the results of the present study revealed significant gender differences in self-consistency, love, environmental sensitivity sub-scales in favor of male students, but in social interest and empathy sub-scale in favor of female students. The findings also yielded that the students who were in a

committed relationship scored significantly higher in love sub-scale than the students who were not in such a relationship. The results also revealed that the students who were not in a committed relationship scored higher in physical wellness sub-scale than the students who were committed to a close relationship. The results also revealed that GPA level 5 which is the highest level (90-100), in other words students who had the highest GPA scores scored significantly higher on mastery orientation sub-scale of WI than the GPA level 1 (Below 50) and 2 (50-70).

CHAPTER V

DISCUSSION

This chapter presents the discussion and interpretation of the results, implications of the findings and recommendations for further research.

5.1. Discussion of the Results

5.1.1. Discussion Regarding the Relationship between Wellness and Relationship Status

The results of MANOVA indicated that the students who were in a committed relationship scored significantly higher in love sub-scale than the students who were not. On the other hand, the results revealed that the students who were not in a committed relationship scored higher in physical wellness sub-scale than the students who were in a committed relationship.

Being in a committed relationship has long been recognised as one of the charesterictics of self-actualizing persons (Maslow, 1954). Fromm (1962) defined love as an act of concern for the life and growth for who is loved. McCabe (1984) argued those three reasons for dating during adolescence: (1) sexual experimentation; (2) companionship (interaction and shared activities in opposite gender relationship; and (3) intimacy (an opportunity to establish a unique meaningful relationship with a person of the opposite

gender). Paul and White (1990) further pointed out the significance of dating relationships in both identity and intimacy development in the progress of late adolescence through young adult. It is reasonable to suggest that the impact of being in a committed relationship on general student wellness is significant since by means of such kind of a relationship they learn intimate interaction or dyadic relationships.

Since there is no published study in literature that investigated the effect of relationship status on university students' wellness, it is not possible to interpret the results of the present study as compared to previous findings. However, In Turkey there are limited published studies that investigated the effects of relationship status on some psychological variables such as self-esteem and loneliness. For example, Çanakçı (2000) found significant differences among self-esteem scores of those students who "always experience dating relationship", "previously experienced dating relationship", "presently experience dating relationship", and have "never experienced dating relationship". The results of the study indicated that, students who were "presently" dating and those who have "never" experienced dating relationship had relatively lower self-esteem compared to those who "always" experience dating relationship.

Similarly, Güngör (1996) found that students who had a date were less lonely than those who did not have a date were. The results revealed that absence of a romantic partner was the best predictor for emotional loneliness.

Oral (1994), in her study of investigating the stress events and coping strategies of Turkish adolescents and young adults, found that the most

frequently reported stress events were related to interpersonal relations, followed by academic problems, and loss of a significant other.

Making inferences from the studies mentioned above, it could be argued that being or not being in a committed relationship has a significant positive effect on several dimensions of wellness (such as self-esteem, coping with stress) which are strongly related to psychological health.

On the other hand, the situation appears to be reverse in physical health. The finding, which indicated that not being in a committed relationship made significant differences in terms of physical wellness sub-scale, seems to be interesting. This finding is inconsistent with the results of several studies. There have been several important and influential studies published over the last 40 years providing evidence for the negative effects of absence of close relationships in both physical and psychological health (Berkman & Syme, 1979; Shek 1995). There are also studies of which results indicate that having a close, supportive relationship and being able to love are the predictors of good physical and mental health (Lawler, Volk, Viviani, & Mengel, 1990; May, & Logan, 1993; Sarason, Shearin & Pierce, 1987). Winefield, Winefield, & Tiggeman (1992) found that contacting with caring others is associated with better physical and emotional responses.

One explanation for this finding might be that Turkish students who are not in a committed relationship might have a strong need to be perceived physically healthy and fit by the opposite sex. Therefore, they may pay more attention to their health and appearance. On the other hand, the students who are in a committed relationship might be already perceived as attractive

by the opposite sex and physical health and appearance may not be the primary focus of their life.

5.1.2. Discussion Regarding Gender Differences in Wellness

The results of the MANOVA employed to the eight wellness sub-scales' scores of the students revealed significant gender differences in self-consistency, love, environmental sensitivity, and social interest and empathy sub-scales. The results also indicated that females scored higher in social interest and empathy sub-scales while males scored higher in self-consistency, love and environmental sensitivity sub-scales.

The lack of direct evidence in the literature regarding gender differences in student wellness made it difficult to interpret the findings of the present study. Although in one study, (Oleckno and Blacconiere, 1990; as cited in Briggs, 2001) the relationship between gender and wellness has been investigated in college student population, the results revealed inconsistent findings. They found that females generally occupied higher levels of wellness than men, particularly on health responsibility, nutrition, and interpersonal support, while males did not score higher on any of the other wellness sub-scales (self-actualisation, health responsibility, exercise, nutrition, interpersonal support, and stress management).

Since there is no published study in Turkish literature that investigated gender differences in wellness, it is not possible to interpret the results of the present study as compared to previous findings in Turkey. However, the socialisation process can explain the gender differences that are obtained in this study.

The results of the present study indicated that male students scored higher on mastery orientation and environmental sensitivity sub-scales. In Turkish society, girls have been rewarded for engaging in nurturing, supportive, and emphatic relationship behaviours, whereas boys have been rewarded for engaging in traditionally masculine behaviours such as achievement, competition, and independence (Kağıtçıbaşı, 1982). Although strong emotional ties are encouraged among all family members in Turkish culture, the parents encourage their daughters to be dependent and obedient, where as boys are allowed to be more aggressive and independent since they are expected to cope with the outside world (Dilek, 1997).

Within such a family environment, as findings of the present study indicated, it might not be surprising that males internalise more responsibility to achieve success and give interest to what happens in the world.

Another finding of this study revealed that male students scored higher in love sub-scale than females. This finding may be explained by the results of another study carried out by Ekşi (1982) which revealed that females tend to have difficulty in establishing relations with the opposite-sex. They tend to form more intimate relations with the same sex than the males. Another study conducted by Özgüven (1974) indicated similar results. So, it can be argued that having an opposite sex friend might be a difficult kind of relation for females. Another reason for this finding may be the cultural characteristics of Turkish society in which dating is a desirable behaviour for males more than for females. While girls spend most of their time in their home environment, boys are let to do outside with peers (Erkut, 1987).

The other finding of the present study which indicated that females had higher scores in social interest and empathy sub-scale is in line with feminist theories which describe females in more relational, care oriented roles (e.g. Gilligan, 1982). This finding is also consistent with the findings of Çok (1993) which showed that females reported greater emotional intimacy with their friends, showed greater loyalty and trust on their friends. The results of another study which was carried out by Yıldırım (1997) are also in line with the results of the present study. He found that females value their friendships and communication skills more than do males. Similarly, Anamur (1998) in her study of investigating sex differences in individuals' self-conceptions and their sources of self-esteem, females were found to mention more allocentric, having relational characteristics and small group memberships.

To summarise, sex difference between males and females in the sub-scales of WI may be the consequence of the effect of the gender role socialisation.

5.1.3. Discussion Regarding the Relationship between Wellness and Place of Residence

The results of MANOVA did not yield significant effect of place of residence on the mean WI sub-scales' scores of the students.

Since there is no published study in literature that investigated the effect of place of residence on wellness for university students, it is not possible to interpret the results of the present study as compared to previous findings. However, in Turkey there are several published studies investigating

the relationship between place of residence and some other psychological variables such as depression, loneliness, etc. However, research on the influence of place of residence on some psychological variables appears to reflect mixed findings. For example, Anamur (1998) found living with family to be positively related to individualistic orientation for university students. On the other hand, the results of her study also indicated that living with family was associated with higher importance given to interpersonal relationships.

Kızıltan (1984) indicated that the university students who were living with their family and living alone had higher levels of adjustment to university life than the students ho were living at dormitory or with relatives.

The results of the study carried out by Lostar (1998) showed that the students who were living in dormitory had higher levels of depression than the students who were living with their families.

In contrast to findings above, Maşrabacı (1989) investigated the relationship between place of residence and psychological health and did not find a significant relationship. Similarly, in the study of Kılıç (1987), no significant relationship was found between place of residence and psychological symptoms.

For instance, Hamarta (2000), in his study of investigating loneliness and social skills levels of university students, indicated that place of residence had an overall effect on social skills levels of the students. The students who were living in dormitory had higher levels of social skills than the students who were living at home did. The results of the study also revealed that the place of residence did not affect the loneliness levels of the students.

It is clear that the relationship between place of residence and some psychological variables is unresolved and requires further study. The findings of the present study did not seem to contribute to the resolution of this controversy.

However one feasible explanation of the result of this study might be that attachment and support from parents might be a very important predictor of positive adjustment to university life for the subjects of this study. Kağıtçıbaşı (1996) suggested that Turkish society could be considered as "culture of relatedness" considering that emotional ties are encouraged among all family members. Kenny and Rice (1995) argued that adaptation to university could be explained in terms of Bowlby's (1973) attachment model. Attachment may be defined as an emotional bond between parent and child. According to Kenny and Rice (1995), the degree of adaptability to stress experienced by students entering university is associated with the perceived availability, responsiveness, and reliability of the attachment figure (the parent). This attachment model predict that students who have supportive links with parents (regardless of whether they live with their parents or not) should successfully cope with new stresses better than those who do not have such supportive relationships. In the study she conducted with Turkish University students, Orung (1998) suggested that, due to advances in telecommunication, technology, emotional interdependence between family members was mentioned even whey they were physically distant.

More extensive outreach may be needed to identify the effects of place of residence on physical and psychological health of university students

5.1.4. Discussion Regarding the Relationship between GPA and Wellness.

Results of MANOVA indicated that students with highest GPA (90-100) scores scored significantly higher on mastery orientation sub-scale of WI than students with lower GPA levels.

There is no published study in literature that investigated the effect of GPA on wellness. Hence it is not possible to interpret the results of the present study as compared to previous findings. However, in the present study mastery orientation sub-scale includes items related with the ability to learn at school, short range planning and long range planning, awareness of skills which are similar to the dimensions of academic self-concept. A number of studies were conducted to investigate the relationship between academic self-concept and academic achievement and they all revealed a positive correlation (Mboya, 1993).

Mboya (1993) indicated that self-concept of academic ability refers to students' perceptions of themselves as students. Self-concept also includes the ability to learn at school. In his study, he found that females had higher scores on self-concept of academic ability and on academic achievement than did boys.

The study conducted by Gadzella and Williamson (1984) investigated the relationship between self-concept and academic achievement among

university students. The results of the study indicated a significant relationship between high scores of self-concept and high GPA.

Gadzella, Williamson and Ginther (1985) conducted another study to examine the relationship between self-concept, locus of control and academic achievement. The results of this study indicated that academic achievement is significantly related to self-concept in the case of males.

Macan, Shahani, Dipboye and Philips (1990) carried out a study on university students and found that the students who perceived themselves to have control over their time felt fewer school and somatic tensions than did the students who did not perceive themselves to have control over their time. The results of a study conducted in Turkey suggested that time management practices and academic achievement were related with each other (Alay, 2000).

However, the results of the studies mentioned above do not explain the effect of GPA on student wellness. Further research seems to be needed to deeply understand the relationship between GPA and wellness.

5.2. Implications of the Findings.

Several implications may be drawn from the findings of the present study for counselors, educators and families. The results of this study pointed to the importance of the effects of gender, relationship status and GPA on student wellness. Hence, the results of this study may provide valuable data for university administrators, counselors and educators. More specifically, the results of the present study pointed out that male students had higher levels of wellness in self-consistency, love, and environmental sensitivity sub-

scales, where females scored higher in social interest and empathy sub-scale in the inventory. One implication that can be drawn from the findings of the present study is that, gender differences in wellness are important among late adolescents. Therefore, counselors working from a holistic or wellness perspective should understand that what indicates to wellness for males may not be the same for females. Consideration of gender differences in wellness will aid the counselors in setting appropriate treatment goals.

Second implication of the findings might be that when working from a holistic perspective, counselors should keep in mind that perceptions of wellness vary with respect to individual's relationship status. As mentioned earlier, it is reasonable to suggest that the impact of being in a committed relationship on student wellness is significant since by means of such kind of a relationship both sexes learn intimate interaction or dyadic relationships.

Finally, making inferences from the results of this study that point out the differences among students with respect to some factors, it can be suggested that wellness courses should be the part of the curriculum. Hence, as the findings of other studies indicated student wellness can be enhanced positively by providing them accurate knowledge (McClanahan, 1993)

5.3. Recommendations for Further Research

Because this study is one of the first attempts to investigate wellness in the university population in Turkey, the results are clearly preliminary. Much more remains to be done. Certainly, further research with larger and more demographically diverse populations would strengthen the findings of

this study. Therefore, it is suggested to conduct future studies with samples from different universities, different regions of Turkey.

Another suggestion for future research might include conducting further studies that investigate the perceptions of relationships of different age populations as well as examining the influence of age on the ratings of wellness.

An additional suggestion can be made about the data collection procedure. Future research should consider the limitations of the data collection procedure used in the present study and try to provide the participants with relevant varbal instructions made by the researcher.

Furthermore, future directions for research with university students may include studies that examine the relationship between an individual's perceptions of his or her wellness and actual health behaviours.

Finally, future research in this area should consider involving diverse samples within demographical and psychological variables. As mentioned in the introduction section, wellness has been found to be associated with a wide range of psychological variables (e.g., problem solving, self-esteem, spirituality, and optimism). All of these variables may be studied in relation to wellness in Turkish samples.

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APPENDICES

APPENDİX A
(In Turkish)

DEMOGRAFİK VERİ FORMU

Sayın Öğrenci,

Bu çalışmanın amacı Başkent Üniversitesi Öğrencilerinin sağlıklı yaşam biçimine sahip olmaları ile ilişkili faktörleri incelemektedir. Aşağıda size bu amaçla bir bilgi formu ve bir anket verilmiştir. Bilgi formunda ve ankette yer alan sorulara vereceğiniz içten ve samimi cevaplar araştırmanın amacına ulaşması açısından büyük bir önem taşımaktadır. Size yöneltilen sorulara vereceğiniz cevaplar gizli kalacak ve sadece araştırma kapsamında kullanılacaktır. Anketlerin üzerine lütfen adınızı yazmayanız.

Yardımlarınız için teşekkürler.

Tuğba Sarı

ODTÜ Eğitim Fakültesi
Eğitim Bilimleri Bölümü

Açıklama: Aşağıdaki formu okuyup sizin için uygun olan cevapları işaretleyiniz.

1. Cinsiyetiniz: K □ E □

2. Akademik ortalamanız (Girdiğiniz sınavların ortalaması):

50’den düşük □
50-70 □
70-80 □
80-90 □
90-100 90-100 90-100 □

3. Nerede kalıyorsunuz ?

Ailemle birlikte □
Akrabalarımın yanında □
Arkadaşlarım ile evde □
Yalnız evde □
Yurtta □

4. Aşağıdaki ifadelerden hangisi sizin şu anki duygusal ilişki durumunuzu tanımlıyor?

Ciddi bir duygusal ilişkim yok □ Ciddi bir duygusal ilişkim var □

APPENDIX B
(In Turkish)

İYİLİK HALİ ENVANTERİ

Aşağıda size sağlıklı yaşam biçimi ile ilgili çeşitli maddeler verilmiştir. Her bir maddeyi lütfen dikkatle okuyunuz ve genel olarak nasıl davrandığınızı ve kendinizi nasıl hissettiğinizi düşünerek, maddenin sağında yer alan **kesinlikle katılıyorum, katılıyorum, kararsızım, katılmıyorum ve kesinlikle katılmıyorum,** seçeneklerinden sizin için en uygun olanı işaretleyiniz. Her bir ifadeyi işaretleyiniz ve lütfen işaretlenmemiş madde bırakmayınız.

	Kesinlikle Katılıyorum	Katılıyorum	Kararsızım	Katılmıyorum	Kesinlikle Katılmıyorum
1. Her akşam o günün benim için ne ifade ettiğini düşünürüm.					
2. İyi anlaşacağımı düşündüğüm kişiler ile arkadaşlıklar başlatır ve sürdürürüm.					
3. Başkaları ile olan anlaşmazlıklarımı, çatışmalarımı olumlu bir şekilde, saygı sınırları içinde çözerim.					
4. Kendimi sık sık nedenini bilmediğim bir üzüntü hali içinde bulurum.					
5. Günde en az beş porsiyon meyve veya sebze yerim.					

	Kesinlikle Katılmıyorum	Katılıyorum	Kararsızım	Katılmıyorum	Kesinlikle Katılmıyorum
6. Ciddi bir işte bile mizahi bir yön görürüm.					
7. Dergi, gazete ve kitaplardan değişik konular hakkında bilgi edinirim.					
8. Sorunlarımı çözerken hayal gücümü, bilgimi ve yeteneklerimi etkili bir şekilde kullanabilirim.					
9. Davranışlarımın sorumluluğunu alırım.					
10. Başkalarının gereksinimlerine duyarlıyımdır.					
11. Beklentilerim gerçekleşmediği için sık sık hayal kırıklığı yaşarım.					
12. Boş zaman etkinlikleri hayatımda önemli bir yer tutar.					
13. Bazen başkalarını utandıracak espriler yaparım.					
14.Kendi hakkımdaki duygu ve düşüncelerim olumludur.					
15. Değerli bir insan olduğuma inanıyorum.					
16. Başkalarının görüş ve düşüncelerine ilgi duyarım.					
17. Bende strese neden olan düşüncelerin üstesinden gelebilirim.					
18. Günlük beslenmem tüm tahılları, sebzeleri ve meyveleri içeren çeşitliliktedir.					
19. Olumlu duygularımı olumlu bir şekilde ifade edebilirim.					
20. Gerektiğinde bana destek olacak arkadaşlarım ve/veya yakınlarım var.					
21. Diğer insanları olduğu gibi kabul edip, değiştirmeye çalışmadan severim.					
22. Genel olarak mutlu bir insanım.					
23. Arabaya her binişimde mutlaka emniyet kemeri takarım.					
24. Hayatımı kendi isteklerime göre yönlendirebiliyorum.					
25. Duygularımdan kendimin sorumlu olduğunu bilirim.					
26. Diğer insanlar ile aramda bir duygusal bağlılık, yakınlık hissederim.					
27. Genel olarak hayatımdan memnunum.					
28. Öfkemi kontrol ederim.					
29. Dünyada olup bitenler ile ilgiliyimdir.					
30. Amaç ve hedeflerimi gerçekleştirmek için planlı olarak çaba gösteriyorum.					

	Kesinlikle Katılıyorum	Katılıyorum	Kararsızım	Katılmıyorum	Kesinlikle Katılmıyorum
31. Diğer insanların benim iyiliğim ve gelişimim konusundaki duyarlılıklarını ve ilgilerini fark edebilirim.					
32. Diğer insanları sözlerini kesmeden ve onların cümlelerini tamamlamadan dinlerim.					
33. Kendimi çok yorgun, enerjim tükenmiş gibi hissederim ve günü yaşayacak kadar enerjim kalmaz.					
34. Araba kullanırken trafik kurallarına ve hız sınırlarına uyarım.					
35. Televizyon programlarında ya da karikatürlerde komik, gülünecek yönler bulurum.					
36. Cinsel yaşamımdan memnunum.					
37. Herhangi bir alanda öğrendiğim bilgileri kolayca başka bir alanda kullanabilirim.					
38. Diğer insanlar ile yakın ve güvene dayalı ilişkiler kurabilirim.					
39. Hayattan zevk alırım.					
40. Beslenmemin yeterli ölçüde vitamin, mineral ve lif içermesine dikkat ederim.					
41. Çeşitli etkinlikler yoluyla (medya, bilimsel toplantılara katılma, okuma) diğer insanların görüş ve düşüncelerini öğrenmek için çaba harcarım.					
42. Kendim için belirlediğim hedeflere ulaşırım.					
43. Fiziksel olarak formda olmak benim için önem taşır.					
44. Kendime olabildiğince stresten uzak bir hayat yaratmaya çalışırım.					
45. Düzenli olarak (haftada en az üç gün, 20-30 dk.) spor (egzersiz) yaparım.					
46. Bir konuda yoğunlaşmak benim için kolaydır.					
47. Bir problemime çözüm bulma aşamasında bilgi toplarım, seçeneklere bakarım ve adım atmadan önce olası sonuçları değerlendiririm.					
48. Gereksinim duyduğumda yanımda olacak ve benim için her şeyi yapabilecek arkadaşlara sahibim.					
49. Gece uykularım düzenlidir, her gün en az 6-8 saat arasında uyurum.					
50. Kendine gülerim.					

	Kesinlikle Katılıyorum	Katılıyorum	Kararsızım	Katılmıyorum	Kesinlikle Katılmıyorum
51. Güven duyduğum, ciddi ve uzun süreli (eş, nişanlı, sevgili vb) bir ilişkim var.					
52. Diğer insanların düşünce ve duygularımı kendiliğinden anlamalarını beklemek yerine onların rahatlıkla anlayacağı bir biçimde açıklarım.					
53. Ait olduğum kültür beni utandırmıyor.					
54. Diğer insanların gelişimleri ve iyi olmaları ile ilgilenirim.					
55. Olumsuz duygularım ile de başa çıkmasını bilirim.					
56. Düzenli olarak sabah kahvaltısı yaparım.					
57. Hayvani yağ veya margarin tüketmemeye dikkat ederim.					
58. Okuduklarımı daha iyi anlamamı ve düşüncelerimi daha iyi yazabilmemi sağlayacak becerileri geliştirmek için çaba harcarım.					
59. Diğer insanların isteklerine hayır demekte güçlük çekmem.					
60.Hayatta ulaşmak istediğim amaçlarım var.					
61. Herhangi bir konuda bilgi edinmeye ihtiyaç duyduğumda bana yardımcı olabilecek arkadaşları var.					
62. Yaptığım bir hatayı kapatmaya çalışmak yerine karşımdaki kişiden özür dilerim.					
63. Stresle baş etme yöntemimden memnunum.					
64. Her öğünde değişik besin gruplarından gıdalar tüketirim.					
65. Sosyal ve politik olaylar ile ilgiliyimdir.					
66. Karşı cinsten bir kişi ile olumlu duygusal ilişki içindeyim.					
67. Hayatta belirlediğim amaçlarıma ulaşacağımı düşünüyorum.					
68. İyi ve kötü günlerimde yanımda olan, yaşama ümitle bağlanmama ve iyimser olmama yardımcı olan en az bir insan var.					
69.Diğer insanları tarafsızca dinleyebilirim ve benim görüşümün karşıtı olan görüşlere saygı duyarım.					
70. Kendim için gerçekçi hedefler koyarım.					
71. Her yeni güne merak ve öğrenme isteği ile başlarım.					
72. İyi bir öğrenciyim.					

	Kesinlikle Katılıyorum	Katılıyorum	Kararsızım	Katılmıyorum	Kesinlikle Katılmıyorum
73. Kimseye açamadığım duygu ve düşüncelerimi paylaşabileceğim en az bir kişi var.					
74. Başkalarına adil davranırım.					
75. Stres düzeyimi kontrol edebiliyorum.					
76. Kalorisi yüksek ancak besleyici değeri olmayan gıdaları (cips, gofret, çikolata, bisküvi vb.) tüketmemeye dikkat ederim.					
77. Kendi ilgi ve yeteneklerimin farkındayım.					
78. Hocalarım tarafından taktir edilirim.					
79. Kendimi olumlu ve olumsuz yönlerimle seviyorum.					
80. Tıbbi müdahale gerektiren sağlık problemlerimi ihmal etmem.					
81. Okul ve boş zaman etkinlikleri arasında kurduğum dengeden memnunum.					
82. Sosyal ortamlarda kendimi rahat hissederim.					
83. Televizyondaki eğitici programları izlerim ya da radyodaki eğitici programları dinlerim.					
84. Okulda benden beklenen ders ve sınav yükünü kaldırabilirim.					
85. İlaç kullanırken doktorun önerilerini takip ederim.					
86. Ruhsal olarak kendimi iyi hissederim.					
87. Karşı cinsten kişilerle duygusal ilişki kurmada güçlük çekmiyorum.					
88. Kendimi birçok konuda yeterli bulurum.					
89. Zamanımı iyi kullanırım.					
90. Yeni bir şeyler öğrenmek ve bilgilerimi tazelemek için kendime fırsatlar yaratırım.					
91. Sürekli birlikte olmamıza rağmen hiç kopmayan en az bir dostluğum var.					
92. Başkalarının duygularını anlar ve onları yargılamam.					
93. Sigara içmem.					
94. Başkaları beni mizah duygusuna sahip birisi olarak tanımlar.					
95. Zihinsel ve duygusal yönden tatmin veren, yaratıcı etkinlikleri düzenli olarak yapıyorum.					
96. Manevi, dini değerler ile ilgili tartışmalar katılırım.					
97. Çözümü güç sorulara yaratıcı çözümler bulabilirim.					

	Kesinlikle Katılıyorum	Katılıyorum	Kararsızım	Katılmıyorum	Kesinlikle Katılmıyorum
98. Uyku düzenimi bozacak şeylerden kaçınırım.					
99. Ortam gerektiriyorsa sorumluluk alır ve inisiyatif kullanırım.					
100. Yakın olduğum insanlara dokunmakta güçlük çekmem; onların bana dokunmasından rahatsız olmam.					
101. Olumlu yönlerimin farkındayımdır.					
102. Yardıma ihtiyacı olanlara yardım ederim.					
103. Gelişmeme katkı sağlayacak değişiklikleri yapmaktan kaçınmam.					
104. Hayatımda önemli yeri olan insanlara şefkat göstermekte ve onların bana şefkat göstermelerini kabul etmekte güçlük çekmem.					