WELLNESS AMONG TURKISH UNIVERSITY STUDENTS: INVESTIGATING THE CONSTRUCT AND TESTING THE EFFECTIVESS OF AN ART-ENRICHED WELLNESS PROGRAM

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I certify that this thesis satisfies all the requirements as a thesis for the degree of Doctor of Philosophy.

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This is to certify that we have read this thesis and that in our opinion it is fully adequate, in scope and quality, as a thesis for the degree of Doctor of Philosophy.

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I hereby 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.

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ABSTRACT

WELLNESS AMONG TURKISH UNIVERSITY STUDENTS: INVESTIGATING THE CONSTRUCT AND TESTING THE EFFECTIVESS OF AN ART-ENRICHED WELLNESS PROGRAM

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This study consists of two phases for the purpose of investigating (a) the construct of wellness and its relationships with self-esteem, physical symptoms, art self-concept, and gender, and (b) the effect of Art-Enriched Wellness Program (AWP) on improving wellness levelof Middle East Technical University (METU) students.

In the first phase of the study, four questionnaires, namely Wellness Inventory, Rosenberg Self-Esteem Scale, Physical Symptom Checklist, and Art Self-Concept Scale were administered to 629 METU students (297 male, 300 female, 32 indicated no gender). The results of explanatory and confirmatory factor analysis yielded a 30 items scale with 4 factors; cognitive-emotional wellness (CEW), relational wellness (RW), life-goal (LG), and physical wellness (PW). The results of five separate multiple linear regression analyses revealed that all the suggested independent variables, i. e., self-esteem, gender, physical symptoms and art self-concept were the predictors of the total wellness scores. As for the subscores, significant predictors appeared as; self-esteem and physical symptom for the CEW scores; gender, self-esteem and art-self-concept for the RW scores; self-esteem and art-self concept for the LG scores; and physical symptom, gender, and self-esteem for the PW scores.

In the second phase of the study, for the purpose of testing the effectiveness of Art-enriched Wellness Program (AWP) developed by the researcher, an experimental design with one treatment and one non-treatment control group and four measurements (pre, post, and two follow-ups with two-week and four-month intervals) was used with a sample of 16 participants ($N = 6$ for the treatment group, 3 females and 3 males; $N = 10$ for the non-treatment control group, 8 females and 2 males). The experimental group participated in 20 hours- 8 week AWP (each session was 2.5 hours), while the non-treatment control group received no treatment during that time. Results of a series of Mann Whitney U tests revealed that AWP was effective in increasing total wellness scores of the experimental group subjects both in post-test and in follow-up 1 measures. It was also effective in increasing CEW scores of experimental group subjects in the post-test and follow-up 1, and in increasing LG scores of them in follow-up 1.

Keywords: Wellness, art-enriched wellness program, university students.

ÖZ

ÜNİVERSİTE ÖĞRENCİLERİNİN İYİLİK-HALİ: KAVRAMIN İNCELENMESİ VE SANAT ETKİNLİKLERİYLE ZENGİNLEŞTİRİLMİŞ İYİLİK-HALİ PROGRAMININ ETKİNLİĞİNİN TEST EDİLMESİ

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Bu çalışmanın iki temel amacı bulunmaktadır. Bunlardan birincisi iyilik-halinin (İH) boyutlarını ve benlik-saygısı, fiziksel belirtiler, sanat benlik-kavramı ve cinsiyet ile ilişkisini saptamak, ikincisi ise Sanat Etkinlikleriyle Zenginleştirilmiş İyilik-Hali Programının (SEZİP) üniversite öğrencilerinin iyilik halini geliştirmedeki etkinliğini test etmektir.

Araştırmanın birinci aşamasında, İH'nin boyutlarının ve ilişkili olduğu değişkenlerin araştırılabilmesi için İyilik Hali Envanteri (İHE), Rosenberg Benlik-Saygısı Ölçeği, Fiziksel Semptom Tarama Listesi ve Sanat Benlik-Kavramı Ölçeği, Orta Doğu Teknik Üniversitesi'nde (ODTÜ) okumakta olan 629 (297 erkek, 300 kız, 32 cinsiyet bilgisi vermemiş) öğrenciye uygulanmıştır. Bu aşamada yapılan açıklayıcı ve doğrulayıcı faktör analizlerinin sonucunda 30 madde ve 4 faktörden (Bilişsel-Duygusal İyilik-Hali, BDİH; İlişkisel İyilik-Hali, İİH; Yaşam-Hedefi, YH ve Fiziksel İyilik-Hali, FİH) oluşan İHE geliştirilmiştir. Çoklu regresyon analizlerinin sonuçları ise İH toplam puanı için benlik-saygısı, cinsiyet, fiziksel belirtiler ve sanat benlik-kavramının yordayıcı değişkenler olduğunu göstermiştir. Alt puanlar açısından, BDİH için benlik-saygısı ve fiziksel belirtilerin; İİH için cinsiyet, benlik-saygısı ve

sanat benlik-kavramının; FİH için ise fiziksel belirtiler, cinsiyet ve benlik-saygısının yordayıcı değişkenler olduğunu ortaya koymuştur.

Araştırmanın ikinci aşamasında ise üniversite öğrencilerinin iyilik-halini arttırmak amacıyla, araştırmacı tarafından Sanat Etkinliklerine Dayalı İyilik-Hali Programı (SEZİP) geliştirilmiş ve bu programın etkinliği, ön-test son-test kontrol gruplu deneysel bir desenle 16 katılımcıdan (deney grubu 3 erkek, 3 kız; kontrol grubu 8 erkek, 2 kız) oluşan bir örneklemde test edilmiştir. Deney grubuna 20 saat- 8 hafta (her oturum 2.5 saat) süren SEZİP uygulanırken kontrol grubuna aynı zaman dilimi içinde hiçbir işlem yapılmamıştır. Hem deney hem de kontrol grubu üyelerinden SEZİP sonunda bir son-test ve programdan iki hafta ve dört ay sonra olmak üzere iki izleme ölçümü alınmıştır. Bu aşamada uygulanan bir dizi Mann Whitney U Testinin sonuçları SEZİP'in deney grubu üyelerinin İH toplam puanlarının son-test ve izleme 1 ölçümlerinde kontrol grubu üyelerine nazaran anlamlı bir şekilde arttırdığını göstermiştir. Ayrıca SEZİP'in, deney grubu üyelerinin son-test ve izleme 1'de BDİH puanlarını ve izleme 1'de YH puanlarını kontrol grubu üyelerine kıyasla anlamlı düzeyde artırdığı görülmüştür.

Anahtar Kelimeler: İyilik hali, sanat etkinlikleriyle zenginleştirilmiş iyilik-hali programı, üniversite öğrencileri

I need to tell you about Ada Perin and İsmail;
their wonderful eyes, smiles and hugs, and the moments we share,
that made me feel blessed.
These are the masterpieces of the art of life for me.
Thus, this thesis is dedicated
to Ada Perin and İsmail Duran;
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CHAPTER I

INTRODUCTION

> *« Our message is to remind our field that psychology is not just the study of pathology, weakness, and damage;it is also the study of strenght and virtue. Treatment is not just fixing what is broken; it is nurturing what is best. » (*Seligman & Csikszentmihalyi, 2000, p.7).

1.1. Historical Background of the Concept of Wellness

For thousands of years, understanding *human nature*, *well-being*, and *good life* has been the concern of human beings. During the history of humanity, many questions have been asked and many answers have been found by philosophers and scientists to make people well and make life worth living. The concept of *wellness*, which became popular especially in the 1990s in the field of counseling, is one of the responses to the need of improving the well-being and quality of life of human beings.

The wellness movement has a long heritage which had its roots at the beginning of Greek philosophy in the sixth century B.C., the times when there was no division between science and philosophy (Depken, 1994; Shillingford & Shillinford-Mackin, 1991). Regarding the nature of spirit and matter, Heraclitus of Ephesus believed in the *"unity of forces",* which is also the core of *Eastern mysticism*, whereas Parmenides of Elea believed in a *permanent, static, and immutable substance or "being"*, which became the forerunner of *Western dualism* (Hershbell, 1998). Since that time, Eastern thought with its holistic, integrative, and organic emphasis has remained to seek unity and balance between opposite forces, and underline the unity and fluidity of the universe, whereas the Western thought has followed its dualistic roots in scientific and philosophical areas for centuries by dividing religion and

science, body and spirit.

In the course of time, by the separation of philosophy and science in the West, some other worldviews also dominated the Western science such as *objectivizm, materialism, reductionism* and *determinism*, whereas the East relatively insisted on its *holistic* and *integrative* roots (Depken, 1994; Hershbell, 1998; Lipman, 1994). In the West, it was the 1980s when Jan C. Smuts, cited as being the father of the word "holism", stated in the Dictionary of Philosophy and Religion (as cited in Udchic, 1984) that *wholes cannot be subdivided without loss of quality.*

Similar trends have been observed in the science of psychology as well as in psychiatry. The science of psychology which emerged at the end of the nineteenth century had its share of dualistic Western worldview for long years. Especially, after World War II, psychology, particularly psychiatry has focused much of its efforts on human problems and how to remedy them. However, this remedial emphasis has declined when scientists and philosophers started to argue for the necessity of a shift to more holistic approaches that respect the *complexity* and *totality* of human beings (Udchic, 1984), and that value *subjectivity, inner experience*, and *the unity of body, mind, and spirit* (Capra, 1996; Tarnas, 1991). Especially in the field of counseling, many endeavors contributed to the rise of the "holistic" movement such as Adler's writings on *individual psychology*, Maslow's description of *self-actualization,* Rogers' view of *fully-functioning person,* Jung's observation of *human psyche*; Gestalt therapists' *holistic phenomenological approach* (Hershbell, 1998; Myers, Sweeney, & Witmer, 2000). Finally, the emergence of *Positive Psychology* provided a base for the "wellness" movement. The interest in positive psychology resulted in a renewed focus on capabilities and potentials of the individuals rather than their problems, unresolved issues or missed opportunities. With this new positive paradigm, several concepts have been investigated which emphasize the potentials of the human beings such as happiness, hope, optimism, appreciation of beauty and art, responsibility, self-determination, creativity, and spirituality (Csikszentmihalyi, 2003; Seligman & Csikszentmihalyi, 2000). Several constructs have also been

proposed over the years such as *subjective well-being*, *psychological well-being*, and *wellness* which refer to optimal experience and functioning, quality of life, and good life (Myers & Diener, 1995; Myers, Sweeney, & Witmer, 2000; Ryan & Deci, 2001). Although well-being and wellness have been used interchangeably, *well-being* has been used as a general mental health term, indicating life satisfaction, positive mental health, and happiness (Diener, 1984; Ryff & Keyes, 1995; Ryff & Singer, 1998a; 1998b; Myers & Diener, 1995) whereas wellness generally refers to the individuals' functioning as a whole –physically, psychologically, socially- and explains a life style and standard providing satisfaction in life (Myers, 1992; Myers, Sweeney, & Witmer, 2000; Ivey, Ivey, Myers, & Sweeney, 2005).

1.1.1. Conceptualization of Wellness

The concept of wellness was first introduced by *Halbert Dunn,* in 1961. Dunn (1977) used the term "high-level wellness" by emphasizing the maximization of the potential of individual's functioning. Afterwards, in 1964, WHO broadened the earlier conceptualization of health, "absence of illness", and redefined "health" as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (as cited in Depken, 1994). This definition had a profound impact on the understanding of health and optimal human functioning and provided seeds of modern wellness movement. This definition also caused a paradigm shift in many fields from the traditional illness-based medical model for treatment of mental and physical disorders and made the subject of health become the interest of more disciplines than the traditional biomedicine (Crose & Nicholas, 1992; Hatfield & Hatfield, 1992; Peterson & Park, 2003). Consequently, the current wellness paradigm emerged with its emphasis on preventive approach, stressing a healthy lifestyle, personal responsibility for one's life, integration, holism, and balance between different aspects of individuals, as its key principles (Myers, 1992; Snyder & Lopez, 2002; Street, 1994).

As outlined in the Literature Review Chapter of this thesis, several wellness models have been developed over the years. Among them, *The Wheel of Wellness Model* was the first model proposed in the field of counseling (Witmer & Sweeney, 1992). In this model the concept of wellness was defined 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."* (Myers, Sweeney, & Witmer, 2000) This model is grounded in Adlerian Individual Psychology and it's counseling applications, and was developed after an extensive review and research in multiple disciplines, including psychology, sociology, anthropology, religion, medicine, and education. Although all the wellness models have some common features covering spiritual, intellectual, emotional, physical, occupational, and social components, contrary to other models which solely focus on an autonomous individual, this interdisciplinary model has an "I/We" contextual framework considering the effects of the socio-cultural context, including family, community, religion, education, government, media, and business/industry and explores both wellness and prevention over the lifespan (Hartwing & Myers, 2003; Ivey et al, 2005; Myers, Sweeney, & Witmer, 2000; Sweeney & Witmer, 1991; Wittmer & Sweeney, 1992).

In the development of the Wheel of Wellness model Adler's three theoretical life tasks (work, friendship, and love) and two additional tasks of self and spirit (self-direction and spirituality) described by Mosak and Dreikurs were taken as a base (Witmer & Sweeney,1992). Some modifications were then made in the Wheel of Wellness model. The self-direction task was renamed as self-regulation and expanded to twelve subtasks (sense of worth, sense of control, realistic beliefs, emotional awareness and coping, problem solving and creativity, sense of humor, nutrition, exercise, self-care, stress management, gender identity, and cultural identity). Likewise, work life task was subdivided as work and leisure. In the model, it was assumed that, although the five life-tasks, and subtasks of self-direction are interrelated and interconnected, they are hierarchical in such a way that the life tasks located in the center of the model are more central and important to human

functioning than are tasks located around the rims of the Wheel (Witmer & Sweeney, 1992).

However, research on this model did not support its hierarchical nature and revealed that the dimensions which take part in the model differ across populations and subpopulations (e.g., Hattie, Myers, & Sweeney, 2004; Myers, Mobley, & Booth, 2003). Consequently, as it was summarized in the Literature Review Chapter, several studies have been conducted to revise the model and to assess the dimensions of wellness. In general, studies carried out on this and several other wellness models suggested that the assessment of wellness is a controversial issue not only because of its multidimensional and integrated nature but also because of its cultural quotations attributed to its meaning. As stated by Christophner (1999), culture is a considerable factor in defining and measuring wellness. In line with the positions of multiculturalists (e.g. Pedersen & Ivey, 1993; Sue , Ivey, & Pedersen, 1996), it is crucial to understand the dimensions and structure of the concept of wellness in Turkish culture. Thus, the first purpose of the descriptive phase of this study is to investigate the factor structure of wellness in a sample of METU students.

1.1.2. Related Variables of Wellness

In addition to the problems related to the assessment of wellness, in the literature, another line of studies concentrated on some physical and psychological characteristics of individuals that affect the improvement of wellness.

With regard to physical characteristics, several studies indicated that wellness was associated with physical and health-related factors such as *stress and headache* (Degges-White, Myers, Adelman, & Pastor, 2003); *physical activity* (Bray & Born, 2004); *health risk behaviors* (Grace, 1997); and *participation in poor health practices* (Sussman, Dent, Stacy, Burton, & Flay, 1995). Overall, the findings of these studies suggested that preferences of sedentary life styles and participation in health risk behaviors such as alcohol, tobacco, and drug abuse, risky sexual

behaviors, unhealthy nutritional priorities were indeed related to low level of wellness. Parallel to these findings, a bulk of research also indicated that physical symptoms were related with various indicators of healthy human functioning. For instance, according to Tanaka, Möllborg, Tershima and Borres (2005), somatization could be a warning that serious emotional morbidity may soon surface. According to Larsen and Kesimatis (1991), the occurrence of physical symptoms is related with neuroticism, and the duration of physical symptoms is related with the trait of aggressive responding. Consistently, those who experience less physical symptoms were found to be more optimistic (Aydın & Tezer, 1991; Jones, O'Connel, Gound, Heller, & Forehand, 2004), have more sense of humor, generalized achievement expectations, and internal locus of control (Aydın, 1993), and are less depressive (Herman & Lester, 1994; Ring, et al., 2006; Simon, VonKorff, Piccinelli, Fullerton, & Omel, 1999). In addition, physical symptoms in adolescents are often found to be associated with impaired psychosocial functioning in family and/or peer relationships (Rauste-von Wright & Von Wright, 1992; Taylor, Szatmari, Boyle, & Offord, 1996), school related performance (Garber, Walker, & Zeman, 1991), and school absenteeism (Aro, Paronen, & Aro, 1987; Rauste-VonWright, & Von Wright, 1992).

Based on these findings it can be concluded that physical symptoms have important implications for individuals not only in terms of physical wellness but also in several areas of psychosocial functioning. Following this conclusion, in the present study, the amount of physical symptoms reported by the students was considered as one of the predictors of their wellness assuming that those who report a high number of physical symptoms would be under the threats of low level of wellness.

As for the psychological characteristics/personality dispositions, wellness was found to be positively related with *positive thoughts and optimism* (Adams, Bezner, Drabbs, Zambarano, & Steinhardt 2000); and negatively related with *shyness* (Page, 1990). In addition, *personality priorities* (dominant behavior pattern related with one's movement in life) were found significantly associated with wellness (Britzman & Main, 1990) in such ways that *achieving* style is positively related with wellness,

whereas *detaching* and *avoiding* styles are negatively related. Among the psychological characteristics, *self-esteem* was one of the variables which yielded strong and positive correlations with wellness (Abood & Convay, 1992; Omizo,Omizo, & D'Andrea, 1992; Shillinford & Shillingford-Mackin, 1991). Based on the consistent findings regarding the strong association between self-esteem and wellness suggested in the literature, in the present study, self-esteem was accepted as one of the strong representatives of personality characteristics and was expected to be one of the significant predictors of wellness. It was assumed that those who have high self-esteem are expected to have a higher level of wellness.

Besides, physical symptoms and self-esteem, in the present study, art self-concept was also examined in relation to wellness. Art-self concept, simply defined as how an individual sees him/herself in art activities, is a new concept in the literature, resulting from the notion of a multiplicity of selves (Vispoel, 1993). In other words, art self-concept was considered as a component of an overall self-concept. Although there are several studies indicating the role of art in the enhancement of individuals, including self-esteem (Berryman-Miller, 1988; Hietolahti-Ansten & Kalliopuska, 1991; Kalliopuska, 1991), the lack of empirical findings showing the direct relationship between art self-concept and wellness urged the researcher of the present study to make further assumptions on this issue. Firstly, it was assumed that those who enjoy and participate in art activities are expected to have higher wellness. Considering a low but significant correlation ($r = 0.15$, $p < .05$) between self-esteem and art self-concept (Duran-Oğuz & Tezer, 2005), it was also assumed that, having a higher art-self concept would make an additional contribution to wellness. Lastly, in the present study, it was assumed that if a relationship exists between art self-concept and wellness, it would then be an evidence for the use of art as a therapeutic tool in improving wellness.

Thus, the second purpose of the first phase of the present study is to investigate the predictive power of physical symptoms, self-esteem, and art self-concept on wellness among METU students by controlling the gender as being one of the most important

controlling variables in wellness studies (Depken, 1994; Garret, 1996).

1.1.3. Wellness Programs

Studies on the conceptualization of wellness and the examination of its correlates are accompanied by the efforts to develop wellness programs after the late 1980's (Millar & Hull, 1997). The purpose of these programs developed in organizations was mentioned as decreasing employee healthcare costs, improving productivity, morale and retention, and enhancing the images of the companies (Anderson, 1999, Anhaldt, 1994; Ginn & Henry, 2003; Kocakulah & Joseforsky, 2002; Milligani, 2000; O'Donnel, 1994;). In schools, the purpose was mainly described as developing the whole potential of students (Pateman, 2004) rather than concentrating on the development of the mind.

Several researchers have criticized the content of these programs (Conrad, 1987; Hollander & Langerman, 1988; Roberts & Harris, 1989) since most of them were cognitive oriented and seemed to be missing the holistic nature of wellness. Another line of criticism was related to the professionals offering these programs. For example, as mentioned by Myers (1991) health educators are take on the role of counselors and claiming that they provide counseling in wellness programs. Thus, counselors and psychologists have been strongly recommended to take an active role in developing and implementing wellness programs (Myers, 1991; Steiger, 1998; Street, 1994).

In developing, implementing, and testing wellness programs counselors are expected to focus on (a) the holistic and the multidimensional nature of wellness and (b) implementing techniques without ignoring the age level characteristics of the population. As it was mentioned by the researchers (Linesh, 1998; Riley, 1994, 1998), while working with younger populations such as children and adolescents, it is essential to implement more creative and entertaining techniques that engage them

easily into the process. Based on these suggestions, in the present study art is accepted as a useful tool in the development of wellness improvement program for university students by considering its holistic quality to connect mind, body, and spirit (Siegel, 1986, 1989), and its capacity to provide a natural, non-threatening, enjoyable, and developmentally oriented environment to engage youth into counseling (Graham, 1994; Linesh, 1998; Mercedes-Ballbe, 1997; Reynolds, 1990; Riley, 1994; Riley, 1999; Robertson, 2001). As emphasized by Soden (1998) the elements of art, such as taking time to relax, play, connect with self, and express emotions are critical factors in wellness. Similarly, Natalie Rogers (2001) stated that the use of imagery and nonverbal modes allows the client an alternate path for self-exploration and communication, since emotional states are seldom logical. The creative process has a powerful integrative force in itself. It provides joy and lively learning on many levels, such as sensory, kinesthetic, conceptual, and emotional. Rogers further argued that using arts as an expression tool can also be considered as an important verbal process in therapy in helping client to achieve the integrity and self direction. The role of art in the integrity and self direction has also been emphasized by most of the authors in describing the characteristic of self-actualized or fully-functioning individuals (Resnick, Warmoth, & Serlin, 2001).

In the literature, the contemporary uses of art with therapeutic purposes have been represented in two perspectives: *art in therapy* and *art as therapy*. The services provided by professionals from these two different perspectives differ in many ways. The former reflects the approach in which the therapeutic process is inherent in talking about a work of art and in expressing oneself, with the help of a therapist or counselor, whereas in the latter therapeutic process is inherent in the specific act of creation. *Art in therapy* approach is based on the theories from the schools of psychotherapy. On the other hand *art as therapy* approach is based on theories from art education. In the former perspective the therapist is generally trained in therapy or counseling, whereas in the latter s/he has generally certified in arts (Elinor,1992; Naumburg, 2001).

Despite all the positive marks and views on art, research on the effectiveness of art based counseling on wellness of youth has been sparse. Actually, art has not been used in a wellness counseling program developed for university students, and composed of the many dimensions of the concept of wellness. Thus, the last purpose of the present study is to develop a wellness program which includes many dimensions of wellness and is based on a holistic art-based counseling approach, and then examine the effectiveness of this program. In this program, art has been used as an auxiliary method for insight and self-expression, based on *art in therapy/counseling* perspective. Thus, rather than artistic skills, the clients' self expression through art and the counselor's ability to respond empathically to these expressions were taken as the basic skills for the process (Coleman & Farris-Dufrene, 1996). Assuming a person-centered approach, drawing, painting, sculpting, music, movement, and writing were integrated as a path to wholeness (Rogers, 2001).

1.2. Purpose of the Study

The purpose of the present study is twofold: First it aims to investigate the dimensions of wellness, and the relationship between wellness and self-esteem, physical symptoms, art self-concept and gender. Second it aims to examine the effect of the Art Enriched Wellness Program (AWP) on improving wellness. More specifically, the statements of the problems of this study are as follows:

1) What are the dimensions of wellness as perceived by METU students?

2) How well do the self-esteem, physical symptom, art self-concept, and gender measures predict the total and subscale wellness scores of METU students?

3) Are there any significant differences between the experimental and control group members in pre-test, post-test, follow-up 1, and follow-up 2 total and subscale

wellness scores?

4) Are there any significant differences between experimental and control group members in pre-test and post-test, pre-test and follow-up 1, pre-test and follow-up 2, post-test and follow-up 1, post-test and follow-up 2, and follow-up 1 and follow-up 2 total wellness scores ?

5) Are there any significant differences between experimental and control group members pre-test and post-test, pre-test and follow-up 1, pre-test and follow-up 2, post-test and follow-up 1, post-test and follow-up 2, and follow-up 1 and follow-up 2 wellness subscale scores ?

1.3. Significance of the Study

As stated by the positive psychologists, the good life deserves its own field of inquiry within psychology (Peterson & Park, 2003). Positive psychologists focus on strength as on weakness, interest in building the best thing in life as in repairing the worst, and give as much attention to fulfilling the lives of healthy people as to healing the wounds of the distresses (Peterson & Park, 2003; Seligman, 2002; Seligman & Csikszentmihalyi, 2000). However, they have been criticized as using an old idea (engage in positive thinking, ignoring the negative side of life) that has been popular as a result of an economically advantaged period of American culture (Lazarus, 2003; Ryan & Deci, 2001). As a response to these critics positive psychologists stated that, the study of people who are happy, healthy, and talented is not a luxury. The concern of psychology with human problems is understandable, but attempts to eliminate sufferings should not be abandoned. A better understanding of well-being allows psychologists to help all people, troubled or not (Peterson & Park, 2003).

The emphasis on prevention-oriented perspective of positive growth, optimal functioning, and good life leads to the development of several positive concepts, one of which is the concept of wellness. Two main reasons are underlined in the development of these concepts. First it was a result of many social, cultural,

technological, and political challenges of modern life which causes negative impacts on human beings. Because of the difficulties of the contemporary world, many people tend to choose unhealthy lifestyles, which cause serious physical and psychological health problems and premature deaths (Cowen & Kilmer, 2002; Iverson & Kolbe, 1983; Myers, 1992). According to the literature, the major health problems resulting in unhealthy lifestyles are largely preventable and can be addressed through positive changes in personal health behaviors (Allensworth, 1993; Cortese, 1993; Jackson, 1994). Wellness programs have been promised to prevent health problems by providing a healthy lifestyle to individuals. Second, since the public became more knowledgeable and discerning about health issues, inevitably there has been some return to personal responsibility for one's own health and wellness (Udchick, 1984).

High level wellness is obviously essential for personal happiness and effective functioning for human beings in all ages. The importance of the present study lays an interest in understanding and improving the wellness level of university students, and consequently expects to have a great impact on how these young people live their lives, and how the society spends its resources for the needs of them.

Acting upon the positive, holistic, and preventative ideas of the wellness paradigm could have many beneficial impacts on the individual students (Galves, 1997). Studies on improving wellness in schools could improve the quality of education, while at the same time improving the quality of the life of the students (Pateman, 2004). It is known that risky behaviors that cause most serious and threatening health problems of the individuals are usually established, developed and sustained during school years. According to the literature, these risky behaviors are related to personal decision-making and lifestyle choices and they are preventable (Iverson & Kolbe, 1983; Seffrin, 1990; Steiger, 1998). In this respect, providing services to prevent the establishment of risky behaviors and to promote wellness during the school years could help students developing healthy lifestyles, taking responsibility on their own lives, and thus provide them with the opportunity to live healthily and well across their life spans (Jubb, 1987; Nolte, 1985; Omizo, Omizo, & D'Andrea, 1992; Steiger,

1998). Furthermore, students who could be affected by wellness programs constitute the human potential, the most important economic resource with the sum of intelligence, creativity, inventiveness, technical ability and skill that is available for the production of goods and services, of modern societies. The level of wellness of this human capital consequently would have a great impact on the ability of the society to meet the economic needs of its members (Galves, 1997). Additionally, improving the wellness level of the members of a society with preventive and developmental interventions will reduce the level of healthcare expenditures (Gebhardt & Crump, 1990).

College years present developmental and behavior-associated threats to health that are unique to this phase of life (Adams, Bezner, Garner, & Woodruff, 2000). In this period of life many youngsters engage in several health risk behaviors and a sedentary life style that place them at risk for diseases (Grace, 1997; Walker & Fraizer, 1993). Thus, wellness programs conducted on university campuses are of special importance in the literature and they have been strongly suggested by many authors (Archer, 2001; Davies, Davies, & Heacock, 2003; McDonald & Davidson, 2000; Walker & Fraizer, 1993; Welle & Kittleson, 1994) to protect the youngsters from the carry over effect of the unhealthy lifestyle choices (Omizo, Omizo, & D'Andrea, 1992). Although concrete data is lacking to confirm the carry over effect of adolescent behaviors into adulthood (Blair, Clark, Cuteton, & Powell, 1989; Burke, Beilin, Millegan, & Thompson, 1995; Rowlond & Freedson, 1994; Sallis & McKenzie, 1991), helping adolescents acquire healthy lifestyles is accepted as an important task in cultivating their future wellness.

Considering the common critics in the wellness literature, the present study aimed at filling some gaps and provided a step for further studies. From the theoretical perspective, first, this study is a response to a need to re-assess the structure of Wellness Inventory (Güneri, 2003) to identify the dimensions and to obtain further evidence for a culture-based, valid and reliable wellness instrument. As mentioned earlier, measuring wellness is a complex process which leads to several changes both

in the models and assessment tools. Although the present study was carried out with a specific sample, the results might be considered as an attempt to re-evaluate the structure of wellness in Turkish culture. Second, this study would provide data related with some predictors of wellness among university students. Self-esteem, physical symptoms, gender, and art self-concept were used as the predictors of wellness among students, considering that they represent the basic indicators of physical (physical symptoms and gender) and psychological (self-esteem and art self-concept) characteristics. It was believed that the results regarding these relationships would not only provide a support for previous studies conducted abroad but also fill the gap concerning the lack of relevant research in Turkey. Besides, in terms of counseling implication, the results would provide some cues for the counselors when working with university students in improving their wellness. Counselors can consider these variables involved not only in developing wellness programs but also in the counseling process by emphasizing the role of them in increasing wellness and in making students fully functioning individuals.

Furthermore, this study could provide considerable contributions to the literature with its experimental phase in developing, implementing and testing the effectiveness of an Art-enriched Wellness program (AWP). To translate the idea behind the wellness paradigm, that health consists of more than the absence of disease and that human beings may have more control over their health, a program was designed to help participants to take more control over their wellness and consequently their lives. Considering its preventive and developmental functions, AWP is expected to be particularly useful for the clients to develop and maintain healthy lifestyles. Moreover, if AWP was found to be an effective tool in improving wellness among university students, it could be implemented in other universities in Turkey, and therefore, it may contribute to the national prevention efforts, as well as the development of healthy young people in other universities.

Another contribution of the experimental part of this study places its emphasis on the role of an art in wellness counseling programs. As it is emphasized throughout the literature review, art in counseling is a new and less applied way in the area of

wellness, especially in Turkey. This study is considered to be a significant contribution in terms of attracting the counselors' attention on how to help youth to improve their wellness mainly with art enriched group counseling programs. The present research study can inspire counselors for developing art enriched wellness programs for different age groups, i.e., children, adults, and elderly in helping them to improve their wellness and their life quality.

1.4. Limitations of the Study

As in many other studies, possible limitations should be considered in the interpretation and the generalization of the findings of the present study.

First of all, since the sample of this study is limited to a group of METU students, the results could not be generalized either to students in other universities or to other age groups.

Secondly, although in the experimental phase of the study the group members were assigned to the experimental and control groups through random sampling, the subjects in the descriptive phase were selected by using convenience sampling method.

The self-report nature of the instruments was another limitation which might lead to some biases including social desirability that could intervene with the results.

In the experimental phase of the study some limitations may be worth mentioning here. First, although a limited number of subjects is considered as an advantage in an art group, the number of subjects in the experimental group was limited to understand the effect of AWP. Second, the intervention period was short to create long-term changes in subjects' behaviors and life-styles. Before and after comparisons with 8-week and 4 month intervals were useful and appropriate, but it is clear that the issue of permanent lifestyle changes may not be determined in such a

short period of time. Longitudinal and well-controlled studies are needed to evaluate the issue of the permanence of behavior changes. Finally, it was not possible to constitute a placebo group to strengthen the experimental design since the number of the students who volunteered to participate in the experiment was already limited.

1.5. Definition of Terms

Below, for the sake of clarity, the definitions of some important terms of the present study have been presented separately.

Wellness: Wellness is 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).

Physical Symptoms: Physical symptoms are those that do not meet the criteria for diagnosable disorders, such as headaches, fatigue, dizziness, back and musculoskeletal pain, and gastrointestinal disturbances (Jones, et al., 2004).

Self-Esteem: Self-esteem is a construct which refers to an individual's perception of his personal worth (Battle, Jarratt, Smit, & Precht, 1988).

Art Self-Concept: Art self-concept is a construct which refers to how an individual sees him/herself in relation to art activities (Vispoel, 1993).

Art-enriched Wellness Program (AWP): AWP is a program created by the researcher, to allow the participants' wellness related self-expressions through art in a group atmosphere, and thus, is expected to effect the engagement of the participants in positive wellness behaviors and healthy lifestyles.

CHAPTER II

REVIEW OF LITERATURE

In this chapter, a review of relevant literature to this study is presented. In the following sections, first the definitions, models, assessment tools of wellness, and factors affecting wellness are outlined. Then, programs designed and tested for wellness improvement in different settings are introduced. The use of art as an additional wellness improvement tool is presented in the following section with respect to its historical framework and rationale. Finally, wellness research that has been done in the West and in Turkey is provided.

2.1. Definitions of Wellness: What is Wellness?

There are many definitions of wellness in the literature. These definitions are chronologically presented in the following paragraphs.

Wellness was first introduced as a concept by *Halbert Dunn,* in 1961. Dunn was credited as being the "architect" of modern wellness movement, and he used the term "high-level wellness" referring to *"an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable within the environment where he is functioning."* (Dunn, 1977, p.9). This first formal wellness definition put emphasis on the maximization of the potential of individual's functioning.

In 1964, WHO broadened its earlier conceptualization of health, *"absence of illness"* proposed in 1947; and redefined "health" as *"a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity"* (as cited in Depken, 1994). This new definition influenced the understanding of health and optimal human functioning profoundly, and provided seeds of modern wellness movement because it stresses the integrated nature of health (Witmer & Sweeney, 1992). All the definitions of wellness presented below are based on this comprehensive and modern definition of health, which resulted in a paradigm shift toward a more protective and preventive approach to health, and an increasing interest of more disciplines than the traditional biomedicine (Crose & Nicholas, 1992).

Coming from the field of sociology and having a PhD. in Health and Public Policy, Donald B. Ardell is known in the literature as the one who developed the first wellness model at the end of 1970s. Ardell defined wellness as *"a proactive approach to life that optimizes one's potential"* (as cited in Ardell, 2003).

At the same years, Hettler (1980, 1984) defined wellness as *"an active process through which people become aware of, and make choices toward a more successful existence."* Hettler is also the co-founder of the National Wellness Institute which was founded in 1977 and has defined wellness as *"An active process or lifestyle that involves becoming aware of and making decisions about the different areas in one's life, with the goal of attaining a higher level of health"* (National Wellness Institute, Inc.).

Parallel to the studies of Ardell and Hettler, Travis wrote The Wellness Workbook (Travis & Ryan, 1988), a pivotal book in the wellness movement, with Ryan. In this book they defined wellness as a *choice* (making to move toward optimal health), a *way of life* (a lifestyle designing to achieve the highest potential for well-being), a *process* (developing awareness that there is no end point, but that health and

happiness are possible in each moment, here and now), a challenging of *energy* (received from the environment, transformed within the individual, and set on to affect the world outside), the *integration of body, mind, and spirit*, and the *loving acceptance of self*. According to Travis (1988), whereas the treatment model brings people to the neutral point, where the symptoms of disease have been alleviated, the wellness model, which can be utilized at any point, directs people beyond the neutral and encourages them to move as far to the right as possible. Additionally, according to Travis and Ryan (1988), wellness is not the strong, brave, successful, young, whole, or even the illness-free being, but in order to be "well", it is important to appreciate yourself as a growing, changing person, and allow yourself to move toward the wellness direction (happier life and positive health) of the continuum.

As it was mentioned in the Introduction section, in the field of counseling, although Adler's writings of *individual psychology*, Maslow's description of *self-actualization,* Rogers' view of the *fully-functioning person,* Jung's observation of the *human psyche*; Gestalt therapists' *holistic phenomenological approach* and many other large and small endeavors contributed to the rise of "wellness" movement, it was Witmer and Sweeney (1992) who translated many of the wellness theoretical and research concepts into a holistic wellness model, and first 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".*

To sum up, as stated by Street (1994), all the wellness definitions reflected the holistic nature of health as a philosophy of wellness which comprises five major tenets of wellness as: interrelated systems, optimal functioning, preventative approach, personal responsibility, and a healthy lifestyle. This philosophy of wellness was emphasized in the definitions and operationalized in the models of wellness. The most frequently cited wellness models in the literature are presented in the following section.

2.2. Models of Wellness

In the literature, several wellness models have been proposed for the purpose of identifying the factors or conditions that enhance or restrict the concept of wellness. A summary of the most cited wellness models in the literature are presented in Table 2.1. In the field of counseling, these models provide useful bases to offer competent services to the clients.

Known as the first one in the literature, in 1977, Ardell developed a multidimensional wellness model, with five wellness dimensions in a simple circle, with responsibility in the center, and nutritional awareness, stress management, physical fitness, and environmental sensitivity around it (as cited in Ardell, 2001). He called it "*The Original Wellness Model".* This earlier model was then revised by Ardell, in 1982, and named as *The Revised and Expanded Wellness Model.* This revised model consisted of five dimensions defined as nutritional awareness and physical fitness, meaning and purpose, relationship dynamics, emotional intelligence, and again self-responsibility in the center (as cited in Ardell, 2001). Finally, in 2001, he developed his third wellness model, which comprised of three dimensions/domains (physical, mental, meaning and purpose) with fourteen skills classified under these three domains: physical wellness included exercise and fitness, nutrition, appearance, adaptations/challenges, and lifestyle habits; mental wellness covered emotional intelligence, effective decisions, stress management, factual knowledge, and mental health; and the last domain included meaning and purpose, relationships, humor, and play.

Table 2.1. *Most Cited Definitions and Models of Wellness*

Name of the model	**Founders**	**Definition of wellness**	**Dimensions of wellness**		
Multidmensional Wellness Model	Ardell, 1977 (as cited in Ardell, 2001)	Wellness is a conscious and deliberate approach to an advanced state of physical and psychological/spritual health	1. Responsibility 2. Nutritional awareness 3. Stress management		4. Physical Fitness 5. Environmental sensitivity
Revised and Expanded wellness model 1	Ardell, 1982 (as cited in Ardell, 2001)		1. Nutritional awareness and physical fitness 2. Meaning and purpose 3. Relationship dynamics		4. Emotional intelligence 5. Self-responsibility
Revised and Expanded wellness model 2	Ardell, 2001 (as cited in Ardell, 2001)		1. Physical Wellness (exercise and fitness, nutrition, appearance, adaptations/challenges, and lifestyle habits) 2. Mental Wellness (emotional intelligence, effective decisions, stress management, factual knowledge, and mental health)		3. Meaning and Purpose (meaning and purpose, relationships, humor, and play)
Hexagon Model	Hettler (1980)	Wellness is an active process through which people become aware of, and make choices toward, a more successful existence.	1. Social 2. Occupational	3. Spiritual 4. Physical	5. Intellectual 6. Emotional
The Wellness Energy System Model	Travis & Ryan (1988)	Wellness is a *choice* (making to move toward optimal health), a *way of life* (a lifestyle designing to achieve the highest potential for well-being), a *process* (developing awareness that there is no end point, but that health and happiness are possible in each moment, here and now), a challenging of *energy* (received from the environment, transformed within the individual, and set on to affect the world outside), the *integration of body, mind, and spirit*, and the *loving acceptance of self*.	1. Self responsibility and love 2. Breathing 3. Sensing 4. Eating	5. Moving 6. Feeling 7. Thinking 8. Playing /working	9. Communi-cating 10. Sex 11. Finding meaning and transcending 12. Seeing
The Wheel of Wellness Model	Witmer & Sweeney, (1992); Myers, Sweeney, & Witmer, 2000)	Wellness is 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.	1. Spirituality 2. Self-direction (sense of worth, sense of control, realistic beliefs, emotional awareness and coping, problem solving and creativity, sense of humor, nutrition, exercise, self-care, stress management, gender identity, and cultural identity)		3. Work and leisure 4. Friendship 5. Love
Indivisible Self Model of Wellness	Sweeney & Myers, (2001)		1. Creative Self 2. Coping Self	3. Social Self 4. Essential Self	5.Physical Self
Indivisible Self Model of Wellness	Myers, Luecht, & Sweeney, (2005)		1. Cognitive-emotional	2. .Relational	3. Physical 4. Spiritual

Coming from the medical profession, Hettler (1980, 1984) with his *Hexagon Model*, and Travis and Ryan (1981, 1988) with their *The Wellness Energy System* model are also considered among the pioneers in the literature. The former model consisted of six dimensions named as, social, occupational, spiritual, physical, intellectual, and emotional; whereas, the latter described twelve human life functions defined as self responsibility and love, breathing, sensing, eating, moving, feeling, thinking, playing/working, communicating, sex, finding meaning and transcending, and seeing as various forms of energy.

Emerging from the field of counseling in the early 1990s, *The Wheel of Wellness Model* (Sweeney & Witmer, 1991; Wittmer & Sweeney, 1992) becomes one of the most cited wellness models in the literature. This model is grounded in Adlerian Individual Psychology and its counseling applications, and was developed after an extensive review and research in multiple disciplines, including psychology, sociology, anthropology, religion, medicine, and education. Although, all the models mentioned above have some common components including spiritual, intellectual, emotional, physical, occupational, and social components, this model has some advantages over the others, which was developed in the physical-health oriented professions. It is an interdisciplinary model that explores both wellness and prevention over the lifespan; an "I/We" contextual framework rather than a naïve focus solely on an autonomous individual assumed in the model, considering the effects of the sociocultural context, including family, community, religion, education, government, media, and business/industry (Myers , Sweeney, & Witmer, 2000; Sweeney & Witmer, 1991; Wittmer & Sweeney, 1992)

The five theoretical life tasks, spirituality, self-regulation, work, friendship, and love, which were also identified by Adler, Mosak and Dreaikurs (as cited in Witmer & Sweeney,1992) provided the bases of the model. Some modifications were then made in The Wheel of Wellness model. The self-direction task was renamed as self-regulation and expanded to 12 subtasks (sense of worth, sense of control, realistic beliefs, emotional awareness and coping, problem solving and creativity, sense of

humor, nutrition, exercise, self-care, stress management, gender identity, and cultural identity). Likewise, work life task was subdivided as work and leisure. In this model, it was assumed that, although the five life-tasks, and subtasks of self-direction are interrelated and interconnected, the model was considered as hierarchical in the sense that the life tasks located in the center of the model are more central and important to human functioning than are tasks located around the rims of the Wheel (Witmer & Sweeney, 1992). However, since further research findings did not support this hierarchical model, it has been updated recently (Hattie, Myers, & Sweeney, 2004; Myers, Luecht, & Sweeney, 2003; Myers & Sweeney, 2003; Myers, Luecht, & Sweeney, 2004; Myers & Sweeney, 2005; Sweeney & Myers, 2001), and the new *Indivisible Self Model of Wellness (IS-WEL)* was developed.

The organization of the components in the new model is different from the organization of the earlier one. IS-WEL is based on a new, five-factor structure, including *Creative Self, Coping Self, Social Self, Essential Self,* and *Physical Self*. Within these five factors, there are 17 components, each of which affects each other, as well as the longevity and quality of human life. The distribution of these components to five factors are: spirituality, gender identity, cultural identity and self-care for the *Essential Self*; realistic beliefs, stress management, self-worth and leisure for the *Coping Self*; friendship and love for the *Social Self*; thinking, emotions, control, humor, and work for the *Creative Self*; and finally, nutrition, and exercise for the *Physical Self*. Moreover, four contexts (local, institutional, global, and chronometrical -time-focused-), are identified in the new model as acting individually and collectively to affect the indivisible self and all aspects of wellness within the self (Sweeney & Myers, 2001).

To sum up, all of the models aforementioned seem to reveal more or less similar components like physical, emotional, cognitive, social, occupational, and spiritual wellness. All of them emphasize the integrated nature of human functioning, and as a result any positive changes made in any one aspect of functioning of the individual result in enhanced functioning in all areas. These models have served as a foundation for the assessment of wellness. In the following section, the wellness assessment

instruments developed on the wellness models are presented.

2.3. Assessment of Wellness (Wellness Instruments)

The development of several models of wellness has resulted in the development of several wellness instruments designed to assess different components of wellness (Palombi, 1992). For instance, Hettler's *Hexagon Model* provides a base for the development of two assessment instruments, *Testwell* (National Wellness Institute, 1988) and the *Lifestyle Assessment Questionnaire* (LAQ; National Wellness Institute, 1983). *Wellness Index* (Travis & Ryan, 1981, 1988) was developed on the basis of Travis and Ryan's *Wellness Energy System Model*. Similarly, based on the *Wheel of Wellness Model* of Witmer, Sweeney, and Myers (1988), *The Wellness Evaluation of Lifestyle* (WEL; Myers, Sweeney, & Witmer, 2001) was developed as a wellness assessment tool.

Researchers (Myers, Luecht, & Sweeney, 2004; Myers & Sweeney, 2005) pointed out a variety of measurement problems in assessing the wellness of individuals. Further analyses in different wellness instruments revealed different and new factor structures requiring changes in the original models. For instance, at the initial study, WEL yielded a five factor structure (5F-WEL), assessing 19 components of wellness with 123 items (Myers, Sweeney, & Witmer, 2001). However, after several studies, the revised version of it (4F-WEL) had a four factor (cognitive-emotional, relational, physical, and spiritual) structure, assessing 16 components of wellness with 56 items (Myers, Luecht & Sweeney, 2005). Similar to the change of "Wheel of wellness model" to the "Indivisible self model", factor analysis of the LAQ, failed to support the six subscales of the instrument (Cooper, 1990). Thus, the studies investigating the dimensions of wellness indicate a need for establishing the components of wellness instruments.

An additional difficulty in assessing wellness appeared due to its subjective nature. Wellness, like well-being, is a subjective state. In this respect, the criterion for the assessment of wellness should be based on the personal evaluation of one's wellness, not on the external criteria derived from the expert's opinion (Diener, 1984). Like the great philosopher, Ludwig Wittgenstein, who was always depressive, irascible, and scathing critical of everyone around him and even more critical of himself ; but said "Tell them it's been wonderful!" when dying alone in a garret in Ithaca (as cited in Seligman & Pawelski, 2003); people may be satisfied with their overall wellness or some components of wellness, although they seem not good at it from an ousider look.

In this respect, Ivey et al. (2005) reported that they use both informal (e.g. clinical interviews, behavioral observations) and formal assessment tools (e.g., Indivisible Self Wellness Inventory; or IS-Wel; Myers & Sweeney, 2002) to assess personal wellness. They reported that the perceptions of the individual regarding his/her overall wellness, and the level of satisfaction of the person with his/her wellness in specific wellness components is important in assessing personal wellness.

Thus, although the problematical and dissatisfied components of wellness should be clearly identified for each person before developing an intentional wellness improvement plan, assessing wellness remains to be a complicated and difficult issue which is waiting for further research in the literature.

2.4. Factors Affecting Wellness

Several studies in the literature provide evidence that wellness can be affected by many factors. These factors and the relevant research on these factors can be exampled as certain demographic variables such as *gender* (Courtenay, 1998, 2000, 2003, 2004; Crose & Nicholas, 1992; Depken, 1994; Garret, 1996; Jones, et al., 2004; Lonnquist, Weiss, & Larson,1992; Myers & Bechtel, 2004; Myers & Mobley, 2004; National Center for Health Statistics, 1994; Oleckno & Blacconiere, 1990;

Parks & Neutens, 1987; Ryff & Heidrich, 1997; Steiner, Pavelski, Pitts, & McQuivey, 1998; Taeuber 1991; Verbrugge, 1985; Wagstaff , 1997) and *age* (Granello, 2001; Hybertson, Hulme, Smith, & Hulton, 1992); some background characteristics such as *ethnicity and race* (Rayle, Dixon, & Myers, 2004; VanDyke, 2001); some factors related to belief systems such as *religiosity* (Oleckno & Blacconiere, 1991) and *spirituality* (Adams et al., 2000); some environmental factors such as *network size* and *perceived support* (Granello, 1999; Sussman, et al., 1995); and some social skills such as *problem solving* (Benson & Stuart, 1992; Elliot & Marmarosh, 1994); psychological characteristics/personality dispositions such as *positive thoughts and optimism* (Adams, et al., 2000); *psychological well-being* (Hermon & Hazler, 1999); *shyness* (Page, 1990); *self-esteem* (Abood & Convay, 1992; Omizo, Omizo, & D'Andrea, 1992; Shillinford & Shillingford-Mackin, 1991); physical and health-related factors such as *stress and headache* (Degges-White, et.al., 2003); *body dissatisfaction* (Bezner, Adams, & Steinhardt, 1997); *objectified body consciousness* (Sinclair & Myers, 2004); *physical self-esteem* (Bezner, Adams, & Steinhardt, 1997); *physical activity* (Bray & Born, 2004); *health risk behaviors* (Grace, 1997); and *participation in poor health practices* (Sussman et al., 1995).

In the following paragraphs, the findings of the studies investigating the relationships of wellness and some factors including gender, physical symptoms, self-esteem, and art self-concept which were of interest in this study are presented in detail.

Gender is one of the most widely used variables in relation to wellness. Studies yielded consistent findings which indicated that women experience lower level of wellness then do men in most of the dimensions of wellness. For instance, Myers and Bechtel (2004) mentioned that women reported significantly lower wellness in the areas of sense of worth, nutrition, stress management, and self-care. Similarly, Myers and Mobley (2004) found that among undergraduate students, women scored lower than men on global indices of wellness and self-direction and on individual wellness factors such as nutrition, stress management, and self-care. Consistent with these findings, Steiner, et al. (1998) reported significant gender differences, indicating that adolescent females experience more difficulties in mental health, sexual risks,

general health, and dietary behaviors than males. Furthermore, in the literature, it is reported that women rate their health more poorly than men, report more health problems and physical symptoms, take more sick days from work, make more physician visits, and take higher levels of prescription and nonprescription medications (National Center for Health Statistics, 1994; Parks & Neutens, 1987; Verbrugge, 1985).

Contradictory to these findings, in some studies, men were found to be as experiencing lower wellness than do women. Oleckno and Blacconiere (1990) examined wellness levels of college students and reported that women generally occupied higher levels of wellness than men, particularly on health responsibility, nutrition, and interpersonal support. Similarly, Wagstaff (1997) reported that after a school based wellness intervention, females scored significantly higher than males in overall wellness scores. These findings are also consistent with other studies in which women appear to take better care of their health than men. For instance, according to Taeuber (1991) women are less likely to drink heavily, smoke, or engage in other detrimental health behaviors. Similarly, Lonnquist, Weiss and Larson (1992) reported that women practice more health protective behavior than men. Courtenay's (1998; 2000) studies showed that particularly among college students, men engage in fewer health-promoting behaviors than women including wearing safety belts, eating well, conducting self-examinations for cancer; and behaviors related to driving, sleep, and exercise; they engage in more risky behaviors such as behaviors related to sex, drug use, carrying weapons, and physical fighting; and they take greater risks while playing sports and driving. Furthermore, they are more likely to drink alcohol, to drink more of it, and to drink more often as well as drive under the influence of alcohol. They are also more likely to use tobacco and have more dangerous smoking habits.

Except these two categories of studies underlying gender differences in wellness, there are also examples in the literature that showed no significant gender differences. For instance, in a study which investigated the relationship between health promoting behaviors and psychological well-being of university students, Lee and Yuen-Loke (2005) reported that relatively few university students (from a Hong Kong university) had a sense of "health responsibility" (6.5-27.1 %), engaged in any form of physical activity (31.2 %), or exercised regularly (13.8 %). Less than half ate fruits (35.2 %) and vegetables (48.9 %) every day. Positive personal growth was reported by 50.6 % of the students; 42.5 % used stress-management skills and 74.1% rated their interpersonal relationships as meaningful and fulfilling. The scores on health responsibility, nutritional habits, spiritual growth, interpersonal relationships, and stress-management scores did not differ significantly by gender in this study. However, it is reported that males scored better than females on the physical exercise sub-scale.

In the literature, gender differences in disease and health are explained largely by health beliefs and behaviors rather than biological factors (Courtenay, 2003). For instance, men are less likely than women to believe that personal behaviors contribute to good health or to accept personal responsibility for their health (Courtenay, 2003).

Although not studied in the literature as widely as gender, *physical symptoms* are also important to understand in relation to wellness, since they could be an important indicator of physical wellness which is one of the major components of the total wellness as mentioned in section 2.3. Models of Wellness. The decrease in physical wellness leads to some physical symptoms and/or health problems, which in turn affect the other dimensions of wellness and thus, the total well-being of the human.

Although limited, the relationship between *physical symptoms* and the components of wellness is also evident in the literature. For instance, Degges-White, Myers, Adelman, and Pastor (2003) studied wellness and perceived stress in a population of 60 adults seeking medical care at a headache clinic, and found that levels of wellness

were low and perceived stress was high compared to a norm group of adults. Results also indicated that, some components of wellness varied with spirituality being higher among the headache population, whereas nutrition, exercise, and locus of control being lower.

In the literature there are some studies providing indirect evidence regarding the relationship between wellness and physical symptoms. As was pointed out by Grace (1997), college years present a critical period of life, in which some health risk behaviors -such as poor eating habits, sedentary lifestyle, alcohol, tobacco, and drug abuse, unhealthy sexual behavior-, which later might result in chronic diseases are experinced. This was supported by the findings of a study conducted by Melby, Famea and Sciacca (as cited in Grace, 1997) which yielded that 69 % of college students did not eat any fruit once a day and 48 % ate vegetables less than once daily. It was also reported that the most rapid reduction in physical activity levels occurs between ages 18 and 24 years (Stephens, Kacobs, & White, 1985). Similarly, Bray and Born (2004) investigated vigorous physical activity and psychological well-being during transition from high school to first-year university in a sample of 145 Canadian undergraduates, and they reported that only 11 % of the students participated in physical activities at university. Additionally, the results of their study revealed that students who had become insufficiently active reported higher levels of fatigue and lower levels of vigor compared with those who continued to be active. The findings of these studies are consistent with these findings of several researchers who suggested that preferences of sedentary lifestyles and participation in health risk behaviours were related to low level wellness (Bray & Born, 2004; Degges-White, et al, 2003; Grace, 1997; Sussman, et al., 1995).

In addition, according to the literature, pronounced somatizations could be an indicator of a serious emotional morbidity which may soon surface (Tanaka et al., 2005). Consistently, several research findings indicated that those who experience less physical symptoms are more optimist (Aydın & Tezer, 1991; Jones, O'Connel, Gound, Heller, & Forehand, 2004), have more sense of humor, generalized achievement expectations, and internal locus of control (Aydın, 1993), and are less

depressive (Herman & Lester, 1994; Ring, et al., 2006; Simon, VonKorff, Piccinelli, Fullerton, & Omel, 1999). Thus, the existent literature on physical symptoms provide evidence for the relationship between physical symptoms and the psychological dimension of wellness.

Self-esteem is also one of the variables which have been frequently investigated in relation to wellness. Shillingford and Shillingford-Mackin (1991) suggested that self-esteem and wellness are related, that self-esteem can enhance wellness, and that wellness programs can enhance self-esteem. According to them, wellness involves a concerted effort on the part of individuals to engage in a healthy lifestyle and strive to reach their unique potential. This relates directly to an understanding of how self applies to everyday life. Consistent with these ideas, several empirical and experimental studies were conducted to understand the role of self-esteem in enhancing wellness of the individuals.

Results of several empirical studies revealed that self-esteem was found to be related with and many variables regarding mental health such as depression (Rosenberg, et al., 1989); anxiety (Rosenberg, 1989); happiness (Perneger, Hudelson, & Bovier, 2004); well-being (Rosenberg, et al., 1995). Self-esteem was also found to be associated with *physical health* such as body image concerns and eating disorders (McVay et al., 2002; O'dea, 2004; Stice, 2002); drug use (Hayes & Fors, 1990; Sullivan & Guglielmo, 1985; Sullivan, et al., 1986); smoking, substance abuse, suicide, and pregnancy (Daane, 2003; Shirk, Burwell, & Harter, 2003); health values and behaviors (Torres & Fernandez, 1995), perceptions of vulnerability and health risk behaviors (Gerrard, Gibbson, Reis-Bergan, & Russel, 2000), self-reported health (Axelsson & Ejlertson, 2002). With regard to *academic life,*self-esteem was found to be related with increased school performance and productive behavior (Leary, et al., 1995), and academic success (Spaights, et al., 1986). In *social life*, it was found that self-esteem was associated with social integration in the community (Herrero & Gracia, 2004), leadership ability (Fox, 1992), dating (Leck, 2006), and loneliness (Haines, Scalise, & Ginter, 1993; McWhirter, 1997a; 1997b).

Underlying the difference between global self-esteem and specific self-esteem, Rosenberg, et al. (1995) claimed that specific self-esteem is most relevant to behavior, whereas global self-esteem is most relevant to psychological well-being. They tested their hypothesis by using structural equation modeling for the case of global self-esteem defined by Rosenberg (1965) and specific (academic) self-esteem. The results revealed that while global self-esteem is strongly related with psychological well-being, academic self-esteem is a better predictor of school performance.

In the present study *art self-concept* has also been investigated in relation to wellness. Art-self concept was defined as the persons perceptions of himself/herself in the field of fine arts (Vispoel, 1993; 1995). Although no study has been found investigating the relationship between art self-concept and wellness, art in general has been emphasized widely in the literature in terms of (a) its' positive effects on several aspects of wellness, such as *self-concept and self-esteem* (Berryman-Miller, 1988; Buege, 1993; Hietolahti-Ansten & Kalliopuska, 1991; Huntsman, 1982; Kalliopuska, 1991; Marsh & Roshe, 1996), and its contribution to enhance *psychological health and general well-being* (Liebner, 1997; Malchiodi, 1998; Riley, O'Dell, & Seigenthaler, 2000); and (b) its role in counselor education and counseling process (Gladding, 1998; Muro & Kottman, 1995; Russel-Chapin & Rybak, 1996; Wilkins, 1995).

With respect to the first category, Rodenhauser, Stricland, and Gambala (2004) reported four distinct "uses" of the arts in the U.S. medical schools: (a) enhancement of student well-being, (b) improvement of clinical skills, (c) allowance of time and space for reflection and contemplation by the medical student (promotion of humanism), and (d) employment by students as a tool for teaching, particularly in community service activities. They reported that extracurricular activities in the arts were often used to promote student well-being in U.S. medical schools. Similarly in these schools, elective courses with the goal of enhancing well-being included some art classes, such as theater/museum, writing and poetry, and visual arts practicum in some universities.

Additionally, as examples for the positive effects of art on several aspects of wellness, involvement in art activities has been shown to increase self-esteem. For instance, girls who were involved in music or played a musical instrument rated higher in self-esteem and empathy than those who were not involved in music (Hietolahti-Ansten & Kalliopuska, 1991). Similarly, Kalliopuska (1991) reported the positive effects of participating in classical bale dancing to increase self-esteem and self-confidence in elementary level girls; Berryman-Miller (1988) reported the positive effects of dance in increasing self-esteem in retired elderly people; Buege (1993) reported the positive effects of drama in increasing self-concept in fourth grade students; and Huntsman (1982) reported the positive effects of drama on the self-confidence of university students. Consistent with this finding, according to Eccless, Barber, Stone, and Hunt (2003), participating in performing arts has a protective role in grades 10 and 12 students in engaging in risky behaviors (especially alcohol-related ones). It also has a promotive role in enjoyment at school at grades 10 and 12; in higher GPA at grade 12; in higher attendance to college full time at age 21-22; and in greater likelihood of graduating from college by age 25-26. These researchers reported significant gender by activity involvement interaction, that is, both the protective and promotive roles of being involved are more significant for boys. When the positive effects that appear in different age groups are taken into consideration, it is possible to conclude that the art self-concept of an individual will effect his/her self-esteem positively. Consistent with this conclusion, Duran-Oğuz and Tezer (2005) reported, although not high, a significant relationship ($r = .15$, $p < .05$) between art self-concept and self-esteem in a Turkish university students sample.

2.5. Improving Wellness (Wellness Programs)

As the concept of wellness becomes popular in societies and the key institutions comprise it, there has been en explosion of wellness programs in industry, hospitals, and universities, in twentieth century. While employers and healthcare institutions have developed wellness programs since they are interested in decreasing employee

healthcare costs, improving productivity, morale and retention, and enhancing the images of the companies (Anderson, 1999, Anhaldt, 1994; Ginn & Henry, 2003; O'Donnel, 1994; Kocakulah & Joseforsky, 2002; Milligani, 2000); elementary, middle, high schools and universities have developed wellness programs, since contemporary education is not only concerned with the development of the mind but also with the development of the whole potential of students (Pateman, 2004). However, the content of wellness programs have been criticized by many authors. Typically, worksite wellness programs are criticized for focusing only on the physical dimension of wellness and ignoring the psychological one. In addition, these programs were criticized due to the cognitive-oriented strategies which were used in them to improve wellness (Conrad, 1987; Hollander & Langerman, 1988; Roberts & Harris, 1989). Another criticism of the wellness programs was related to the professionals offering these programs. For instance, according to Myers (1991) health educators claim that they provide counseling services in wellness programs. Thus, especially in school settings, counselors and school psychologists have been strongly recommended to take an active role in developing and implementing wellness programs (Myers, 1991; Steiger, 1998; Street, 1994).

Depending on the population of the present study, the aims, contents, techniques, and results of several wellness programs in elementary, middle, high school and college levels are presented in the following sections.

Street (1994) offers a wellness program, *Life-style Choices*, conducted in public middle or high schools for successful education of students regarding lifelong health habits. According to him, the steps of the development of a wellness program in school settings could include the following steps: (1) informal *discussions about developing a wellness focus at the school* level with the school principal, teachers, students, parents, community members, and if possible, district level administrators and school board members; (2) submitting a *written program proposal,* which includes a rationale, goals and objectives, developmental outcomes for students, tentative ideas for monthly topics, potential speakers and activities, and evaluation

procedures, for the principal's approval, (3) *forming an advisory committee that includes teachers, students, parents, and various community members.* (Also some health and social services, law enforcement agencies, and other individual community members who may have interest in an area of wellness may be included), (4) gathering *an active student group* (in an extra-curricular club or a course elective) to provide critical support, (5) conducting *needs assessments* during program planning to determine areas for which students most need information, (6) *constructing a plan for the year's topics and speakers and secure tentative engagements,* (7) submitting the plan to the advisory board and principal for final approval; and (8) implementation of the program. In such a school wellness program, the counselor cannot provide all the services and acts as a coordinator and consultant but generating student interest and support to the program is the task of the counselor. Using the available wellness assessment instruments will be useful for evaluating and providing feedback to both the students and the effectiveness of the program. Since the content of a school wellness program is different depending on the needs of the students in the school, Street also offered some alternative topics, such as nutrition, safe sex, alcohol awareness, mediation and spirituality, psychological wellness, exercise, drug abuse, child care and pregnancy, and occupational planning (as one topic for a month). Using guest speakers, films, handouts, reading lists, lists of community sources; wellness activities for lunchtime, a walking program, aerobics, or yoga at lunch; t-shirts bearing wellness slogans, etc. were also offered as possible techniques for the school counselors.

Wagstaff (1997) examined the effects of a school based wellness program, *Looking Good Feeling Great!* (LGFG) on ninth grade students, and evaluated student and teacher impressions of the program. Experimental groups (N = 62) from one urban and two suburban secondary schools participated in a four day 175 minute program while control groups (N = 37) from the same schools followed their regular academic schedules. Although the program was not focused on all six wellness dimensions, major principles of wellness including the notions of personal responsibility, a health lifestyle, and the interrelatedness of mind, body, and spirit were stressed. LGFG program focused on the integration of four components for good health: physical

activity, healthy eating, good mental health practices and sound personal hygiene habits. The implementation tool of the study consisted of lectures and personal records. Personal care issues were recorded by the students on "daily personal records". Students were encouraged to share the information from their diaries with classmates to use peer support to help them analyze behaviors and complete the diary. At the end of the intervention, students were also asked to set goals with respect to their lifestyles. This goal setting was done in the form of a written contact which involves a three day commitment. All participants completed a wellness inventory for high school students as a pretest, one week later as a posttest, and one and one half months later as a follow up test. Student focus groups and teacher interviews were conducted after the posttest. Results showed that (1) experimental group wellness scores significantly increased from pretest to posttest, (2) experimental groups maintained their increased wellness levels one and one half months following completion of the program, (3) and there was no significant effect of gender on experimental group wellness scores, although females scored significantly higher than males in overall scores. In general students and teachers conveyed favorable impressions of the program, except some negative impressions of the program from the students and the teacher at the urban secondary school implied that this type of school may benefit from a wellness program that better suits the needs of its constituents.

Fowler (1988) investigated the effects of a seven-week health education program (HEP) on health locus of control (HLOC), health knowledge (HK), and reported health behaviors (HB) of 83 high-risk adolescents between ages of 14 to 17 years. The program included health related topics in the weekly presentations on nutrition education, sleep/rest practices, hygiene and self-care practices, safety practices and risk factors, substance use and abuse. Each topic was presented in a 30 minutes period. 61 students in the experimental group were enrolled in one of three alternative education programs for high- risk adolescents: (1) job preparation, a one-year education program that was developed for youths who are potential candidates for school failure or school drop-out. It consisted of 22 students and was in operation

six hours per day; (2) area day treatment, a one-year program that was developed in conjunction with the Cabinet for Human Resources. It was based on a behavior modification framework and was in operation six hours per day with 18 students; and (3) project transition, which was developed for the younger adolescents who have demonstrated periodic truant behavior in the district high school. After the completion of the 10-week education program, they were provided with an opportunity to remain in the program for a second session, return to the regular classroom setting, or be referred to one of the other alternative education programs. The number of subjects in this group was 21. In this study, a pretest and a posttest were administered to the subjects prior to each health education presentation. Next, the subjects were provided with a 5-minute period to discuss their health diaries. Additional 10-minutes were included in the day's activities for the subjects to discuss their health related concerns and to lead in the discussion of the day's activities. This activity was followed by a 30-minute presentation on a variety of health related topics in which the investigator assumed full responsibility for the classroom presentations. The class periods ended with a summary of the day's activities. The results of the Analysis of Variance employed to pre-test and post-test scores of the experimental and control groups revealed no significant differences on HLOC, although the experimental group members' external and internal dimensions of multidimensional HLOC scores increased and chance scores decreased after HEP when compared with the control group. Additionally, many of the experimental group subjects shifted from engaging in high-risk to low-risk health behaviors.

Gallagher and Satter (1998) offered a comprehensive high school wellness and awareness program, IMPACT, which they used in North Kansas City High School. According to them, this program promotes a positive and supportive environment by involving students, faculty, and the community in a variety of prevention, collaboration, and intervention activities in response to students' needs. It also provides students with a support network of peers, teachers, parents, and school and community. Students learned about the program's activities during registration and freshmen orientation sessions. Throughout the school year, posters and announcements were made inviting students to join. IMPACT consisted of two

major components: “participation” and “helping”. The first component was composed of a variety of student activities that included SAVE (Students Against Violence Everywhere; a group of students who work closely with local police departments and community agencies to find ways to decrease violence), Peer Mediation (Students who, with adult supervision, help resolve disputes between students), Impact IMPROV (a group of students who perform skits with wellness themes to preschool, elementary, middle school, and high school students), SADD (Students Against Destructive Decisions; a program designed to raise students’ awareness of the dangers of drinking and driving), Hi-Step (High School-Taught Elementary Program; a cross-age teaching program in which high school students teach fourth graders about peer pressure, conflict mediation, drug and alcohol abuse, and relationships), PAL (Peers Always Listen; a group of students to whom other students can talk), High School Heroes (a group of students who teach a tobacco prevention program to fourth, fifth, and sixth graders), and TRY (Teaching and reaching youth; composed of parents and community members: aims at engaging community in focusing on wellness issues). The helping component includes PATHS (Practical academis transition to high school; which is a 3-week summer course designed for eight grader); SRO (school resource officer which is available for students to assist students with various legal concerns); and counseling services.

As well as wellness programs in elementary, middle and high schools, wellness programs in college campuses are of importance in the literature. College years present developmental and behavior-associated threats to health that are unique to this phase of life (Adams, et al., 2000). Many youngsters engage in several health risk behaviors such as smoking, using alcohol, tobacco, and drugs, eating too much; unsafe sexual behaviors; avoidance to struggle with life stresses; and a sedentary life style that place them at risk for lifestyle diseases (Grace, 1997; Walker & Fraizer, 1993) in this period. About the signs of lifestyle diseases in these years, the worry is not that they will die as a result of these diseases at the present time, but that their unhealthy behaviors will carry over into adulthood (Omizo, Omizo & D’Andrea, 1992), and thus the result of this carry over would be adults who continued to exhibit unhealthy behaviors placing them at risk for illness and death. Although concrete

data is lacking to confirm the carry over effect of adolescent behaviors into adulthood (Blair, Clark, Cureton, & Powell, 1989; Burke, Beilin, Millegan, & Thompson, 1995; Rowland & Freedson, 1994; Sallis & McKenzie, 1991), helping adolescents acquire healthy lifestyles is accepted as an important undertaking in shaping their future wellness.

Traditionally, wellness programs on campuses have appeared in a cognitive-based wellness education (wellness courses) format. Since these *wellness courses* have only recently emerged in the college and university curriculum, few studies have examined their impact on student life (McCalanahan, 1993). Some of these studies indicated positive outcomes (McCalanahan, 1993; Lee & Graham, 2001; Romano 1984), whereas others did not show significant increases in scores of wellness (as cited in McCalanahan, 1993).

For instance, Shillingford and Shillinford-Mackin (1991), started to provide a wellness program in Bryn Mawr College, in 1981, as a highly structured course offered for credit. After two years, although they observed that students gave high marks to the effort, assessments indicated little student behavior change. Thus, after some reviews and experiential learning, they decided to change the structure and content of their program, and finally the program turned to 10 Saturday morning seminars. The topics included were: self-defense on campus, time and stress management, identity and relationship, leadership skills, examining values and setting priorities in making career decisions, women's worries, assertiveness and you, emergency cares, addictive behavior, your back and you. The people who led these topics had different titles from the dean, to a physician, or counselor.

Romano (1984) offered a psychologically oriented instruction (a classroom intervention) that has been designed, implemented, and evaluated to help undergraduate students learn strategies for altering potentially harmful life-style habits. The intervention was a credited**,** undergraduate course, entitled "Psychology and the Management of Stress: Theory and Application", that taught about stress and methods to better manage it along with the influence of life-style on the quality of

life. It was a 3-credit, quarter-long course. The course instructional format was a combination of lecture, class discussion, and small group interaction. 102 students were enrolled ranging in age from 19 to 63 years. The course presented the study of stress through a holistic model that focuses on four major dimensions of the individual: affective, cognitive, physical, and spiritual. Specific stress management interventions that are explained, demonstrated and practiced include: progressive relaxation training, diaphragmatic breathing, biofeedback training, stress inoculation training, assertiveness training, and reduction of stress-producing cognitive behaviors. Additionally, several texts, a number of self-assessments and diaries were designed during the quarter to facilitate student awareness. These assessments also assisted in the completion of a major course project –a 10-week assignment-, a personal goals paper. Results of the t-tests employed to four scores (trait anxiety, facilitative academic anxiety, debilitative academic anxiety, and life score) revealed significant differences except the debilitative academic anxiety score. Results also revealed that the students learned principles and techniques to apply in their lives (76 %), and they had acquired techniques to better manage stress (89 %). Students reported that their stress levels were lower as a result of the course (87 %); and that they were continuing to work on their personal goals as identified through the class project (9 %).

Similarly, Lee and Graham (2001) investigated the students' perception of medical school stress and assessed the students' perspective on the *Help Wellness* elective. Physician presenters provided information on wellness, stress reduction, and coping strategies in a series of six, weekly, one-hour lectures. They assessed the 60 medical students' final essays and their answers to questionnaires mailed to the students 2 years later. Results of the student essays indicated that, wellness issues were accepted by the students who took the course; their own well-being had been diminished by the burden of information to be learned in medical school; talking to peers was a useful coping mechanism; and the elective gave permission to engage in wellness activities without feeling guilty. In addition, the comments of the students regarding the elective were extremely positive. The results were supported by the reponses to the mailed questionnaires, showing that a wellness elective could be

useful for medical school students in addition to the first or second-year medical curriculum.

In another study, McCalanahan (1993) examined the effectiveness of two approaches, cognitive-based and activity-based, to wellness instruction, in a pretest-posttest experimental research design, with students in three university classes. Students enrolled in Concepts of Fitness and Wellness served as the cognitive-based group, students enrolled in Aerobics served as the activity-based group, and students enrolled in introduction to Business served as the control group of the study. Although both treatment approaches of the study produced increased Testwell scores, results indicate that wellness programs using an instructional approach which includes participation in physical activity and participant involvement in the learning process are more effective than those which use a cognitive-based approach and rely on lecture and paper-pencil assessments.

Griffin, Klinzing, and Ziegler (as cited in McCalanahan, 1993) found no significant differences in wellness measures of a traditional physical activity class compared to a holistic physical fitness/wellness class. They concluded that, just being physically active could not make wellness programs more effective. Rather, more holistic treatment approaches were required.

Watt, Verma and Flynn (1998) reviewed studies on wellness programs which took place between 1980 and 1996, except studies of patients with cancer and HIV, and studies of health promotion programs in workplace. Of the 1082 references initially identified, 11 studies were selected since they met the criteria that are being a primary study of a randomized controlled trial or a prospective study involving an intervention aimed at improving wellness and valid outcome measures. Results indicated that all studies reported some positive outcomes following the intervention in question, although many had limitations precluding applicability of the results to a wider population. All studies yielded evidence to support the use of the intervention in question; the results were usually statistically or clinically significant but

inconclusive because of small sample size or methodological bias. In general, the interventions resulted in improved scores on one or several psychological scales, such as measures of mood, anxiety, self-esteem and coping skills. The studies that did not directly measure the quality of life implied an improvement based on other scales. All of the studies used predominantly validated scales to measure outcomes. All of the studies reported high levels of significance.

Finally, as an example to college wellness improvement programs, Light (1995) developed, applied and improved a 2-semester wellness course. Since the goals of wellness and the goals of the liberal arts curriculum at Incarnate Word College were considered to be related and compatible, that is, both were based on the holistic philosophy, not just the intellect, a 2-semester wellness course as an introduction to the liberal arts was developed. Hettler's (1984), six factor wellness model was used as a base for this course. At the end of the first year, the students reported that this course was just like their traditional high school health classes. Based on these critics, the concept of wellness was re-evaluated, and viewing the wellness through the eyes of philosophy, religion, and the arts, a course was designed by emphasizing self-discovery, critical thinking, and creativity. As a result of a brainstorming with the students, six dimensions of wellness were presented in two semesters as physical, spiritual and occupational dimensions in the first semester, and emotional, social, and intellectual dimensions in the second semester. The information gathered from the students indicated that they were mostly satisfied with getting to know themselves better (increased self-awareness), learning how other students view the world, developing exercise and stress management skills, and developing friendships. As a problem, the students reported that some minority students felt discomfort and needed expanded explanations in relation to the dimension of spirituality.

To sum up, in the literature there are many studies that concentrate on the effectiveness of wellness improvement programs. Among them wellness programs which developed particularly in college campuses are important since these years are considered as establishing healthy lifestyles that will be carried over into adulthood. However, results of the many wellness improvement programs which developed

and were conducted in college campuses revealed wellness programs which deal with wellness in a holistic manner and incorporate holistic counseling techniques seem to be required. Art, due to sevaral reasons cited in the relevant literature, seems a valuable tool for wellness counseling programs especially designed for young people. In the following sections, the review of the literature on the use of art in counseling with the theory background and research findings will be presented to provide a base for the use of art-based wellness program (AWP), which was developed in the present study for the university students by considering the common theoretical elements of wellness, art and counseling.

2.6. Art : One More Tool for Wellness Improvement Programs

> *"All the arts that we practice are apprenticeship. The big art is our life."* (M.C. Richard, in Appalachian Expresive Arts Collective, 2002, p.101)

Counseling and art are considered as two old close friends working hand in hand for human well-being (Gladding, 1998). Counseling is a profession with the common purpose of making human experience constructive, meaningful, and enjoyable, while it is art, by its enriching, stimulating and therapeutic nature, that fosters different ways of experiencing the world. All good counseling employs an artistic quality that enables clients to express themselves in a creative and a unique way. By engaging in the playful, cooperative, and communicative dimensions of art, individuals recognize more clearly the complexity and simplicity of their lives. By being used both independently and complementarily in the counseling process, art helps counselors and clients gain unique and universal perspectives on problems and possibilities.

2.6.1. The History of the Use of Arts in Therapy and Counseling

Like many forms of treatment, art has its roots that extend far back into history. Since the beginning of human history, it has been used as a way of self-expression in various forms. Without labeling it as an art and without being aware of its healing effect, human beings expressed themselves though their bodies, sounds,

symbols, etc. Native cultures for example expressed their fears of nature through ceremonies of dance or construct totems. The early philosophers were highly influential in the evolving of arts in therapeutic uses. In Greeks, Pythagoras (580-500 BC) was one of the first known persons who used arts therapeutically (Feder & Feder, 1981; as cited in Gladding, 1998). After him, Plato's words underlined his belief in the power of the influence of arts on emotions and behavior, and his student Aristotle observed that people experienced emotional catharsis from listening to music (Meyer, 1999)**.** The *Greeks* of the classical period viewed mind, body and soul as intertwined. Based on this view, they used drama, music, and poetry to maintain and promote individual and societal harmony (Meyer, 1999). As in Greeks, the ancient *Roman* philosophers, such as Lucretius, Cicero, and Seneca, encouraged the public to use arts to achieve health and happiness. According to Peters (as cited in Gladding, 1998) Romans used music, cymbals, flutes, and other sounds to dispel melancholic thoughts as well as to promote wellness.

During the *Middle Ages,* in Europe, magic and superstition replaced arts in many quarters as the primary way to treat the emotionally disturbed. Arts fell into a feeble position. At this time, the Church had an ambivalent attitude toward art. While some music was considered profane and dance was seen as an instrument of Satan, the traditions and actual work of music, art, and literature were preserved in monasteries. The Church, with its music and ritual, contributed to the psychological comfort of large numbers of people (Coughlin, 1990; Meyer, 1999). During this period of time, in contrast to its position in the west, art was used abundantly as a healing and transcendenting force in *African, Native American,* and *Asian cultures* for years. Art in the form of paintings, jewelry, mask, and architecture flourished and helped to give cultures and people in these geographical areas a distinctiveness and freedom unknown in Europe during the Middle Ages (Meyer, 1999). Art became an integral part of these cultures. The traditions (e.g., sand paintings, songs, dance, and mandalas, chants) of these indigenous peoples were passed down through successive generations and to some extent continue today (Gladding, 1998; Malchiodi, 1998; Meyer, 1999). Like the indigenous cultures, both the *Judaic* and *Islamic cultures* believed in an interlinked body and soul. As a result of this belief, for instance, music

was integrated into medical practice in Egypt, Ottoman Empire (as cited in Meyer, 1999). In many spiritual and sacred traditions, such as the Jewish, Christian, and Sufi traditions of Islam music remains to be an essential part (Lipe, 2002).

Coming in *more modern times*, the European *Renaissance*, known as The Age of Enlightenment, brought open inquiry to the sciences and the arts and allowed for great intellectual growth. (Meyer, 1999). By the admiration for earlier classical civilization (Meyer, 1999), the use of the arts was emphasized in preventative and remedial mental health services, as it had been with ancient cultures (Gladding, 19998)**.** Then, by the time of the *industrial revolution in England,* 18th century, the use of the arts in the service of healing had expanded. A form of counseling known as *moral therapy* was begun. In this approach to treatment, mental patients were sent to country retreats where they received individual attention including occupational training and special times of involvement in the arts including selected reading, music, and painting (as cited in Gladding, 1998). This movement lasted only a few years, since it was considered as time consuming and expensive, but it resurfaced in the 20th century in what were eventually known as *milieu therapies*. Increasingly, hospitals, clinics, and rehabilitation centers began to include not only visual arts but also music, movement, and creative writing along with "talk therapies" (Malchiodi, 1998).

During the 20th century, the advent of psychology and psychiatry, World War I and II, psychiatry's interest in the art of hospitalized patients, the development of projective testing, the artists' interest in symbolic and spontaneous images and in U.S. funding for community mental health by President Kennedy were the relevant political, social, and psychological contexts influencing the development of the uses of arts as a therapeutic tool (Malchiodi, 1998; Meyer, 1999; Gladding, 1998). As stated by Malchiodi (1998), at the beginning of the century, the interest in the meaning of art created by the mentally ill and children resulted in the accumulation of scholar books and articles on the artwork of them. Many psychiatrists published their studies on these people; while some of those had large collections of these artworks. According to Malchiodi, investigations of this type of artwork increased

interest in the *diagnostic possibilities* of art. In 1906, German psychiatrist Fritz Mohr described the first drawing test for psychological purposes. The Rorschach test was first published in Europe in the early 1920s (and shortly after in the United States) by Hermann Rorschach, and in 1926, Florence Goodenough designed Draw-A-Man test to measure intelligence and personality characteristics through the number of details in their drawings of a man. Other tests (the Thematic Apperception Test, and the House-Three-Person procedure) were developed in the 1940s to assess personality through drawings. Furthermore, the *Menninger Clinic,* in Kansas, founded by Charles Menninger and his two sons Karl and William, in 1925, was particularly influential among many of these contributions. They believed art could help patients recover from mental illness, and they encouraged the development of activity. Also, in the early 20th century, while psychiatry was attempting to understand the inner workings of the mind, *artists,* affected by the advent of psychiatry and psychology, began to look inward for images for their work. According to Malchiodi, unfortunately, since many of these greatest artists, composers, and writers have suffered from mental illness, prejudices about creativity and mental illnesses connection appeared at that time. Finally, on the *political front,* by the 1960s, conditions were favorable for the development of art therapies. Community mental health, founded by President Kennedy, allowed some fledgling programs to incorporate art therapies. Training opportunities for mental health practitioners multiplied (Meyer, 1999).

The writings of powerful personalities in the field of psychology and therapy have advocated/emphasized the importance of therapy and counseling as an artistic endeavor or a profession that can make a difference through the use of arts (Gladding, 1998). Following World War I and II, needing new approaches to working with the impaired, increased interest in the arts, both as an adjunct to traditional "talk therapies" and as a unique and valuable discipline gained new recognition and acceptance. In the 1960s universities began designing degrees in the "arts therapies". Standards and guidelines of the field developed and the number of publication of periodicals dealing with the arts in counseling increased (Gladding, 1998).

Thus, coming from an enormously distant road, helping people to heal, develop, change, integrate, be self-aware, and/or transcendent, art appeared in the fields of therapy and counseling either as independent or complementary tools in the second half of the twentieth century. Basically, the applications of art in counseling polarized as art in therapy and art as therapy. The differences between these two applications and the theoretical framework regarding the use of art in counseling are explained in the following section.

2.6.2. Theoretical Framework for the Use of Art in Therapy and Counseling

As mentioned in the Introduction Chapter of this thesis, the contemporary uses of art with therapeutic purposes have been represented in the literature in two perspectives as *art in therapy* and *art as therapy*. The former reflects the approach in which the therapeutic process is inherent in talking about a work of art and in expressing oneself, with the help of a certified therapist or counselor (Elinor, 1992; Naumburg, 2001), whereas in the latter therapeutic process is inherent in the specific act of creation (Elinor,1992). Of course, in the latter a trained professional, called an art therapist should be available during the process, but, this person generally has certified in arts rather than therapy or counseling. The difference between these two poles could also be explained by the foundations of them. *Theories from the schools of psychotherapy* provide the bases for the former one, whereas *theories from art education* provide the bases for the latter.

Moreover, the former group splited in itself on the view whether the counselor or therapist needs specific art training or not. According to Coleman and Dufrene (1996), regardless of their orientations, therapists must be able to respond empathically with a variety of clients populations and situations. Art's power to evaluate, intensify, increase, and clarify one's awareness is the key to connection between therapeutic and artistic skills. By the side of the counselor, acknowledging therapy as an "art" reinforces acceptance of art into the therapeutic structure and facilitates the integration of art and therapy/counseling. Furthermore, a balanced

integration of art and therapy can be achieved by giving equal weight to both disciplines.

Devoted to the *art in therapy* perspective, various schools had used art as an auxiliary method for expression, emotional release, diagnosis, and as occupational therapy, as well as making valuable contributions on the use of arts in counseling (Appalachian Expressive Arts Collective, 2002). That is, art practices provided the professionals an opportunity to use them integrated with many contemporary counseling approaches**.** According to Riley (1999), the most critical task here is just creating a workable mix of theory. For instance, from a *client-centered* perspective, which comes from humanistic origins that have a tradition to honoring art; art can be used to encourage people for self-actualization via self-expression and integration of perception with an understanding of self and environment (Cochran, 1996). Assuming a person-centered expressive arts therapy approach, Natalie Rogers (2001) described her therapy approach, as an integrative multi-modal therapy, using movement, drawing, painting, sculpting, music, writing, sound, and improvisation as a path to wholeness. According to her, all arts that come from an emotional depth provide a process of self-discovery and insight. Involving the mind, the body and the emotions bring forth intuitive, imaginative abilities as well as logical, linear thought.

From a *Gestalt* perspective it is also possible to integrate art experiences into the therapy/counseling process to reach a psychic wholeness. Jane Rhyne (1996), renowned for developing the "gestalt art experience", an activity that gives participants a chance to integrate themselves using art materials, stated that in Gestalt art experience, clients are provided the process of making art forms for making them being involved in the forms they created, observing what they do, and hopefully perceiving not only themselves as they are now, but also alternate ways for creating themselves as they would like to be. Thus, art-making can uncover the hidden aspects of self, consolidating disconnected parts into a unified whole.

In addition to these two theoretical approaches, client-centered and Gestalt, it is possible to integrate art into the processes of other theoretical approaches such as *cognitive* perspective to explore and change irrational thoughts; to *solution-focused* perspective in order to help the person identify what he/she is already doing well and then build on these strengths (Kahn, 1999); and to *behavioral* perspective, *to* establish goals and express more adaptive behaviors (Kahn, 1999). Riley (1999) suggested the combination of the philosophy of the *narrative-social constructivist* view with the practice of *solution-focused* art therapy. According to her, the therapist in this approach could help the client to experimentally change the product, which, in turn, metaphorically suggests new resolutions to old scripts.

Whatever the orientation of the counselor, there are many *reasons* underliened in the literature *to use art in counseling and therapy* processes. For instance, known as the founder of art in therapy approach, Naumburg (1958; cited in Elinor, 1992) cited the advantages of introducing painting and clay modeling into analytically oriented psychotherapy as follows: First, it permits direct expression of dreams, fantasies, and other inner experiences that occur as pictures rather than words. Second, pictured projections of unconscious material escape censorship more easily than do verbal expressions, so that the therapeutic process is speeded up. Third, the productions are durable and unchanging; their content cannot be erased by forgetting, and their authorship is hard to deny. Fourth, the resolution of transference is made easier.

In the field of counseling, Gladding (1998) stated that, arts in counseling are contributing tools since they are primary means of assisting individuals to become more completely in touch with themselves, that is, promoting the connectedness between their minds and bodies; used in the process; they energize people; especially those that involve vision allow clients to see their focus more clearly; they enrich and expand the universe of the counselor; help people to establish a new sense of self; provide concreteness since the client is able to conceptualize and duplicate beneficial activities; results in insight; and foster socialization and cooperation in the counseling process. He also emphasized that the creative arts in counseling can provide multicultural opportunities. They involve playfulness; promote a collegial

relationship by breaking down the professional barriers; promote communication by "universal language" of artistic expression; enable clients to recognize the multiple nature of themselves and the world; seen as neutral and fun, and they are not resisted; they allow and even encourage nonverbal clients to participate meaningfully in counseling relationship; give the counselor one more tool to use in promoting understanding, dialogue or diagnosis in the professional relationship.

Moreover, the act of shaping raw material or emotion into symbol or image is healing as it helps to objectify the emotions, get some distance from them (Resnick, Warmoth, & Serlin, 2001); products of artistic creativity can be referred to in later days or weeks, unlike verbal expression, which fades quickly (Malchiodi, 1998); and art provides opportunity for the release of physical energy (Wadeson, 1980). Additionally, art making is possible for everyone and creating art enhances the life of human beings (Malchiodi, 1998).

Consistently, Riley (1999) indicated that, art therapy has some advantages due to its action oriented nature. In this respect, in an art activities based process, talking through metaphors could provide a non-threatening environment; the "truth" of the individual could be made concrete by the artwork; the problem could be externalized; the clients would have the chance to observe their own actions through the art tasks; the artworks informs the therapist and helps him/her assess the progress of treatment; artwork is pleasurable, and offers clients a new approach which suggests new solutions; and art shortens therapy. Concrete products of art can be referred to over time. This provides a chance to reinterpreting and rediscovering.

According to Reynolds (1990) while in the act of creation, the client experiences (1) an enlargement of human experience, (2) a self-balancing, life integration, and an increased self-understanding; and (3) a potential to reach normally inaccessible places inside him/herself.

According to Malchiodi (1998) art is helpful in identifying strengths. New samples of productive behavior can be learned, rehearsed, and practiced while painting or sculpting. These behaviors include making decisions (what subject to draw), tolerating frustrations (this paint brush is hard to control), delaying gratification (I want this to look perfect now!), and confronting a conflict (this hard clay reminds me of how stubborn I am). The art materials and process serve as a mirror for the movement (Franklin, 2000).

Using several art modalities in their work, Appalachian Expressive Arts Collective (2002), indicated that, arts provide a *collaborative process* between therapist and client; provide a *holistic approach* aiming at optimum health and well-being, rather than diagnosis and treatment; *make healing and personal growth possible* in the process, since the capacity for creative expression is a fundamental aspect of health; provide a chance to express and honor *body knowledge, intuitive wisdom, subjective experience, and emotions as valid ways of knowing in and of themselves*; provide a *depth-oriented* process, and an *interdisciplinary work* possible; allow the therapist/ counselor an *ongoing personal use of creative expression*; could be integrated with healing experiences in the context of *community*, assuming art and therapy and life are not separate, and that all are practiced in community for the healing of both the individual and community as a whole; provide a *spiritual practice*; and offer the possibility for *meditative practice* and entry into what may be described as *an experience of universal consciousness.*

In sum, regardless of the orientation of the counselor, the goal of therapy/counseling based on art activities, and the *art in therapy approach* should be found in the *process* and not in the *product*. It *does not require any particular skill or talent to participate* in such a process (Reynolds, 1990; Ross, 1997). Participation in all of the art-enriched counseling and therapy processes provides people with ways to express themselves that may not be possible through more traditional therapies. The nonverbal language of art could be used for personal growth, insight, and transformation and could be a means of connecting the inside – thoughts, feelings and perceptions- with outside realities and life experiences (Malchiodi, 1998).

Emphasis is placed on the individual who is encouraged to empower him/herself through the self-exploration and self-interpretation of his/her own art. The artwork can be spontaneous but may also be directed by the counselor/therapist. Through the art process, individuals can often approach difficult issues and convey a message much clearer and safer than with words. The art product serves as a record of these events which the individual can later reflect on and eventually understand with greater clarity (Canadian Art Therapy, 2001). Thus, the *role of the counselor* in such a process is keeping the space safe and creative (McNiff; as cited in Rubin, 2001); to make a space of freedom and playfulness, full of choice and inspiration; understand and use the arts to bring to bear all the senses, the body as a whole, emotion, intuition, dreams, visions, expressive skills, and intelligence to support the client's natural movement toward meaning making and wholeness (Appalachian Expressive Arts Collective, 2002).

Selecting the art materials and *activities* appears as important as an issue to consider in this process. The types of art materials and activities used in group process are limitless. However, there are some issues to consider. For instance, according to Ross (1997) although any of a wide range of creative materials are appropriate in this process, aside from practical constraints, there are important considerations around selecting materials in relation to both the aims of the sessions and the personalities of the clients. For instance, since the choice of materials affects the way in which activities are engaged, it is important to be aware of the fact that some materials, such as pencils, crayons and felt tips, allow 'tighter' control, while others, such as pastels, paint and clay, can give rise to 'looser' and 'freer' expression. Materials which are easily controlled are appropriate when the clients are tentative, unsure, or worried, because the clients may feel safer with them. Similarly, it can be safer, more contained and can reduce a 'sense of chaos' to begin with 'controllable' materials with clients whose behavior is difficult to manage. If people are seriously unconfident about their art ability, cutting out pictures and making collages can encourage people to join in the activities, and once they are confident about engaging, materials such as paint or clay can give rise to deeper and wider self-expression. Also, according to Ross (1997), working with expressive materials can

be in itself therapeutic. Consistent with Ross (1997), Rubin (1988) indicated that practitioners should consider developmental issues of their clients when planning activities.

Using one or *more than one art modality* is another issue to consider. Traditional arts range from those that are primarily auditory or written (e.g., music, drama, and literature) to those that are predominantly visual (e.g., painting, mime, dance, and movement). According to Gladding (1998), many overlaps exist between these two categories, and in most cases using two or more art combinations, such as literature and drama or dance and music, provides fruitful results in counseling. According to McNiff (as cited in Rubin 2001), using many different modalities of art provides multi-sensory experiences, and the ecology of different sensory expressions not only increases the creative vitality of the whole environment but also furthers imaginative expression within a particular medium. Furthermore, he reported that he has always chosen to use different arts in his studio practice since the breadth of resources and materials enriches the creative process and is more satisfying for participants. Similarly, according to Natalie Rogers (2001) incorporating more than one modalities of art enhances the therapeutic relationship in many ways such as helping clients to identify and be in touch with feelings, explore unconscious material, release energy, gain insight, solve problems, and discover the intuitive and spiritual dimensions of the self.

Additionally, *deciding on the degree of structure*, while using art in counseling process, is also vital. Some art groups work in a "non-structured" way; that is the group meets as a group at a specific time and place, but apart from that everyone pursues his or her own work. These groups are generally called *Open Studio Groups*. In this kind of groupwork, the leader is there to facilitate what the members want to do and they interact with her more or less as they choose. There may be little group interaction as there is likely to be no consistency in attendance (Wadeson, 1995). Short-term art therapy groups generally require more structured art activities. Structured art groups are those which meet to share a common task or explore a common theme. Sharing a theme can help to join a group together. The group can get

to the point more quickly if it focuses on a suitable theme (Leibmann, 1986). Working in a "structured" way can mean many things. It can mean using just a simple boundary rule or it can mean a more prescribed activity. Again, there is a continuum from instructions which are so loose that they do not constitute a theme at all, to activities which could be described as very specific themes (Leibmann, 1986). Many groups will combine elements of both, and alternate between structured work and sessions in which everyone "does their own thing". The groups may be more or less structured, depending on population, goals, and circumstances (Wadeson, 1995).

Furthermore, *while using art in group format*, counselors should also consider some other essential issues. For instance, in the *discussion* of the art activities, the leader should be active in drawing connections among the art products and trying to involve all the participants in discussion. (Wadeson, 1995). As mentioned by Leibman (1986) d*uring the activity time* of the group, it could be very worthwhile for the leader to observe what is going on in the non-verbal process while people are working to think through art. Since people work at very different speeds the members of an art group often finish their work at different times. The leader could encourage the fast workers to do something more while waiting; and she could help slow workers by informing them when time is nearly up so that they can decide what is most important. When some members are really "stuck", the leader could help with some gentle questions to draw out what that person feels about the theme rather than leave everyone struggling. Furthermore, the leader should manage the physical arrangements well, especially for the *discussion* time. Everybody needs to be able to see what is being discussed and it can facilitate group cohesion and interaction if everyone can also have eye contact with one another. It is essential to say whether everyone is expected to share their art works or whether there is no obligation. The leader may ask if anyone would like to start, and everyone else follows on round the circle in turn; or the first person can choose the next one, and so on; or everyone takes a turn when it feels right. Three of the most usual modals of group discussions about the artwork produced are: (a) everyone takes turns, (b) focus on one or two pictures, and (c) focus on group dynamics. If the leader had taken part in the activity, she would be expected to share too. Since interpretation takes place in

psychoanalytical school, and requires considerable training and experience, the leader should avoid and prohibit interpretation. Finally, while *ending the session,* it is good to try to end the session with a positive note, perhaps with a comment that sums up the session or thanks people for coming.

2.6.3. Cautions for Using Art in Counseling

In spite of all the positive qualities mentioned above, creative art causes some limitations when used in counseling process. Gladding (1998) listed some warnings about the use of creative arts in the counseling process as follows: Those who are professional artists, irrationally minded, and mentally unstable may not be appropriate for therapeutic treatment using the arts. Popular misperceptions about arts; especially links between creative arts and mental health may influence the use of arts. Arts may be employed in non-therapeutic and nonscientific ways; and finally, clients may become too introspective, passive, or overcritical of themselves or the situation.

2.6.4. Research Findings Regarding the Use of Art as a Wellness Improvement Tool

Parallel with the increased popularity of the use of art in therapy and counseling, there appeared an increasing interest in studies investigating the effectiveness of art in several issues, settings, age groups, races, and ethnic backgrounds. Findings of these studies revealed that art has been able to provide meaningful therapeutic opportunities for many of them. Moreover, art has been found effective when it is used in different formats of counseling like individual, couple, family, and group counseling. Below, a sample of studies representing the effectiveness of art-based interventions which resulted in physical and mental health improvements in different populations is presented.

In the literature it is possible to find several examples on the effective uses of art activities based interventions for youngest people. According to Ross (1997), art can be a vehicle for developing communication skills, for promoting self-esteem and raising confidence; moreover, it is an effective way of exploring specific issues, problems or incidents while working with children. Art can also be used to promote cooperative behavior and group building in school settings and it can help children express things for which they have no language or are unable to say aloud. Its enjoyable nature is another worthwhile side. Ross declared the positive outcomes of art activities based intervention when used with marginalized children within the class, "worst class" syndrome, to build skills and strategies to cope with the demands of secondary school and offer emotional support, to build cooperation and trust in groups, to enhance social interactions (to shift dynamics, change roles, build social skills, and develop mutual respect) with individual children to build confidence, improve self-image, self-esteem, increase self-awareness and an understanding of their own behavior, and provide emotional and psychological support, in issues forums to allow a variety of issues to be aired, explores, shared, and discussed, to promote understanding of conflict situations and support a problem solving approach, to improve communication skills, to deal with bullying and harassment, and to support the work of pastoral staff. Art activities improve group identity, develop a cooperative attitude, increase assertiveness, and reduce anxiety. Consistent with the ideas of Ross (1997), looking at the studies on children, research findings revealed that, art is an effective counseling tool to enhance self-esteem (Castro, 1999), to motivate the children at risk (Cho, 1996), to assist children of divorce (Loges, 2000), to communicate feelings in pediatric setting (Raghurman, 1999), and to decrease disruptive classroom behaviors in elementary school (Ronaldson, 1995). Art is also commonly cited in the literature as an effective tool in grief work with children (Finn, 2003; Huss & Ritchie, 1999; Tonkins & Lambert, 1996). In addition, numerous studies show the impact of the creative arts on children from different cultures, such as those by Omizo, Omizo, and Kitaoka, (1989) with Hawaiian children; Constantino, Malgady, and Rogler (1986) with Latino children; Appleton and Dykeman (1996) with Native American children.

As in children, art has been found effective in studies with adolescents, due to several reasons. For instance, since there is an important relationship between adolescent emotional health and self-expression, art at this stage of life could provide a useful tool for the youngsters to express themselves and thus to be healthier (Linesch, 1988). According to Blos (as cited in Kahn, 1999), teenage diaries and journals are good examples of the healthy youngsters' ability to find ways of exploring and experimenting with identity concerns by using creativity that helps her transition from childhood to adulthood. Additionally, it is known that adolescents live in a world of images; therefore they are comfortable with a counseling process utilizing images. Using images is additionally therapeutic in that it decreases the defenses which typically slow traditional talk therapy (Wadeson, 1980). Moreover, art helps to break the ices between counselor and the youngest (Riley, 1999). Therefore, considering all the other advantages, art-enriched counseling at this developmental stage of life seems a natural and appropriate counseling tool as well as one providing a developmentally oriented rationale (Gladding,1998; Linesh, 1998; Naumburg, 2001; Riley, 1999). Finally, the comprehensive language of arts could also help the counselors to reach the complex world of their adolescent clients (Linesch, 1988).

Furthermore, several research findings indicated that different modalities of art lead to effective results in adolescent population. For instance, *music activities* were found effective in adolescents in juvenile delinquency programs because they became increasingly aware of connectedness between hard work and achievement (Johnson, 1981). *Imagery exercises* found effective in depression (Schultz, 1984) and modification of anger (Kaplan, 1994). Additionally, *visual art* has been found to have a potency in many treatment situations with adolescents such as working with juvenile sexual offenders (Gerber, 1994), with juvenile delinquents to learn about themselves and to coping with emotional problems (Howard, 2001), and with emotionally disturbed adolescents to address violent imagery (Graham,1994), with nonaggressive peer-rejected youths (Margolin, 2001), and with adopted adolescents (Robertson, 2001). Daniels (2000) combined art therapy and guided imagery in her qualitative study to show an increase in self-concept of adolescent female sexual

abuse survivors and found that this research approach was an effective way to gauge the client's self-concept, as was viewing their art and listening to their verbalizations. Additionally, Shaffer (as cited in Gladding, 1998) has used a *psychodrama* technique based on Shakespeare's play Hamlet to help middle school students to learn to become more aware that what they do has an impact on others as well as themselves and that they have choices in what they do. Similarly, *videotaped improvisational drama* has been found to significantly increase the ability of adolescents to maintain internal locus of control (Dequine & Pearson-Davis, 1983). Similarly, Reynolds (1990) used art with artistic adolescents in a five years group mentoring model and reported positive outcomes.

Research findings also indicated that the simple act of *expressive writing* improved eating disorders (Scmidt, Bone, Hems, Lessem, & Treasure, 2002), and general health (Pennebaker, 1999; Pennebaker & Seagal, 1999; Campbell & Pennebaker, 2003) in college students. There are also many other studies in the literature showing significant physical and mental health improvements in different age groups after writing expressively about emotional experiences. The basic paradigm for these studies is known as *Pennebaker Paradigm* (Pennebaker, 1997). Studies conducted on this paradigm typically involved randomly assigning participants to two or more groups, and then asking them to write about assigned topics for 3 to 5 consecutive days, 15 to 30 min each day. Generally, control group participants are asked to write about superficial topics, whereas the experimental group participants are asked to write about deepest thoughts and feelings about various topics depending on the purpose of the study. Using this paradigm, several studies have found that participants who write down their deepest thoughts and emotions about a significant event show increased general health and well-being (Pennebaker, 1997); reduced medical visits (Pennebaker & Beall, 1986), fewer absentee days, improved liver enzyme function (Francis & Pennebaker, 1992), increased immune function (Esterling, Antoni, Kumar, & Schneiderman, 1994), decreased sleep onset latency (Harvey & Farrel, 2003), increases in upper respiratory symptoms, tension, or fatigue, and more likely to reunite with ex-partner after a breakup (Lepore & Greenberg, 2002); increases in medication adherence and decrease in symptom

distress among pessimistic individuals (Mann, 2001).

Despite the many advantages of using art in young populations, as mentioned in section 2.6, most of the wellness improvement programs developed for young people were based on cognitive-based instruction strategies. In the following paragraphs, some examples for the art-enriched programs which aim at improving wellness or some components of wellness are outlined.

In a study conducted by Evans, Valadez, Burns, and Rodriguez (2002) art has been reported as most frequently used nontraditional therapy approach for wellness. In this study, they examined the attitudes of 151 mental health service providers of diverse racial, ethnic, and gender classifications toward brief and nontraditional approaches. According to them, the shared links among the alternative therapy modalities are the holistic approach to physical and mental wellness that mind, body and spirit are intercorrelated and wellness depends on the equilibrium between these three components. The results showed that the majority of these professionals believe that their clients' respond favorably to the use of these nontraditional techniques. Also the results indicated that, frustration with traditional approaches, attraction of holistic approach; seeing these approaches as quick fix and trendy are the reasons that the professionals think their clients prefer nontraditional therapies.

Kennet (2000) reported the effective results of the participation of terminally ill patients in a creative arts project in St Christopher's day centre. By the help of professional artists, an art therapist and a writer, the patients were involved in pottery, painting, craft, textiles, art therapy and creative writing groups, and they took part in an exhibition of their creative arts work. Results of the semi-structured, audiotaped interviews revealed the main themes as enjoyment, enthusiasm, excitement, pride, achievement, satisfaction, sense of purpose, mutual support and permanence. These themes were interpreted as positive expressions of self-esteem, autonomy, social integration and hope by the researcher.

Ragle (1996) investigated whether participating in a group art therapy with caregivers who work with Mentally Retarded/Developmentally Disabled and psychiatric clients explored and decreased work related stress through the use of art media and techniques. Using a quasi-experimental approach, she conducted two separate art therapy groups (with 11 caregivers) to meet weekly during 8 weeks, using a variety of art media and techniques. The groups also came together for follow-up sessions. Assessment procedures including a pre-, and post-session art therapy assessment, a pre-, mid-, and post-session stress self-evaluation, and weekly pre-and post-session stress level were rated by color charts. In general pre, mid, and post evaluations both groups showed decrease in "things they did", and "things that cause them stress". Additionally, she found that art therapy decreased work related stress in caregivers.

Maselli (1998) investigated the effectiveness of a 10 ½ month pilot program, "open studio art experiences", created for a Health and Wellness Social Ministry. The hypotheses proposed that a person-centered art-therapy, experiential approach, conducted in a community based open studio can help to motivate "normal" individuals to take increased responsibility for personal health and wellness as evidenced by (1) an absence or reduction in depression levels as measured by Beck Depression Inventory scores and/or (2) a change in life-style choices and use of time. A total of 56 participants from ages 8 to 82 years represented the "normal" "healthy" people from the community. Weekly group dyad and individual sessions focused on personal expression and facilitated self-exploration, aspects of wellness and personal health issues. The outcome study focused on two adult groups. Adult Studio group-1 consisted of 1 male and 7 females and participated in 37 sessions, while Adult Studio Group-2 consisted of 8 female members, and participated in 23 sessions. Results from both quantitative data and qualitative information indicated positive changes in self-esteem, personal insight, self-awareness, understanding others, lifestyle choices, personality characteristics, and fluctuations in mood, specifically levels of depression. An increased responsibility for personal health and wellness were concluded by these factors.

Similarly, Siegel and Bartley (2004) organized a series of art sessions for the community, and as a result of the success of their sessions, they decided to make art a permanent part of their health centers services. This study is an example for health promotion through the arts. By starting with a holiday art program and obtaining successful results, the researchers scheduled artist-led workshops for 10 weeks in the main community room of the health center. Art supplies were available for 25 participants. Before and after the session, staff members took the blood pressure of art course participants who were also being treated at the health center for hypertension. Blood pressures taken after the art session were consistently lower than those recorded before the session.

In the field of art therapy, the studies of Soden (1998) and Odle (1998) are examples for the ones trying to reach personal wellness through art in a case study format. Soden (1998) reported the effectiveness of art making and empathic co-reflection on personal wellness as a result of his study on two cases. Similarly, Odle (1998) used mandala as a tool for spiritual healing, self-discovery, and a personal exploration, and reported its effectiveness as a result of her case studies.

In sum, empirical research findings provide evidence that art is a useful tool for improving wellness in all ages, but especially in adolescent years. However, there was no study in the literature examining wellness in a holistic manner and testing the effectiveness of a counseling program enriched by art activities in promoting wellness among college students.

2.7. Research Findings Regarding Wellness and Wellness Programs in Turkey

Wellness is a new interest area in Turkish literature. Studies, based on holistic models of wellness are few. However, there are many studies investigating the variables related to health habits and life-style choices, such as *nutrition* (Korkmaz, Özçelik, Akıncı, & Alphan, 2004); *smoking, alcohol, and substance use* (Soyer, Şentürk, & Atlı, 2004 ; Polat, Arslan, & Kumbasar, 2004); *physical activity*

(Karaca, Polat, & Şalom, 2004); *health knowledge and behavior* (Ulutatar, Çalık, & Avcı, 2004); *health promoting behaviors* (Sevil, Çoban, & Taşçı, 2004); *healthy living behaviors* (Özdemir, Göz, & Kutlu, 2004); *school health services and health education programs* (Özyurt, Dinç, Eser, Özcan, & Cengiz, 2004). These studies have been conducted by the researchers coming from the fields of nursing and public health. The results of these studies provide data emphasizing the common poor health habits of Turkish people, especially, Turkish students.

In Turkish literature, there are also some health education programs conducted by professionals from the field of nursing and health education. For instance, Bektaş (2002) reported the positive outcomes of a health education program on self-concept, anxiety level and positive health behaviors of elementary level students. The program consisted of 10 sessions concerning self-awareness; exercise, nutrition, stress and stress management- problem solving, time management, good health habits, and school accidents and prevention. Similarly, Durusu (1996), and Yiğit, Tokgöz and Esenay (2001) found significant increases in health knowledge of elementary level students after attending health education programs which focused mainly on nutrition and physical health.

In the field of counseling, many researchers investigated some variables that are related to the dimensions of wellness, such as *self-esteem and physical symptoms* (Maşrabacı, 1994); *physical self-concept* (Aşçı, 2002); *eating attitudes (*Baş, Aşçı, Karabudak & Kızıltan, 2004); *humor and physical symptoms* (Aydın, 1993); *optimism and physical symptoms* (Aydın & Tezer, 1991; Üstündağ & Mocan-Aydın, 2005); *well-being* (Aygün-Karakitapoğlu, 2004; Gençöz & Özlale, 2004). Results of these studies are presented below.

For example, Aydın (1993) investigated the predictors of physical symptoms in a sample of lycee and college students and found that internal-external locus of control, generalized achievement expectations and sense of humor are predictors of physical symptoms of students. Aydın and Tezer (1991) investigated the relationship

among optimism, health problems and academic achievement in a sample of 392 university students. Results revealed a negative relationship between optimism and health problems, and a positive relationship between optimism and academic achievement. Similarly, Üstündağ-Budak and Mocan-Aydın (2005) reported that, while optimism and internal health locus of control best predicted physical health for males, optimism and chance health locus of control best predicted the physical health symptoms of females.

Aşçı (2002) investigated the age and gender differences in physical self concept among university students (N = 995). Results of MANOVA revealed a main significant effect for gender, but no significant main effect for year in school. In addition results of ANOVA revealed significant gender differences in sport competence, physical condition, body attractiveness, and physical strength in favor of male students (except for body attractiveness).

Baş, Aşçı, Karabudak, and Kızıltan (2004) investigated the eating attitudes and psychological characteristics of university students (N = 783). Results revealed that 11.5 % of the students had disturbed eating attitudes; these attitudes were more prevalent in females than in males, although the difference was not statistically significant; but consumptions of unhealthy foods was found to be correlated with several psychological characteristics such as lower self-esteem, higher trait anxiety, and higher social physique anxiety.

Aygün-Karakitapoğlu (2004) investigated the relationships of self-descriptions, identity orientations and emotional well-being in a sample of 205 (96 male, 109 female) university students. The results of the study revealed that emotional well-being was positively associated with all types of identity orientations as well as with independent and relational-independent domains of self-description. Similarly, Gençöz and Özlale (2004) investigated the direct and indirect effects of social support (Aid-Related and Appreciation-Related Social Support) on the psychological well-being of university students (N = 342). Results indicated that aid-related social support and psychological well-being association was partially mediated by

experiencing fewer life stress, whereas appreciation-related social support had a direct effect on psychological well-being. As another example to the studies on well-being Dost-Tüzgöl (2005) developed a 46 items Likert type scale called *Subjective Well-Being Scale* in a sample of 209 college students. She reported that this instrument is a valid and reliable one to measure subjective well-being.

Almost all of the studies mentioned above are descriptive in nature and provide indirect supports concerning the holistic nature of wellness. However, there are some recent studies investigating the different dimensions of wellness. For example, Sarı (2003) and Doğan (2004) investigated the variables which are related to wellness among university students, and Maşraf (2003) investigated the effectiveness of a wellness oriented stress management program on stress level and coping strategies of university students.

Sarı (2003), investigated the relationships among wellness relationship status, gender, place of residence, and GPA among university preparatory school students (N = 389). She examined 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 students with respect to gender, relationship status, place of residence, and GPA. She used Wellness Inventory (WI) developed by Güneri (2003). Results of the MANOVA's revealed significant gender differences in self-consistency, love, environmental sensitivity sub-scales scores of WI in favor of male students, but in social interest and empathy sub-scales in favor of female students. Students who were in a committed relationship scored significantly higher in physical wellness sub-scale. In addition, students whose GPA changed between 90-100, scored significantly higher on mastery orientation subscale of WI.

After adapting WEL (Witmer, Sweeney, & Myers, 2001) to Turkish culture, Doğan (2004), in a sample of 936 (623 female, 313 male) university students, investigated the impact of physical exercise, smoking, the frequency of alcohol consumption, opinions about future, level of family support, and level of support from friends on

wellness of university students and found that although the wellness level of students differed significantly in terms of physical exercise, opinions about future, level of family and friend supports, there were no significant differences in wellness terms of smoking status and frequency of alcohol consumption.

Maşraf (2003), examined the effect of a wellness oriented stress management program on stress level and coping strategies of university preparatory school students, in a pre-test, post-test experimental, control group design. The participants of the study were 14 students (9 boys and 5 girls), selected from 223 Middle East Technical University prep school students on the basis of Life Events Inventory. The experimental group that received the eight session wellness oriented stress management program was composed of 7 students (4 boys, and 3 girls); whereas the control group that received no training was composed of 7 students (5 boys, 2 girls). The sessions of the training program took 90 minutes with a cognitive based approach. Results of the Mann Whitney-U Test revealed that the program was not effective in reducing the stress level of the experimental group subjects. The results also demonstrated that although wellness oriented stress management program did not significantly change the problem-focused, seeking social support, wishful thinking, and avoidance subscale scores obtained from the Ways of Coping Checklist, it did significantly change self-blame subscale scores.

Similar to the wellness literature, the literature on the use of art activities in counseling is rather scarce in Turkey. In Turkish culture, the use of art in the treatment of mind, body, and soul of those who suffered from mental or emotional disorders has a long tradition, which began with shamans in Central Asia and then was followed with the mental health hospitals of Ottoman Empire (Güvenç, n.d.). Recently, as a sign of the maintainance of this tradition, an Art and Psychopatology Association has been founded, and the first International Mental Health and Artistic Creativity Symposium was organized in 2002, in Ankara. However, the use of art activities as a therapeutic tool in counseling processes with “normal” people to help their personal development and well-being is a new interest area for Turkish counselors.

In Turkish literature, there are a few studies concerning the use of art in counseling processes. Among these, Uçar (1996) and Yılmaz's (2000) studies on the use of bibliotherapy in counseling practices in Turkish high schools showed the significant contributions of using art in counseling practices.

To sum up, little research has been conducted about wellness improvement programs in Turkey despite its growing popularity. In addition, art has never been used as a counseling tool in improving wellness in Turkey. Thus, it is expected that a study on developing and testing the effectiveness of a holistic and art-enriched wellness program can make a contribution to field of counseling in Turkey.

CHAPTER III

METHOD

In the present chapter, the methodological procedures followed in the study are presented. The first section introduces the overall design of the study. The second section describes the sample and the selection of the subjects. The third section describes the instruments used for data collection. The fourth section presents the training procedure and the training material. The fifth section explains the data analysis procedures.

3.1. Overall Design of the Study

In the present study, two consecutive phases were followed: (1) a descriptive study was conducted to investigate the dimensions of wellness and their relationships with some selected variables, and (2) an experimental study was carried out to test the effectiveness of Art-enriched Wellness Program (AWP) on wellness scores of experimental group students.

In the first phase of the study, instruments for measuring wellness, physical symptoms, self-esteem, and art self-concepts were administered to 415 (233 male, 162 female, and 20 indicated no gender) students from the METU preparatory school in fall 2003; and 214 (63 male, 139 female, and 12 indicated no gender) junior and sophomore students from the Faculty of Education of METU, in spring 2004. An explanatory factor analysis (EFA) was employed in the data gathered from 629 students (296 male, 301 female, and 32 indicated no gender) to test the dimensions of the 103-item Wellness Inventory (WI). Confirmatory factor analysis (CFA) was also performed to examine the construct validity of Wellness Inventory (WI). The results of EFA and CFA yielded a scale consisting of 30 items with 4 factors. These factors

were named as cognitive-emotional wellness (CEW), relational wellness (RW), life-goal (LG), and physical wellness (PW). The detailed information of both the EFA and CFA and the resulting 30-item WI were presented in the Results chapter. In the second stage of the first phase, five separate multiple linear regression analyses were conducted to investigate the possible contributions of independent variables (self-esteem, physical symptoms, art self-concept, and gender) to dependent variables (overall wellness, CEW, RW, LG, and PW).

In the second phase of the study, Art-enriched Wellness Program (AWP) was developed by the researcher for the purpose of improving the wellness of university students. In order to test the effectiveness of the program, a pre-test post-test control group experimental design study was carried out with a sample of 16 participants (N = 6 for the treatment group, N = 10 for the non-treatment control group) selected from a sample of Faculty of Education students (N= 214; 63 male, 139 female, and 12 gender missing). The follow-up tests were administered two weeks and four months after the treatment.

In the selection and assignment of subjects to experimental and control groups, two criteria were used: (1) scoring –one standard deviation- above the mean both in Wellness Inventory and Symptom Checklist, and (2) being volunteering to participating in the AWP. Subjects who met these criteria randomly were assigned to experimental and control groups and they invited were to contact with the researcher. The experimental study was conducted between April 7 and June 1, 2004. Equality between the experimental and control group subjects' pre-test total wellness scores (z = -.33, p = .79) and physical symptom scores (z = -.65, p = .56) was ensured before the application of AWP. Thus, two groups; one experimental group and one non-treatment control group were established. The experimental group received a 20 hours- 8 weekly AWP (each session was 2.5 hours), while the non-treatment control group received no training during that time. For the purpose of collecting qualitative data about the effectiveness of the AWP, a questionnaire was administered to the subjects of the experimental group at the end of the program. The follow-up test

instruments were administered to both groups first in June of 2004, and second in November of 2004.

3.2. Population and Sample Selection

The first phase of the study was carried out with the volunteered students from METU Preparatory School and Faculty of Education. A total of 638 questionnaire packets were distributed to the sample. As a result of data cleaning procedures, 7 cases were omitted since missing values were greater than 5 % (Tabachnic & Fidell, 2001). For the rest of the sample, the missing values were replaced by series mean scores. In addition, two cases were omitted from the sample due to having severe health problems (psychiatric problems and a heart operation) in the last year. The final sample included 629 students (296 male, 301 female, and 32 indicated no gender) with a mean age of 18.96, and a standard deviation of 1.47. The distribution of the participants by gender is presented in Table 3.1.

Table 3.1. *Participants of the Descriptive Phase of the Study*

	Male	Female	Indicated no gender	Total
Preparatory School	233	162	20	415
Faculty of Education	63	139	12	214
Total	296	301	32	629

In the second phase of the study, the experimental and control group members were recruited from the volunteered students of Faculty of Education who met the criteria of 1 standard deviation below the mean of the total scores of the new version of Wellness Inventory (see Results Chapter) and Physical Symptom Checklist. Subjects who met these criteria were randomly assigned to experimental groups and control groups. The distribution of the students in the experimental phase of the study by groups and gender is presented in Table 3.2.

Table 3.2. Participants of the Experimental Phase of the Study

GROUPS	Male	Female	**Total**
EXPERIMENTAL GROUP	3	3	**6**
CONTROL GROUP	8	2	**10**
TOTAL	**11**	**5**	**16**

As seen in Table 3.2, the experimental group who completed the AWP consisted of 6 students (3 female and 3 male; with a mean age of 21.17 and a standard deviation of 3.06). The no-treatment control group consisted of 10 students (8 female, 2 male; with a mean age of 19.90, and a standard deviation of .88).

3.3. Data Collection Instruments

In this study, four instruments were used in the collection of data namely Wellness Inventory, Rosenberg Self-Esteem Scale, Physical Symptom Checklist, and Art Self-Concept Scale. Information regarding these instruments are provided below.

3.3.1. Wellness Inventory

Wellness Inventory (WI; see Appendix B) is a self-report instrument developed by Güneri (2003). Güneri created an item pool which included items from previously developed wellness scales together with original ones. The scale consisted of 103 items with a 5-point likert scale ranging from (1) “strongly disagree” to (5) “strongly agree” The inventory yields a total score and eight sub-scores. Higher scores indicate having high level of wellness in each sub-scale and in the total scores. The validity and reliability studies of WI have been carried out by Güneri (2003). As for the construct validity of WI, Güneri conducted principal component analysis with varimax rotation followed by the Kaiser normalization procedure. Results revealed eight meaningful factors with the range of loadings of .674-.292 for relational self, .525-.310 for social interest and empathy, .510-.297 for self-consistency, .558-.265 for mastery orientation, .620-.263 for physical wellness, .656-.392 for humor, .715-.375 for love, and .691-.290 for environmental sensitivity. The reliability coefficients were, .94 for the overall scale (103 items), .88 for relational-self sub-scale (20 items), .76 for social interest and empathy (11 items), .80 for self-consistency (29 items), .91 for mastery orientation (11 items), .76 for physical wellness (16 items), .59 for humor (5 items), .72 for love (4 items), and .77 for environmental sensitivity (7 items).

In the present study, the factor structure of WI was reevaluated both by EFA and CFA to determine the dimensions of WI. The results yielded a 30-items questionnaire with 4 factors. As for the reliability and validity evidence, the results of EFA and CFA together with the correlations between WI scores and self-esteem, physical symptoms, and art self-concept scores were reported in the Results section of this study.

3.3.2. Physical Symptom Checklist

Physical Symptom Checklist (PSC; see Appendix C) was developed by Scheier and Carver (1985) for the purpose of measuring the physical symptoms of the individuals. Most of the symptoms on the checklist were relatively mild and included items that the individuals might be expected to experience, such as fatigue, coughs, headaches, muscle soreness, and dizziness. The subjects were asked to indicate, on a scale of 1 (never) to 5 (very often), how frequently, if at all, they experienced the symptoms over a four-week period. The checklist contains 38 items with possible scores ranging from 38 to 190, a high score indicates high occurrence of the symptoms. PSC was translated into Turkish by Aydın and Tezer (1991). These researchers reported negative relations between physical symptoms and optimism ($r = -.21$; $p < .001$).

In the present study, PSC was administered to 629 METU students. Cronbach Alpha coefficient was found as .90 ($N = 621$) indicating that PSC has a satisfactory level of reliability.

3.3.3. Rosenberg Self-Esteem Scale

Rosenberg Self-Esteem Scale (RSES; see Appendix D) is a commonly used measure of global self-esteem. It was originally developed by Rosenberg (1965). It is a 10-item Likert type scale with the response alternatives ranging from 1 = strongly agree to 4 = strongly disagree. Positive and negative items were presented alternatively to

reduce the effect of the respondence set. The possible scores that can be obtained from the scale changed between 10 and 40.

The scale was translated into Turkish by Çuhadaroğlu (1985). She also used psychiatric interviews as criteria for the original scale, and reported .71 correlation coefficient between the interview scores and the scores of RSES. Additionally, Çankaya (1997) reported modest but significant correlation coefficients between the scores of Self-Concept Inventory and the scores of RSES ($r = .26$ for the whole group; $p < .001$, .26 for the boys; $p < .05$; and .24 for the girls; $p < .05$).

In the present study, RSES was administered to 629 METU students. From this sample 7 RSES forms were excluded due to the incomplete information. For the remaining 622 students, Cronbach Alpha coefficient for RSES was found as .87. This indicated that RSES has a satisfactory level of reliability for the use of the present study.

3.3.4. Art Self-Concept Scale

Art Self-Concept Scale (ASCS; see Appendix E) was developed by Duran-Oğuz and Tezer (2005) based on Vispoel's (1993) Arts Self-Perception Inventory. Different from Vispoel's scale in the development of ASCS items were developed to measure how individuals see themselves in participating in art activities without identifying art modalities. ASCS is a 10-item Likert type scale for measuring art self-concept with the alternatives ranging from (1) "strongly disagree" to (5) "strongly agree". Higher scores indicate more positive art related self-evaluations. The construct validity of the scale was investigated by employing Principle Component Analysis with Varimax rotation. Results yielded that the scale was a unidimensional one. Although low, the correlation between ASCS and RSES was significant ($r = .15$, $p < .05$). The correlation between ASCS and the social desirability measure was not significant ($r = .03$) indicating further evidence for the validity of the scale. The internal consistency coefficient was found as .92. Test-retest reliability with one month interval was found as .74.

In the present study, ASCS was given to 629 METU students. From this sample one ASCS form was excluded due to the incomplete information. For the remaining 628 students, Cronbach Alpha coefficient for ASCS was found as .95. This indicated that ASCS has a satisfactory level of reliability for the use of the present study.

3.3.5. AWP and Self-Evaluation Form

A self-evaluation form was developed by the researcher and given to experimental group participants at the end of the treatment to collect qualitative information about the effectiveness of the program. It included 2 likert scale items and 6 open ended questions (see Appendix F).

3.4. Data Collection Procedures

In this study, data were gathered both from METU preparatory school and from METU Faculty of Education. In the preparatory school, the investigator was granted permission by the school officials to administer the instruments at various times through the day for a 3-week period. In the administration of the scales the researcher received help from eight research assistants from the department of Educational Sciences. In the Faculty of Education, the scales were administered to the students who attended the courses offered by the Department of Educational Sciences.

In both groups, students were administered the scales in their classrooms. The instruction written on the cover page of the scales was read to the entire class. Participants were given relevant directions about the completion of the test; and they were asked to be honest when responding to the test items. The administration took about 35-40 minutes. The names of the students were not requested on the form, but they were asked to indicate e-mail addresses or telephone numbers if they are interested in the results and the program following this assessment.

During the experimental phase of the research, the instruments were administered four times as pretest, posttest and two follow-ups. In this phase of the study, subjects were selected according to their scores obtained in the descriptive phase. The second administration took place at the end of the 8 week group treatment processes, third, two weeks after the post-test, and fourth, three months after the post-test as a second follow-up.

3.5. Art-enriched Wellness Program (AWP) Procedure

The AWP was developed in the present study in order to promote wellness among university students (see Appendix G). In the development of the program, the researcher received feedback from three counseling professors regarding the aim, the content, and the process for each session and the whole program. This section presents the theoretical frame of the program; the goals of the program; description of the art room; pattern of sessions; the training material used in the group sessions; recording; attendance; and content of the sessions, respectively.

3.5.1. Theoretical Frame of AWP

AWP is based on a positive and holistic oriented wellness paradigm (Myers, Sweeney & Witmer, 2000). More specifically, it is based on the ideas of positive psychology, and humanistic approaches. It is humanistic with a view of the human being as irreducible to parts, needing connection, meaning, and creativity, and with an aim to be faithful to the full richness of human experience (Resnic, Warmoth & Serlin, 2001). Based on this view, AWP is developed with a positive perspective where the leader encourages the growth of positive qualities of the members and their experimentation with positive ways of doing things. More specifically, AWP is developed to help the group members to learn better skills for a healthy life; to refocus on their positive feelings; to strengthen their courage, not just to eliminate a frustration but to inspire a creative enthusiasm for the challenge (Resnick, Warmoth, & Serlin, 2001). AWP is also client-centered because the purpose of the group is to

provide a warm, and trusting environment in which the members can feel at ease in revealing personal matters and enjoy being there. In this program the major principles of wellness are stressed including the notions of personal responsibility, a healthy lifestyle, and the interrelatedness of mind, body, and spirit.

Additionally, this program was developed on the bases of *art in counseling* approach. In this respect, the art method used in this program involved production of and reflection upon spontaneous art images for the purposes of personal growth and health. The program was primarily process-oriented rather than product driven. Art-making was positioned as a holistic vehicle within an ongoing program of wellness, and also as an educational tool by exposing the individual to hidden aspects of self and visibly reformulating the meaning of one's life narrative (Soden, 1998).

In order to maximize the advantages of groupwork, in the present study, a group program was utilized rather than using individual strategies. Additionally, because of its short-term nature and wellness focus, in the present study, an always-structured art group process was used in the AWP (Leibmann, 1986)**.**

3.5.2. Goals of AWP

In the present study, AWP was mainly developed for helping university students changing their lifestyles into one that values health and wellness of the body, mind and the spirit, as it is consistent with the wellness models. The goals of the AWP were identified as follows:

a. Focusing on the physical, psychological, and social needs of the students, and thus promoting a more holistic and more integrated mind-body awareness.
b. Helping the group members to become aware of the benefits of healthy lifestyles and increase awareness about their own lifestyle choices.
c. Helping the group members to become aware of their wholeness not just in pain or trouble but also during times of pleasure.
d. Focusing on self-discovery and development through art activities based group counseling process.

3.5.3. Setting of AWP (The Art Room)

As cited in the literature (Leibmann, 1986), an art group can be affected very much by the space at its disposal. Groups which have to be in small and dark rooms are restricted in what they can achieve –as are groups in rooms which are 'through-routes' to other rooms and subject to constant interruptions. Noise from adjacent rooms, lack of suitable tables and presence of unsuitable carpets can further inhibit groups. By contrast, a quiet, light room with a messy painting area and a comfortable discussion space can do much to enhance a group's experience (Leibmann, 1986).

In the present study, the group sessions took place in the group counseling room of the Department of Educational Sciences of METU. It was located in the building of Faculty of Education in which all of the group members take their classes. The room consisted of two parts: a front room for conducting group sessions, and a back room for after group discussions and the video-recording system. The front room was mainly used in the present study. The back room was just used for the storage of the art works of the group members. The walls and doors of the room were soundproof. The furniture consisted of chairs, pillows, a tape and stand, and a cabinet full of art supplies (on the right wall). On the left wall of the group room there was a mirror. In the opposite corner of the tape stand, there was also a stand for the meals, plates, and glasses. During the semester, besides these group activities, this group room was used for the group classes of the department. But the key was kept by the researcher and the arrangements were done by her. Thus no confidentiality problems occurred. Below, a sketch of the group room is presented in Figure. 3.1.

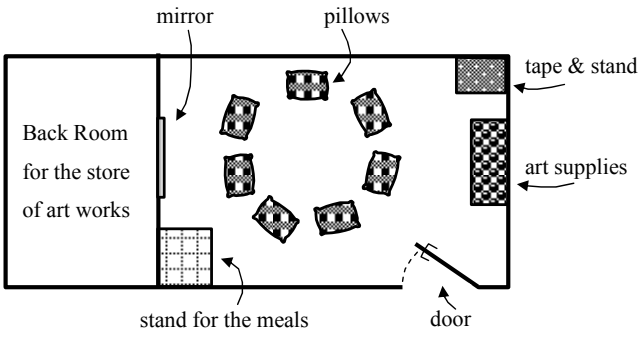

Figure 3.1. The Sketch of the Group Room

3.5.4. Pattern for Sessions

AWP composed of eight 150 minutes (2.5 hours) sessions. The researcher herself conducted the sessions. As suggested by Leibman (1986), the structure of sessions was as follows:

- Each week's session began with a 15-minute (eating-drinking-relaxing-and preparation) period.
- WARM-UP: the subjects were provided with a 15-20 minute period to talk about their wellness related concerns and to discuss their wellness diaries.
- INTRODUCTION: The warm-up period was followed by a 10-15 minute introduction to the topic of the present session and the related materials.
- ACTIVITY: 40-45-minute for art activities.
- DISCUSSION: 40-45-minute sharing (discussions about the content of the materials and examples they experienced in their lives)
- ENDING THE SESSION: 10 minutes summing up and homework assignments for the next week.

3.6. AWP Materials

3.6.1. Content of AWP

The AWP and wellness diary named "A Book About Me" and several art materials such as papers in different sizes, crayons, pencils, play-doh, etc. were utilized as the group materials in this study. In addition, music was used in each session, and healthy foods and beverages were served. Based on the rationale and goal of the program established in the light of the literature review, the content of the AWP was written by describing the content, activities, and format included in each session (see Appendix G). In AWP, the activities were developed based some general exercises used in group counseling such as relaxation (Davis, McKay, M., & Eshelman, 1982), guided imagery and developing alternative authomatic thoughts (Cormier &

Cormier,1998) In some other activities the exercises used in art therapy were adapted including island, body contour and mandala (Leibman, 1986). The summary of the content is also presented in Table 3.3.

Table 3.3 *Weekly Themes and Tasks in AWP*

NUMBER OF SESSIONS	WEEKLY THEMES	NAME OF ACTIVITIES	ARTS USED IN SESSIONS
1	Getting started	Who am I?	Drawing, music
2	Body	Body contour	Drawing, music
3	Emotions	Emotion dance	Drawing, music
4	Cognitions	Sculptures	Imagination, sculpting, music
5	Relationships	Island	Drawing, music
6	Work & Leisure	Story	Imagination, writing, music
7	Wholeness	Creating a mandala	Drawing, music
8	Termination	Reviewing previously made art projects and working on “A Boook about me”	All the art products produced in the sessions

The summary of the AWP sessions are presented in the following paragraphs by introducing preparation process and the content of each session.

Preparation: If possible the leader in art counseling or art therapy groups should meet with prospective group members individually prior to their entrance into the group. There are three reasons for this: (1) to screen the individual to determine his appropriateness for the group and the group's appropriateness for her/him; (2) to prepare her/him for the group by letting him know what is expected of her/him, including some information about art therapy/counseling and how the group operates in terms of openness, confidentiality, and goals; and (3) to establish contact with him so that when he enters a group of strangers, at least s/he knows the leader (Wadeson, 1995). In the present study, although the researcher/group leader sent invitation letters to the members in order to invite them to a group meeting, because of their course schedules, the students preferred to contact the leader individually before the first session. Thus, the leader interviewed and informed them individually. The aims and content of the interviews can be seen in Appendix G.

Session 1: The first session was devoted to setting the group norms and getting acquainted. The leader said welcome to everyone in the group; then introduced herself and provided information on her professional qualities. She explained the purposes of the group, how long the program would take, and how often the group would meet. The rules that should be respected were also explained to the members. They included attendance, punctuality, encouragement of openness and honesty, and a prohibition of physical violence. Since the present group was an art group, it was important to encourage free use of the materials so long as they were properly cleaned up and put away, and to stress that the purpose in this group was self-exploration rather than artistic accomplishment. Establishing a framework for commenting on other members' artworks was also important in an art group. To emphasize this, the phrase of Leibmann (1986) was used: "Comments about others' art are statements about the person who has made them, rather than definitive analysis of another" Thus, the interpretation of other members' art work was prohibited in the sessions, and as a group rule the leader said that "if a member

"analyzes" another's picture, the leader will turn it back to him and ask him how the picture makes him feel." (Wadeson, 1995). The "group rules" poster was hung on the wall by the leader.

Furthermore, the leader also explained the nature of the art activity part of the group work. By using some useful phrases emphasizing (1) not to try to produce beautiful works of art; (2) paint as we did when we were children -spontaneously-; (3) no "right" way of doing art; (4) express feelings by using art materials; (5) use art in a personal way; (6) no special ability or disability is required; (7) relax and use whatever media you want (Leibmann, 1986).

The "A Book about Me" files of the members were given and explained in this session. Than, the leader made an introductory speech about wellness and she gave the document about "the wheel of wellness" to the group.

Since people did not already know each other, an initial ice-breaker was used to help the members to get to know each other a little, so that they would feel more comfortable when working together. The leader structured this task and asked for, say (a) the members' names, (b) where they are from, and (c) their classes and departments. After this, in order to help the members to become more acquainted with each other, to feel comfortable with each other in expressing themselves and to establish rapports among them, a name-game was structured as presented in Appendix G. After the name-game, they shared their goals of participating in the program. Then, the group went through the art activity part of the session. The leader passed out the art materials and asked the members to draw a picture about "Who they are". She placed the papers, crayons, pencils in the middle of the group room. She let them sit at a place that they could draw comfortably. While they were drawing, she went round and gave individual encouragement for assuring them that she appreciated their drawings and their willingness to share. After they finished drawing, she invited them to the group circle and asked who would like to share first. The group members discussed the following questions: *How was picturing themselves? What did they notice about others' pictures? How are they alike? How*

are they different? How do they feel about sharing their feelings with others?

At the end, the first homework from "The Book About Me" was assigned to the members toward the end of this session; the group contract for the AWP was distributed and read aloud to all members (see Appendix J) The leader and the members agreed on the contract and signed it.

Session 2: The second session was started with discussing the homework assignments. The members shared their wellness related experiences throughout the week. The leader summarized the previous section and made an introduction to the present session. The theme of the second session was "body"; physical appearance, physical health, and self-care. After the leader's introductory speech, a mirror exercise was used as a warm-up. The members were asked to work in pairs and draw their body contours. Then, they discussed the following questions: *What things about their body are changing and growing? What can they change? How can they do that? What things they cannot change in their body? How can they deal with that?* At the end, the homework from "The Book About Me" was assigned to the members.

Session 3: The third session was started by discussing the homework assignments. The members shared their wellness related experiences through the week. The leader summarized the previous section and made an introduction to the present session. The theme of the third session was "emotions". The group started with the breath exercise. Then it was followed by the "Dance of Emotions" activity. At the end, the group discussed the following questions: *Which of their feelings do they like best? Which of their feelings do they dislike? What could they do to have more positive feelings? What could they do to have fewer negative feelings?* Then, the homework from "The Book About Me" was assigned to the members and the session was terminated.

Session 4: The fourth session was focused on "Cognitions". It was started by discussing the homework assignments. The members shared their wellness related experiences through the week. The leader summarized the previous section and made

an introduction to the present session. Then, the group continued with the "main guided imagery" activity. At the end of this activity the members were asked to create sculpture with play doh. They shared their experiences and the session ended by assigning the homework from "The Book About Me".

Session 5: The theme "relationships" was emphasized during the fifth session. It was started by a discussion of the homework, sharing the members' experiences, and a summary of the previous session. The leader explained the session theme "Relationships" and structured the main art activity of this session called "Island". The group created a big island all together and then shared their experiences regarding this process. Finally, the homework from "The Book About Me" was assigned to the members and the session ended.

Session 6: The session started with the summary, homework and experience sharing activities. Then, the leader introduced the theme of "A trip to the future" imagination technique which was mainly a writing activity. After sharing their experiences, the homework from "The Book About Me" was assigned to the members at the end of the session.

Session 7: This was the last session before termination. Starting with the usual opening activities, the leader introduced the theme of the session, "wholeness". The main art activity in this session was creating a mandala. Discussion part of this activity was followed by asking members to think about the whole group process that would be considered in the last session.

Session 8: The last session focused on general evaluation and termination of the program. The leader gave a brief review of the sessions covered in order to refresh members' minds. In order to overview the whole process the art products made by the members during the process were used in this session. It was seen that, art made unique contributions to this process, as mentioned in the literature: First of all, the tangible products created by the members were used as reminders of the therapeutic journey for the members; as well as gave a chance to the leader to review. Patterns

that emerged were highlighted as all the arts were viewed together. Finally, as expected, the art expressions provided an important vehicle for the expression of feelings around the ending of the treatment and means for saying goodbye. After this review, members were also asked to project for the near future in relation to their experience in the group. As a closing technique, "The love bombarding", that is sharing positive thoughts, feelings, and good wishes for each other was used. The members were asked to act as if they were taking a group photograph, and preserved this photograph about the group in their minds. Finally, the leader asked members to think critically about the group process, and she delivered the qualitative evaluation forms. At this last session, the instruments were also administered to the group members as a post-test.

3.6.2. Wellness Diary ("A book about me")

Keeping personal wellness journals are recommended in the literature (Travis & Ryan, 1981, 1988; Wagstaff, 1997). In the present study, throughout the period of eight weeks, the treatment group members were provided with an opportunity to keep a journal named "A Book About Me" (see Appendix J) as a form of expression and means of introspection. The purposes of this diary were threefold: (a) to assist the members to assume the responsibility for their wellness behaviors, (b) to provide them with an opportunity to privately explore their wellness concerns in relation to the group experience, and (c) to provide the members with an opportunity to share relevant changes in their wellness related behaviors, feelings, and thoughts with their peers while participating in a group program. Moreover, this book included the summary and reminders related with the weekly topic. At the completion of each group session, the diary tasks were administered to the subjects with the instructions to complete them in privacy prior to the next group session. The results of the "A Book About Me" were not collected or tabulated by the investigator.

3.6.3. Music Used in Sessions

The effects of music and musical interventions on the mind, body, and spirit have evident throughout history and across cultures. The multidimensional nature of music touches the individual's physical, psychological and spiritual levels of consciousness (Lou, 2001). Recently, a great deal of work has been done (1) on the effects of music in medical settings (Kemper & Danhauer, 2005; Twiss, Seavey & McCaffrey, 2006); to enhance cognitive development, i.e., the "Mozart effect" (Giletta, Vrbanic, Elias & Saucier, 2003; Thompson, Schellenberg & Husain, 2001); and the effects of music on various aspects of learning, including concentration, memorization, and the acquisition of information (Davidson & Powell, 1986); (2) on psychological consequences such as arousal of positive emotions in listeners (i.e., happiness, relaxation, calmness, etc.) by decreasing both distress and depression, and increasing self-esteem (McQuinn & Nesslage, 2003); and to decreasing agitated behaviors (Goddaer & Abraham1994).

Literature also revealed that certain kinds of music appear to have consistent physiologic effects. For instance, in a study on adults and teenager listeners, it was found that classical music had an effect to decrease tension but had little effect on other feelings. Listening to grunge rock led to significant increases in hostility, fatigue, sadness, and tension, and significant decreases in relaxation, mental clarity, vigor, and a sense of compassion. With new age music, there was a significant increase in relaxation and reductions in hostility, mental clarity, vigor, and tension. After listening to designer (designed to enhance a sense of well-being) music, subjects reported significantly decreased hostility, sadness, fatigue, and tension. Teenagers had negative psychological and emotional responses to grunge rock music, even when they usually liked listening to it outside the study setting (McCraty, Barrios-Choplin, Atkinson & Tomasino, 1998). Similarly, it is found that listening to classical music increases heart rate variability, a measure of cardiac autonomic balance (in which increased levels reflect less stress and greater resilience), whereas listening to noise or rock music decreases heart rate variability (reflecting greater stress) in animals (Umemura & Honda, 1998; White, 1999).

Kibler and Rider (1983) measured the efficacy of music (M), progressive muscle relaxation (PMR), and a combination of both (M+PMR) variables on tension reduction on 76 students of an introductory music class. Finger temperature was used to measure stress level prior to and after the intervention. Results indicate that, the effect of combining the PMR and M treatments appeared to have an increased relaxing effect, although it was not significantly higher than that of the M or PMR groups.

Music was constantly used throughout AWP. Starting from the very beginning of the sessions, while welcoming the students, and even during the times of activity classical and new age music was introduced. The melodies played were selected by the researcher depending on the characteristics of the weekly activities.

3.6.4. Foods and Beverages

The first 15 minutes of each session was allocated to the consumptions of food and beverages. The reasons of offerening them to the members were based on both theoretical and practical considerations. Each session was started at 16.00 p.m., the time which is appropriate for eating fruits and vegetables. Since nutrition is one of the basic elements of physical wellness and health, participants were encouraged to develop a good habit of nutrition by consuming healthy foods and beverages (e.g. fruit juices, fruit teas, milk, fruits, home made cookies, cakes, vegetable pastries) offered at the beginning of each session. They were then asked to pack up the garbages and put them into the waste basket close to the door outside the room.

3.7. Recording

Although there was an audiovisual recording system in this group room, since the group members did not accept the recording of sessions, the leader preferred a written record keeping procedure. The leader kept some sort of record of the group in detail at the end of each session. As Liebman (1986) suggested, these records

included: (a) basic information: date, present or absent members, (b) how the group went; what actually happened, (c) how the group felt; initial mood, leader's feelings, levels of interaction, disclosure, etc., (d) individuals: What work they produced? How they reacted to discussion of it? (e) summary and future plans.

3.8. Attendance and participation

The group met one evening in a week between 16.00 and 18.30, in the group counseling room of the faculty. Attendance was 100 % at all sessions except for one where one of the members was absent because he was the participant of a judo exhibition.

3.9. Data Analysis Procedures

The data obtained from the study were analyzed in several steps by following the two phases of the study. In the initial stage of the first phase of the study, exploratory factor analysis (EFA) and confirmatory factor analysis (CFA) techniques were employed to examine the dimensions of WI. Later on, data screening was run on the final data in order to output the distributions of the variables in these files and check their normality.

In the second stage of the first phase, mainly descriptive statistics and stepwise multiple linear regression analyses were used to analyze data. After computing the means and standard deviations of independent (gender coded as dummy variable, physical symptoms, self-esteem, and art self-concept) and dependent variables (total wellness score, four wellness factor scores), five separate multiple linear regression analyses were conducted for the total sample to investigate the predictors of wellness.

In the experimental phase of the study, nonparametric statistics were used because of the small sample size (Pallant, 2001). For the purpose of investigating the effect of AWP on the wellness of the subjects, a series of Mann Whitney-U Tests was employed in the Wellness Inventory (WI) total and subscale scores of experimental and control group subjects to examine the difference among the pre-test, post-test, and follow-up tests. Additionally, Wilcoxon Sign Test was used to investigate the differences within groups.

Except in CFA which was carried out by using LISREL 8.30 program, all the other statistical analyses were carried out by the SPSS for Windows 11.5 software program. In order to decide the statistical significance, .05 Alpha Level was taken into consideration for all the statistical procedures performed.

CHAPTER IV

RESULTS

This chapter consisted of the results of the present study which aims at (1) investigating the dimensions of wellness and their relationships with some selected variables, and (2) testing the effectiveness of art activities based wellness group counseling program, shortly called Art-enriched Wellness Program (AWP) on the wellness level of METU students. First, after a brief summary of the preliminary analysis regarding the data collected in the first phase of the study, the results concerning the first phase of the study are presented. This section consists of two sub-sections; the results concerning the dimensions of wellness, and the results concerning the relationship between wellness and some selected variables (self-esteem, physical symptoms, art self-concept, and gender). The former sub-section consists of the results of the exploratory and confirmatory factor analyses and other evidences for the reliability and validity of Wellness Inventory (WI) whereas the latter sub-section consists of the results of five separate multiple linear regression analyses conducted for the total WI score and four subscale scores of WI. In the third section, the results concerning the experimental phase of the study are presented. In this section, after the summary of the pilot study of AWP, the quantitative and qualitative results regarding the effectiveness of the AWP in the main study are presented respectively.

4.1. Preliminary Analyses

In the present study, Wellness Inventory (WI) together with Rosenberg Self-Esteem Scale (RSES), Physical Symptom Checklist (PSC), and Art Self-Concept Scale (ASCS) were administered to 638 METU students from preparatory school and from the Faculty of Education in order to (1) examine the dimensions of WI, (2) obtain evidence regarding its reliability and validity, and (3) select the participants for AWP. Before the analyses, first, each of the variables was checked for the missing values and for the scores that are out-of-range. Regarding missing values, 7 cases were omitted since missing values of them were greater than 5% (Tabachnic & Fidell, 2001). For the rest of the sample, the missing values were replaced by a series mean scores. In addition, two cases were omitted from the sample due to having severe health problems (psychiatric problems and a heart operation) in the last year.

Thus, the total sample of this study consisted of 629 (297 male, 300 female, and 32 gender missing) students. 47.2 % of the sample were male students, 47.7 % were female students, and 5.1 % were students indicated no gender. The mean age for the total sample was 18.96 with a standard deviation of 1.47.

4.2. Results Concerning the First (Descriptive) Phase of the Study

This section provides the results concerning the first main purpose of the study. For this purpose first the results concerning the exploratory and confirmatory factor analyses were presented under the heading of "Results Concerning the Dimensions of Wellness". Secondly, the results of five separate stepwise multiple linear regressions were introduced. These procedures are presented in the following sub-sections.

4.2.1. Results Concerning the Dimensions of Wellness

In the following sections the results of exploratory and confirmatory factor analyses were presented respectively.

4.2.1.1. Exploratory Factor Analysis of WI Scores

Before starting the factor analysis of WI, the suitability of the data for factor analysis was assessed through examining: (1) the adequacy of the sample size, and (2) the strength of the relationship among the items. In these assessments, "5 cases for each item formula" suggested by Tabachnick and Fidell (1996); Bartlett's test of sphericity, that should be statistically significant at .05 and the Kaiser-Meyer-Olkin (KMO) measures of sampling adequacy, that should be .6 or above, were utilized generated by SPSS to assess the factorability of the data (Pallant, 2001). The Barlett's test of sphericity was found as 23297.848 ($p < .05$) and the KMO measure was found as .892 revealing the adequacy of the present data for a good factor analysis in addition to the adequacy of the sample requirements.

Then, for the purpose of verifying that the original version of 103 items WI (Güneri, 2003) has the hypothesized 8 dimensions, Principal Component Analysis with varimax rotation was applied to the WI scores of the students.

The initial solution revealed 27 factors with eigenvalues greater than 1. Although these 27 factors explained the 61.21 % of the total variance, the examinations of items loaded in the factors were not theoretically sound and were loaded on several factors. Thus, it was decided to restrict the number of factors. Four criteria were used to determine the number of factors to rotate: (1) the a priori hypothesis stemming from the previous studies that the wellness measure has 4 to 17 dimensions, (2) the scree test together with the eigenvalues, (3) the interpretability of the factor solution, and (4) the factor loadings of the items. Items having factor loadings smaller than .40, and items having high loadings on more than one factor were omitted from the scale to get more coherent factor patterns (MacCallum & Austin, 2000;

Tabachnick & Fidell, 2001). After repeating the analysis several times, the final analysis yielded 4 factors with 30 items. The eigenvalues of the four factors, percentages and cumulative percentages of the explained variance for the factors of WI are shown in Table 4.1.

Table 4.1. *Rotation Sum of Squared Loadings of Factors of the WI*

Dimensions /Item Numbers	Eigenvalue	% of Variance	Cummulative %
Cognitive-emotional wellness (13, 16, 85, 54, 78, 14)	3.24	10.80	10.80
Relational wellness (91, 68, 53, 101, 9, 3, 30, 15, 20, 103)	3.19	10.62	21.42
Life-goal (29, 64, 6, 83, 59, 98, 69)	2.64	8.79	30.20
Physical wellness (17, 4, 97, 75, 56, 55, 48)	2.24	7.48	37.68

As Table 4.1 shows, the results of Principal Components Factor analysis with varimax rotation revealed 4 identifiable factors with a different organization of the items than that of the original factor structure. The eigenvalues of the 4 factors were 3.24, 3.19, 2.64, and 2.24 respectively. These factors accounted for 37.68 % of the total variance. The existence of these 4 factors was also confirmed by the scree test (see Appendix M). The subscales explained the total variance of 10.80 % for the first factor, 10.62 % for the second factor, 8.79 % for the third factor, and 7.48 % for the fourth factor. In this new factor structure of the WI, the 4 subscales consisted of 6, 10, 7, and 7 items, respectively. Table 4.2. presents the factor pattern, the factor loadings and commonalities of the WI in the EFA. Factor loadings below .10 were omitted in Table 4.2.

Table 4.2. *Factor Loadings and Commonalities of the Items of WI Obtained Through Principal Component Analysis with Varimax Rotation.*

Item No	Commonalities	F1	F2	F3	F4
13	.580	**.743**		.148	
16	.469	**.671**	.103		
85	.489	**.661**			.201
78	.457	**.645**		.191	
54	.437	**.636**	.152		
14	.426	**.595**	.127	.236	
91	.433	.114	**.636**		
68	.399		**.628**		
53	.386		**.559**	.273	
101	.353		**.557**		.201
9	.331		**.549**	.143	
3	.320	.163	**.530**		
30	.358		**.521**	-.175	.111
15	.351		**.509**	.294	
20	.321		**.464**	.357	
103	.322	.120	**.423**	.359	
29	.452	222		**.601**	.187
64	.339	-.115		**.564**	
6	.341		.114	**.550**	.137.
83	.372	.278		**.539**	
59	.352	.252	.186	**.502**	
98	.277	.184		**.488**	
69	.381	.345	.123	**.485**	.108
17	.447	.176		.102	**.635**
4	.332				**.567**
97	.351	.160	.165		**.546**
75	.305				**.540**
56	.342	.252			**.523**
55	.325	.219			**.519**
48	.254	.244		.100	**.423**

As can be seen from Table 4.2 the factor loadings changed between .743 and .595 in the first factor, .636 and .423 in the second factor, .601 and .485 in the third factor, and .635 and .423 in the fourth factor. These factors were named as cognitive emotional wellness (CEW), relational wellness (RW), life goal (LG), and physical wellness (PW), respectively. Nine of these items (9, 14, 16, 17, 29, 54, 91, 97) were the same items of WEL (Myers, Sweeney & Witmer, 2000) and the rest of the items were originally writen by Güneri (2003).

4.2.1.2. Confirmatory Factor Analysis of WI Scores

In the present study, in order to confirm the factor structure of 30-item WI, a second-order CFA, based on the data from 629 METU students, was performed through the LISREL 8.30 program (Jöreskog & Sörbom, 1993). Depending on the suggestions of the existing literature on CFA, multiple goodness of fit (GOF) indices, were used to assess the model fit (McDonald & Ho, 2002; Schumacker & Lomax, 1996; Thompson, 2004). Table 4.3 summarizes the GOF criteria and acceptable fit interpretation.

Table 4.3. *GOF Criteria and Acceptable Fit Interpretation*

GOF Criterion	Acceptable Level	Interpretation
Chi-square	Tabled χ^2 value	Compares obtained χ^2 value with tabled value for give df.
Goodness-of-fit index (GFI)	0 (no fit) to 1 (perfect fit)	Value close to .90 reflects a good fit.
Adjusted GFI (AGFI)	0 (no fit) to 1 (perfect fit)	Value adjusted for df, with .90 o good model fit.
Standardized-root-mean-Square residual (SRMR)	<.05	Value less than .05 indicates a good model fit.
Root-mean-square error of Approximation (RMSA)	<.05	Value less than .05 indicates a good model fit.

Schumacher and Lomax (1996)

GFI, AGFI, RMSA, and SRMR are the multiple GOF indices used in the present study. Additionally, Chi-square-degrees of freedom ratio was used rather then the chi-square which is highly sensitive to sample sizes and has to be interpreted with caution especially with larger samples. The value less than 5 is considered as rough rule of thumb for the Chi-square-degrees of freedom ratio index (Klem, 2000).

To run CFA, first, the results of EFA were estimated as the optimal model. A four factor model for the WI was hypothesized and correlation matrices were used in the analyses. The factors (cognitive-emotional wellness, relational wellness, life goal, and physical wellness) including 6, 10, 7, and 7 items respectively were used as

the latent variables, and 30 items of the WI were used as the observed variables of the CFA.

The results of the CFA for the 4 factor model of WI yielded the following GOF indices; χ^2 /df = 1648.06/401 = 4.11, RMSA = .07, GFI = .85, AGFI = .83, and SRMR = .06. These indices were deemed poor fit to the respective observed variable groups as distinct latent variables. Hence, modifications to the CFA model of the WI items were performed based on empirical and theoretical information to improve the factorial validity of the WI.

The standardized Lambda values, standard errors, t-values, and squared multiple correlations as obtained for each of the observed variables from the CFA conducted on 30 items WI are presented in Table 4.4. Additionally the path diagrams of LISREL estimates of parameters in measurement model of WI with coefficients in standardized values and t-values (see Appendix N) are presented in Appendices section.

Table 4.4. *The Standardized Lambda values, Standard Errors, t-values, and Squared Multiple Correlations of the Observed Variables of the WI*

Item no	λ	SE	*t*	R^2
13	.72	.04	12.69	.52
16	.57	.04	10.97	.33
85	.66	.04	12.17	.44
78	.68	.04	12.43	.47
54	.58	.04	11.07	.33
14	.63	.04	11.67	.40
91	.53	.04	11.94	.29
68	.58	.04	13.06	.34
53	.60	.04	13.62	.37
101	.60	.04	13.32	.35
9	.60	.04	13.53	.36.
3	.53	.04	12.06	.28
30	.51	.05	11.77	.27
15	.59	.04	13.55	.35
20	.40	.05	8.98	.16
103	.55	.04	12.29	.30
29	.69	.04	7.93	.47
64	.25	.05	4.90	.07
6	.36	.05	6.10	.13
83	.59	.04	7.60	.34
59	.71	.04	7.99	.51
98	.45	.05	6.94	.21
69	.69	.04	7.95	.48
17	.53	.05	9.88	.28
4	.30	.06	5.63	.09
97	.48	.05	9.10	.23
75	.32	.05	6.16	.10
56	.37	.05	7.13	.13
55	.56	.05	10.21	.31
48	.43	.05	8.14	.18

The goodness of fit values are presented in Table 4.5.

Table 4.5. *Goodness of Fit Statistics for the 30-Item Factor Structure of WI*

Goodness of Fit Index	Value
χ^2 /df	998.38/388 = 2.57
GFI	.90
AGFI	.89
SRMR	.05
RMSA	.05

As Table 4.5 shows, the CFA results of the WI with 30 items yielded the following GOF indices; χ^2 /df = 2.57, RMSA = .05, GFI = .90, AGFI = .89, and SRMR = .05. These goodness of fit statistics showed that the model seems acceptable although a slightly lower value of AGFI was obtained than expected (AGFI > .90).

4.2.1.3. Reliability of WI

Internal consistency of the WI was calculated by using the Cronbach alpha formula. The results showed that the Cronbach alpha coefficient was .82 for the total scale, .79 for the cognitive-emotional wellness subscale, .76 for the relational wellness subscale, .67 for the life goal subscale, and finally .63 for the physical wellness subscale. Taken together, these results showed that although modest, these coefficients can be considered as satisfactory support for the internal consistency of WI.

The intercorrelations of WI subscales for 629 METU students are presented in Table 4.6. As seen in the Table, the highest correlation coefficient among the subscales was between the CEW and LG (r = .387; p < .05) subscales for WI, whereas the lowest correlation was found between LG and PW (r = .241; p < .05) subscales.

Table 4.6. *Subscale Intercorrelations of WI*

	WTOT	WF1	WF2	WF3	WF4
WTOT	1				
WF1	.693**	1			
WF2	.701**	.312**	1		
WF3	.664**	.387**	.310**	1	
WF4	.696**	.289**	.274**	.241**	1

p < .01 (two-tailed)

4.2.1.4. Concurrent Validity of WI

Among the correlations calculated before the regression analyses the coefficients obtained between overall wellness scores and the scores of self-esteem (r = .486; p < .01), physical symptom (r = -. 211; p < .01), and art self-concept (r = .158; p < .01) can be considered as evidence for the concurrent validity of WI. Although

non significant correlations were observed in some of the sub-scores of wellness, most of the correlations were significant ranging from .70 to .13 and could be accepted as sufficient evidence for the validity of WI. Table 4.8 in section 4.2.2 presents the correlations among the variables.

4.2.2. Results Concerning the Stepwise Multiple Linear Regression Analyses

In this study, five separate stepwise multiple linear regression analyses (SMLRA) were conducted to predict the effect of the independent variables (gender coded as dummy variable, self-esteem, physical symptom, and art self-concept) on five separate dependent variables (total wellness, cognitive-emotional wellness, relational wellness, life-goal, and physical wellness).

Before conducting the analyses, crucial assumptions were checked out for SMLRA. First, dummy coding for the categorical variable (gender) was done. Thereafter, *multivariate outliers* were analyzed by taking into consideration Mahalonobis distance. As a rule of thumb, the maximum Mahalonobis distance should not exceed the critical chi-squared value with degrees of freedom equal to the number of predictors and Alpha Level = .001, or else outliers may be a problem in the data (Stevens, 2002). In this respect, in this study, Mahalonobis distance was taken into consideration with $p < .001$ and $\chi^2 = 22.46$. Two variables were found as outliers and omitted from the analyses. The means, standard deviations, minimum and maximum values and sample sizes after the outlier test is presented in Table 4.7.

Table 4.7. *Mean and Standard Deviation of the Variables as Well as the Scores Ranging between Minimum and Maximum*

	Total Sample (*N*=627)				Females (*N*=299)				Males (*N*=296)			
	X	SD	Min	Max	X	SD	Min	Max	X	SD	Min	Max
Wtot	112.87	11.33	75	141	115.01	11.07	87	141	110.90	11.52	75	141
CEW	23.08	3.78	6	30	22.91	3.93	6	30	23.27	3.68	10	30
RW	41.42	4.41	26	50	42.64	3.94	30	50	40.31	4.62	26	50
LG	28.18	3.62	14	35	28.17	3.51	14	35	28.16	3.82	15	35
PW	20.19	4.88	7	33	21.29	4.98	7	33	19.16	4.60	7	30
RSE	18.06	5.00	10	36	18.04	5.20	10	36	18.12	4.86	10	32
PSC	68.78	17.24	38	130	73.43	18.24	42	130	64.14	14.88	38	116
ASCS	27.50	10.29	10	50	28.12	9.72	10	40	26.83	10.71	10	50

Additionally, the assumption for Multiple Regression normality, linearity, independence observation, and independence of error (residual) were performed. In order to examine the *normality*, descriptive statistics including mean, standard deviation, skewness, and kurtosis; visual inspection of data including and P-P plots, and histograms with curves (Osborne & Waters, 2002) were conducted. For the normality assumption, it was assumed that the dependent variables which had total WI score and CEW, RW, LG, and PW scores were distributed normally in the population. In the light of information obtained from descriptive statistics and normality test; it was assumed that normality was not violated.

In order to check the *linearity* between the dependent and independent variables of the study, scatterplots as well as Q-Q Plots were performed (Osborne & Waters, 2002) and found that linearity assumption was not violated.

Finally, *multicollinearity*, which is defined as an "unacceptably high level of intercorrelation among predictor variables" (Stevens, 2002), was taken into account while checking the assumptions for Multiple Regression. As a rule of thumb, intercorrelation among the independents above .80 signals a possible problem (Jacop, 1969). Therefore, any intercorrelation higher than .80 among independent variables was detected for the present data. The results of the bivariate correlation among eight variables; namely, dependent variables which are total WI score, CEW, RW, LG, and PW scores; and independent variables which are dummy coded gender, self-esteem, physical symptom, and art self-concept are presented in the Table 4.8. As seen in this Table, low correlations among predictors indicated no multicolinearity existed among the variables. Additionally, tolerance and VIF values were used for indicators of *multicollinearity.* Stevens (2002) reported that tolerance should *not* be less than .20 and VIF should *not* be higher than 4. Multicollinearity was not detected for the present data.

Table 4.8. *Bivariate Correlations among Independent (Dummy Coded Gender, Self-Esteem, Physical Symptom, And Art Self-Concept) and Dependent (Total Wı Score, Cognitive-Emotional WI Score, Relational WI Score, Life-Goal, and Physical WI Score) Variables*

	Self-Esteem	Physical Symptom	Art Self-Concept	Gender
Self-Esteem	1			
Physical Sympt.	.221**	1		
Art Self-Concept	.088*	.073	1	
Gender	.004	.261**	.057	1
Wellness Total	.486**	-.211**	.158**	.180**
Cog.-Emot. Well.	.702**	-.303**	.085*	-.043
Relational Well.	.195**	-.003	.164**	.264**
Life-goal	.328**	-.053	.134**	-.003
Physical Well.	.169**	-.220**	.054	.215**

** $p < .01$, two tailed; * $p < .05$, two tailed.

4.2.2.1. Results Concerning the Predictors of Total Wellness Scores

In order to examine how well the self-esteem, physical symptom, art self-concept, and gender measures predict total wellness scores of the students a SMLRA was conducted by taking self-esteem, physical symptom, art self-concept, and dummy coded gender as the predictors, and while the total wellness scores of the students were taken as dependent variables. Table 4.9 presents the summary of SMLRA predicting the total wellness scores of the sample.

Table 4.9. *R and R Square Change Predicting the Total Wellness Scores*

Variable	Multiple R	R Square	Adjusted R Square	R Square Change	F Change	df 1	df 2	Sig. F Change
ROS	.488	.239	.237	.239	192.304	1	614	.000
ROS, GENDER	.520	.270	.268	.032	26.701	1	613	.000
ROS, GENDER, SYMP	.545	.297	.293	.026	22.900	1	612	.000
ROS, GENDER SYMP, ART	.558	.311	.306	.014	12.651	1	611	.000

*p < .01 (Note: ROS: self-esteem score; GENDER: dummy coded gender; SYMP: physical symptom

score; ART: art self-concept score.)

Table 4.10 presents the *ß* and beta coefficients for each step and other coefficients.

Table 4.10. *ß, Beta's Correlations and Significance Level Predicting the Total Wellness Scores*

Variables	*ß*	Std.Error	Beta	t	Significance
(Constant)	132.820	1.489		89.191	.000
ROS	1.102	.079	.488	13.867	.000
(Constant)	130.848	1.508		86.769	.000
ROS	1.102	.078	.488	14.144	.000
GENDER	4.032	.780	.178	5.167	.000
(Constant)	136.594	1.907		71.623	.000
ROS	1.016	.079	.450	12.920	.000
GENDER	5.056	.796	.224	6.352	.000
SYMP	-.113	.024	-.173	-4.785	.000
(Constant)	132.955	2.148		61.886	.000
ROS	.986	.078	.437	12.596	.000
GENDER	4.958	.789	.219	6.283	.000
SYMP	-.120	.024	-.183	-5.104	.000
ART	.132	.037	.121	3.557	.000

As can be seen in Table 4.9, since stepwise regression was requested, SPSS first tested a model with the most correlated independent, that is self-esteem. The regression equation with the self-esteem scores was significant, R^2 = .24, F (1, 614) = 192.304, p < .01. This variable alone accounted for approximately 24 % of the variance.

Then a model was tested with self-esteem plus the variable with the highest partial correlation with the dependent variable controlling the self-esteem. This second variable was gender. The second regression with gender was also significant with the values of R^2 = .27, F (1, 613) = 26.701, p < .01. Gender alone accounted for an additional 3 % of the variance.

The third variable entered into the equation was physical symptom. The regression equation with physical symptom score was also significant, R^2 = .27, F (1, 612) = 22.90, p < .01. Physical symptoms alone accounted for an additional 3 % of the variance.

Finally, the fourth variable entered in to equation was art self-concept. The regression equation with art self-concept score was also significant, $R^2 = .30$, $F(1, 611) = 12.65$, $p < .01$. Art self-concept alone accounted for an additional 1 % of the variance.

In sum, the results of this analysis indicated all the suggested independent variables appeared as significant predictors explaining 31 % of the total variance of the total wellness scores of the students, indicating that female students who score higher on self-esteem and art self-concept, and lower on physical symptom tended to have higher scores on total wellness.

4.2.2.2. Results Concerning the Predictors of Four Wellness Subscale Scores

Similar to the overall wellness score, four SMLRA were conducted to evaluate how well self-esteem, physical symptom, art self-concept, and gender variables predicted the wellness subscale scores of the students. In the first SMLRA the predictors of CEW scores were examined. Table 4.11 presents the summary of SMLRA predicting the CEW scores of the sample. Then, Table 4.12 presents the *ß* and beta coefficients for each step and other coefficients.

Table 4.11. *R and R Square Change Predicting the CEW Scores*

Variable	Multiple R	R Square	Adjusted R Square	R Square Change	F Change	df 1	df 2	Sig. F Change
ROS	.704	.496	.495	.496	603.175	1	614	.000
ROS, SYMP	.721	.519	.518	.024	30.438	1	613	.000

*p < .01

Note: ROS: self-esteem score; SYMP: physical symptom score.

Table 4.12. *ß, Beta's Correlations and Significance Level Predicting the CEW Scores*

Variables	*ß*	Std.Error	Beta	t	Significance
(Constant)	32.660	.406		80.512	.000
ROS	.532	.022	.704	24.560	.000
(Constant)	34.578	.527		65.604	.000
ROS	.506	.022	.669	23.311	.000
SYMPT	-.035	.006	-.158	-5.517	.000

As can be seen in Table 4.11, the first variable entered into the equation was self-esteem. The regression equation with the self-esteem score was significant. $R^2 = .50$, $F(1, 614) = 603.175$, $p < .001$. This variable alone accounted approximately for the 50 % of the variance.

The second variable entered into the equation was physical symptom. The regression equation with physical symptom score was significant, $R^2 = .52$, $F(1, 613) = 30.438$, $p < .001$. This variable alone accounted for the 2 % of the variance.

In sum, self-esteem and physical symptom appeared as significant predictors explaining approximately 52 % of the total variance of the CEW scores of the students indicating that students who scored higher on self-esteem and lower in physical symptoms tended to have higher scores on CEW. Results showed that neither gender nor art self-concept made a unique contribution to the model.

The second SMLRA was conducted to evaluate how well the self-esteem, physical symptom, art self-concept, and gender measures predict RW scores of the students. Table 4.13 presents the summary of multiple linear regression analysis predicting the RW scores of the sample. Then, Table 4.14 presents the B and beta coefficients for each step and other coefficients.

Table 4.13. *R and R Square Change Predicting the RW Scores*

Variable	Multiple R	R Square	Adjusted R Square	R Square Change	F Change	df 1	df 2	Sig. F Change
GENDER	.264	.070	.068	.070	45.910	1	614	.000
GENDER, ROS	.328	.108	.105	.038	26.209	1	613	.000
GENDER, ROS, ART	.354	.125	.121	.017	12.156	1	612	.001

*p < .01

Note: GENDER: dummy coded gender; ROS: self-esteem score; ART: art self-concept score.

Table 4.14. *ß, Beta's Correlations and Significance Level Predicting the RW Scores*

Variables	*ß*	Std.Error	Beta	t	Significance
(Constant)	40.338	.237		170.472	.000
GENDER	2.301	.340	.264	6.776	.000
(Constant)	43.409	.643		67.481	.000
GENDER	2.298	.333	.263	6.903	.000
ROS	.170	.033	.195	5.119	.000
(Constant)	41.719	.801		52.090	.000
GENDER	2.230	.330	.256	6.749	.000
ROS	.160	.033	.184	4.836	.000
ART	.056	.016	.133	3.487	.001

As can be seen in Table 4.13, the first variable entered into the equation was gender. The regression equation with the gender dummy score was significant, $R^2 = .07$, $F(1, 614) = 45.910$, $p < .001$. This variable alone accounted for the 7 % of the variance.

The second variable entered into the equation was self-esteem. The regression equation with self-esteem score was significant, $R^2 = .108$, $F(1, 613) = 26.209$, $p < .001$. This variable alone accounted approximately for the 4 % of the variance.

The third variable entered into the equation was art self-concept. The regression equation with art self-concept score was significant, $R^2 = .125$, $F(1, 612) = 12.156$, $p < .05$. This variable alone accounted approximately for the 2 % of the variance.

In sum, gender, self-esteem and art self-concept appeared as significant predictors

explaining approximately 13 % of the total variance of the relational wellness scores of the students. This means that females who scored higher on self-esteem and art self-concept tended to score higher on relational wellness.

The third SMLRA was conducted to evaluate how well the self-esteem, physical symptom, art self-concept, and gender measures predict LG scores of the students. Table 4.15 presents the summary of multiple linear regression analysis predicting the LG scores of the sample. Then, Table 4.16 presents the *ß* and beta coefficients for each step and other coefficients.

Table 4.15. *R and R Square Change Predicting the LG Scores*

Variable	Multiple R	R Square	Adjusted R Square	R Square Change	F Change	df 1	df 2	Sig. F Change
ROS	.327	.107	.105	.107	73.305	1	614	.000
ROS, ART	.343	.118	.115	.011	7.839	1	613	.005

*p < .01

Note: ROS: self-esteem score; ART: art self-concept score.

Table 4.16. *ß, Beta's Correlations and Significance Level Predicting the LG Scores*

Variables	*ß*	Std.Error	Beta	T	Significance
(Constant)	32.415	.515		62.952	.000
ROS	.235	.027	.327	8.562	.000
(Constant)	31.268	.656		47.680	.000
ROS	.229	.027	.317	8.327	.000
ART	.037	.013	.107	2.800	.005

As can be seen in Table 4.15, the first variable entered into the equation was self-esteem. The regression equation with the self-esteem score was significant. R^2 = .107, F (1, 2614) = 73.305, p < .001. This variable alone accounted approximately for the 11 % of the variance.

The second variable entered into the equation was art self-concept. The regression equation with art self-concept score was significant, R^2 = .011, F (1, 613) = 7.839, p < .001. This variable alone accounted for the 1 % of the variance.

Results showed that, self-esteem and art self-concept appeared as significant

predictors explaining approximately 12 % of the total variance of the life-goal wellness scores of the students, indicating that students who scored higher on self-esteem and art self-concept tended to have higher scores on life-goal.

The fourth SMLRA was conducted to examine how well the self-esteem, physical symptom, art self-concept, and gender measures predict PW scores of the students. Table 4.17 presents the summary of SMLRA predicting the PW scores of the sample. Then, Table 4.18 presents the *ß* and beta coefficients for each step and other coefficients.

Table 4.17. *R and R Square Change Predicting the PW Scores*

Variable	Multiple R	R Square	R Square Change	F Change	df 1	df 2	Sig. F Change
SYMP	.222	.049	.049	31.716	1	614	.000
SYMP GENDER	.355	.126	.077	53.715	1	613	.000
SYMP GENDER, ROS	.370	.137	.011	7.998	1	612	.005

*p < .01

Note: SYMP is the physical symptom score, ROS is the self-esteem score,

Table 4.18. *ß, Beta's Correlations and Significance Level Predicting the PW Scores*

Variables	*ß*	Std.Error	Beta	T	Significance
(Constant)	24.551	.798		31.105	.000
SYMP	-.063	.011	-.222	-5.632	.000
(Constant)	24.654	.758		32.544	.000
SYMP	-.084	.011	-.297	-7.582	.000
GENDER	2.795	.381	.287	7.329	.000
(Constant)	26.100	.910		28.668	.000
SYMP	-.077	.011	-.271	-6.777	.000
GENDER	2.727	.380	.280	7.177	.000
ROS	-.106	.038	-.109	-2.828	.005

As can be seen in Table 4.17, the first variable entered into the equation was physical symptom. The regression equation with the physical symptom score was significant, $R^2 = .50$, $F (1, 614) = 31.716$, $p < .001$. This variable alone accounted approximately for the 5 % of the variance.

The second variable entered into the equation was gender. The regression

equation with dummy coded gender was significant, $R^2 = .126$, $F (1, 278) = 53.715$, $p < .001$. This variable alone accounted approximately for the 8 % of the variance.
The third variable entered into the equation was self-esteem. The regression equation with self-esteem score was significant, $R^2 = .137$, $F (1, 612) = 7.998$, $p < .01$. This variable alone accounted for the 1 % of the variance.

In general, results showed that physical symptom, gender and self-esteem appeared as significant predictors explaining approximately 14 % of the total variance of the physical wellness scores of the students. These findings indicated that female students who scored lower on physical symptom and higher on self-esteem tended to have higher scores on physical wellness.

4.3. Results Concerning the Second (Experimental) Phase of the Study

In the second phase of the study, a pre-test, post-test, control group experimental design with 2 follow-us were used to examine the effect of AWP on the improvement of wellness among experimental group subjects. At this phase, a study were conducted to evaluate the effectiveness of the program. The subjects were randomly assigned to experimental and control groups and they were invited to contact the researcher.

The data was collected from 214 (63 male, 139 female, and 12 gender missing) junior and sophomore students from the Faculty of Education of METU. The basic reason behind the selection of students from the Faculty of Education was mainly to assure the attendance (or to prevent the fluctuations) since most of the students in the pilot study complained about the difficulty in arriving at the group room which is in the Faculty of Education building. Based on this data participants were assigned to the experimental and control groups by changing the selection criteria as “scoring 1 standard deviation below the WI and PSC”. With this new criteria, the experimental group consisted of 6 (3 female and 3 male) students, and the waiting list control group consisted of 10 (8 female, 2 male) students. The subject assignment and

invitation procedures applied in the pilot study were repeated in the main study as well.

Table 4.19 presents the means, standard deviations of overall 30-item WI scores, physical symptom scores and age for the total of 214 students in the experimental and control groups.

Table 4.19. *The Means, Standard Deviations of 30-Item WI Scores and Age for Faculty of Education Sample, and the Experimental and Control Groups of the Study*

	Total sample (N= 214)		Experimental Group (N=6)		Control Group (N=10)	
	X	SD	X	SD	X	SD
Wellness Total	111.79	12.14	98.00	6.63	99.20	8.09
Cogn-Emot. Wellness	22.30	3.98	17.17	2.86	18.30	2.95
Relational Wellness	42.03	4.27	39.00	3.85	40.20	4.49
Life Goal	27.08	3.69	23.67	2.58	24.60	3.63
Physical Wellness	20.36	4.89	18.17	5.38	16.10	2.88
Physical Symptom	71.54	19.01	61.67	9.48	73.00	10.59
Age	19.86	1.56	21.17	3.06	19.90	.88

Since the data of the experimental part of the present study was not suitable for the use of Multivariate Analysis of Variance (MANOVA) because of small sample size (Pallant, 2001), non-parametric tests were used as an alternative to examine the effect of AWP on improving the wellness level of students.

Two separate Mann-Whitney U Tests were applied to the overall WI scores and the physical symptom scores of the experimental and control group subjects in order to control the equality of the groups before the treatment procedure. Table 4.20 presents the mean ranks of the experimental and control group subjects on the 30-item overall WI scores, and the physical symptom scores.

Table 4.20. *The Mean Ranks of the Experimental and Control Group Subjects on the Total WI Scores and Physical Symptom Scores*

Scores	Group	*N*	Mean Ranks	*p*
Total Wellness Pre-test Scores	Experimental	6	8.00	.79
	Control	10	8.80	

Physical Symptom Pre-test scores	Experimental	6	5.75	.07
	Control	10	10.15	

p < =.05

As Table 4.20 shows, the results of the Mann-Whitney U Test performed were not significant for the total WI scores (z = -.33, p = .79), and for the physical symptom scores (z = -.65, p = .56), indicating that the groups were equal before the treatment. As a result, with 16 volunteered students the program started on April 7, 2004. The experimental group that completed the AWP consisted of 6 (3 female and 3 male) students and received AWP during 8 weeks, 2.5 hours, once a week, while the non-treatment control group consisted of 10 (8 female, 2 male) students that received no treatment during that time.

4.3.1. Results Concerning the Effect of AWP on Wellness

In order to examine the effectiveness of the AWP first, 20 separate Mann Whitney U tests were conducted to evaluate whether the medians on pre-post-follow up test of total and four subscale WI scores differ significantly between experimental and control groups of the study. Then, 24 separate Wilcoxon tests were conducted to evaluate whether experimental and control group members showed any significant differences in their WI sub-scale scores on pre-test to post- test, pre-test to follow-up 1, pre-test to follow-up 2, post-test to follow-up1, post-test to follow-up 2, and follow-up 1 to follow-up 2 tests.

4.3.1.1. Results of the Mann Whitney U Tests

The relevant research question was *"Are there significant differences between the experimental and control groups with respect to their total and subscale wellness scores in pre-test, post-test, follow-up 1, and follow-up 2?"* To answer this question, the Mann-Whitney U Tests were employed to examine the differences between WI scores of the experimental and control group subjects. Table 4.21 presents the mean

ranks of the WI scores of the experimental and control group subjects.

Table 4.21. *The Results of the Mann Whitney U Tests Comparing the Pre-Test, Post-Test, Follow-up 1, and Follow-up 2 total WI scores of the Experimental and Control Groups*

Measure	Group	*N*	Mean Ranks	*p*
PRE-TEST	Experimental	6	8.00	.79
	Control	10	8.80	
POST-TEST	Experimental	6	11.58	.04**
	Control	10	6.65	
FOLLOW-UP I	Experimental	6	12.58	.00*
	Control	10	6.05	
FOLLOW-UP II	Experimental	6	10.83	.15
	Control	10	7.10	

*p < = .01, **p < = .05

As shown in Table 4.21, the results yielded significant differences in the post test scores (z = -2.01, p = .04) and in the first follow-up scores (z = -2.66, p = .00) of the subjects. In other words, treatment procedure was effective in increasing total wellness scores of experimental group subjects both in the post-test and in the follow-up 1 mesures.

The Mann-Whitney U Test was also employed on the WI subscale scores of the experimental and control group subjects. Table 4.22 presents the mean ranks of four subscale scores of WI of the experimental and control group subjects.

As can be seen from Table 4.22, the results regarding CEW subscale were significant in the post-test (z = -2.26, p = .02) and in the first follow up (z = -2.40, p = .02). In the LG subscale, a significant difference was found in the first follow up (z = -2.33, p = .02). That is, treatment procedure was effective in increasing CEW scores of experimental group subjects in the post-test and first- follow-up, and treatment procedure was effective in increasing LG scores of them only in the first follow up.

Table 4.22. *The Results of Mann Whitney U Test Comparing Pre-test, Post-test, Follow-up 1, and Follow-up 2 Scores of Four Subscales of WI of the Experimental and Control Groups*

Subscales of WI	Groups	*N*	Mean Ranks	*p*
CEW				
Pre-Test	Experimental	6	7.42	.49
	Control	10	9.15	
Post-Test	Experimental	6	11.58	.02*
	Control	10	6.65	
Follow-Up 1	Experimental	6	12.33	.02*
	Control	10	6.20	
Follow-Up 2	Experimental	6	10.83	.49
	Control	10	7.10	
RW				
Pre-Test	Experimental	6	7.67	.64
	Control	10	9.00	
Post-Test	Experimental	6	9.42	.56
	Control	10	7.95	
Follow-Up 1	Experimental	6	9.75	.43
	Control	10	7.75	
Follow-Up 2	Experimental	6	8.08	.79
	Control	10	8.75	
LG				
Pre-Test	Experimental	6	7.33	.49
	Control	10	9.20	
Post-Test	Experimental	6	10.50	.22
	Control	10	7.30	
Follow-Up 1	Experimental	6	12.08	.02*
	Control	10	6.35	
Follow-Up 2	Experimental	6	10.00	.37
	Control	10	7.60	
PW				
Pre-Test	Experimental	6	9.50	.56
	Control	10	7.90	
Post-Test	Experimental	6	10.33	.26
	Control	10	7.40	
Follow-Up 1	Experimental	6	10.50	.22
	Control	10	7.30	
Follow-Up 2	Experimental	6	11.00	.12
	Control	10	7.00	

*p < .05

4.3.1.2. The Results of the Wilcoxon Tests

The last two research questions of the study *were "Are there any significant differences in the wellness total scores of the experimental and control group members between the pre-test and post-test, pre-test and follow-up 1, pre-test and follow-up 2, post-test and follow-up 1, post-test and follow-up 2, and follow-up 1 and follow-up 2?"* and "*Are there any significant differences in the wellness subscale scores of the experimental and control group members between the pre-test and post-test, pre-test and follow-up 1, pre-test and follow-up 2, post-test and follow-up 1, post-test and follow-up 2, and follow-up 1 and follow-up 2?"* To answer these questions a series of Wilcoxon Tests were performed and the results of these analyses are presented below.

Table 4.23 presents the results of the six Wilcoxon Tests conducted separately to evaluate whether each of the group members showed any significant improvement between their pre-test and post-test, pre-test and follow-up 1, pre-test and follow-up 2, post-test and follow-up 1, post-test and follow up 2, and follow up 1 and follow up 2 scores of total WI.

Table 4.23. *The Results of the Wilcoxon Test for Total Wellness Scores of the Experimental and Control Group Subjects.*

	EXPERIMENTAL GROUP					CONTROL GROUP				
	N	Mean Rank	Sum of Ranks	z	*p*	*N*	Mean Rank	Sum of Ranks	z	*p*
Post-test - Pre-test										
- Ranks	0	.00	.00	-2.214	.027*	7	5.50	38.50	-1.899	.058
+ Ranks	6	3.50	1.00			2	3.25	6.50		
Ties	0					1				
Total	6					10				
Follow up 1- Pre-test										
- Ranks	1	1.50	1.50	-1.897	.058	10	5.50	55.00	2.821	.005*
+ Ranks	5	3.90	19.50			0	.00	.00		
Ties	0					0				
Total	6					10				
Follow up 2- Pretest										
- Ranks	0	.00	.00	-2.207	.027*	6	5.08	30.50	-.306	.759
+ Ranks	6	3.50	21.00			4	6.13	24.50		
Ties	0					0				
Total	6					10				
Follow up 1- Post-test										
- Ranks	2	5.00	10.00	-.106	.916	8	5.19	41.50	-2.257	.024*
+ Ranks	4	2.75	11.00			1	3.50	3.50		
Ties	0					1				
Total	6					10				
Follow up 2- Post test										
- Ranks	3	4.00	12.00	-.316	.752	1	8.00	8.00	-1.718	.086
+ Ranks	3	3.00	9.00			8	4.63	37.00		
Ties	0					1				
Total	6					10				
Follow up 2- Follow-up 1										
- Ranks	2	5.50	11.00	-.105	.917	1	2.00	2.00	-2.601	.009*
+ Ranks	4	2.50	10.00			9	5.89	53.00		
Ties	0					0				
Total	6					10				

*p<.05

As seen in Table 4.23, concerning experimental group members, the results yielded significant differences between the pre-test and post test total wellness scores ($z = -2.214$, $p = .027$) and between pre-test and follow-up 2 total wellness scores ($z = -2.207$, $p = .027$). Results suggested that total WI scores of the experimental group members significantly increased between pre-test and follow-up 2. The results indicated no significant differences for the experimental group members between pre-test and follow-up 1, post-test and follow-up 1, post-test and follow-up 1, follow-up 1 and follow-up 2 total wellness scores.

As seen in Table 4.23, concerning the control group members, the results showed significant differences between pre-test and follow-up 1 ($z = 2.821$, $p = .005$), post-test and follow up 1 ($z = -2.257$, $p = .024$), and between follow-up 1 and follow-up 2 ($z = -2.601$, $p = .009$) in the total wellness scores. Total WI scores of the control group members decreased significantly between pre-test and follow-up 1, between post-test and follow-up 1, and between follow-up 1 and follow-up 2. The results indicated no significant differences for the control group members between pre-test and post-test , pre-test and follow-up 2, and post-test and follow-up 2 total wellness scores.

After the twelve analyses on the total WI scores, 48 separate Wilcoxon Tests were conducted to evaluate the differences in the experimental and control group members in four WI subscale scores. First, six analyses were conducted to evaluate the differences in experimental group members. Then six analyses were conducted to to evaluate the differences in control group members in cognitive-emotional WI scores. The results of these analyses are presented in Table 4.24.

As seen in Table 4.24, concerning experimental group members, the results indicated significant differences between the pre-test and post test CEW scores ($z = -2.041$, $p =$

.041), and between pre-test and follow-up 1 CEW scores (z = -2.207, p = .027). CEW scores of the experimental group members significantly increased between pre-test and post-test, and between pre-test and follow-up 1. The results indicated no significant differences for the experimental group members between pre-test and follow-up 2, post-test and follow-up 1, post-test and follow-up 2, follow-up 1 and follow-up 2 CEW scores.

As seen in Table 4.24, concerning control group members, the results indicated significant differences between pre-test and follow-up 1 (z = 2.058, p = .040), post-test and follow up 2 (z = -2.680, p = .007), and between follow-up 1 and follow-up 2 (z = -2.677, p = .007) CEW scores. The CEW scores of the control group members significantly decreased between pre-test and follow-up 1, whereas their CEW scores significantly increased between post-test and follow-up 2, and between follow-up 1 and follow-up 2. The results indicated no significant differences for the control group members between pre-test and post-test, pre-test and follow-up 2, and post-test and follow-up 1 CEW scores.

Table 4.24. *The Results of the Wilcoxon Test for CEW Scores of the Experimental and Control Group Subjects.*

	EXPERIMENTAL GROUP					CONTROL GROUP				
	N	Mean Rank	Sum of Ranks	z	*p*	N	Mean Rank	Sum of Ranks	z	*p*
Post-test – Pre-test										
- Ranks	0	.00	.00	-2.041	.041*	7	6.29	44.00	-1.693	.090
+ Ranks	5	3.00	15.00			3	3.67	11.00		
Ties	1					0				
Total	6					10				
Follow up 1- Pre-test										
- Ranks	0	.00	.00	-2.207	.027*	7	4.64	32.50	-2.058	.040*
+ Ranks	6	3.50	21.00			1	3.50	3.50		
Ties	0					2				
Total	6					10				
Follow up 2- Pretest										
- Ranks	1	1.50	1.50	-1.897	.058	2	4.00	8.00	-1.750	.080
+ Ranks	5	3.90	19.50			7	5.29	37.00		
Ties	0					1				
Total	6					10				
Follow up 1- Post-test										
- Ranks	1	3.00	3.00	.000	1.000	5	4.00	20.00	-.284	.776
+ Ranks	2	1.50	3.00			3	5.33	16.00		
Ties	3					2				
Total	6					10				
Follow up 2- Post test										
- Ranks	3	2.50	7.50	-.921	.357	0	.00	.00	-2.680	.007**
+ Ranks	1	2.50	2.50			9	5.00	45.00		
Ties	2					1				
Total	6					10				
Follow up 2- Follow-up 1										
- Ranks	2	3.50	7.00	-.736	.461	0	.00	.00	-2.677	.007**
+ Ranks	2	1.50	3.00			9	5.00	45.00		
Ties	2					1				
Total	6					10				

* p < .05; **p < .01

Additional twelve analyses were conducted to evaluate the differences in experimental and control group members in RW scores. The results of these analyses are presented in Table 4.25.

As seen in Table 4.25, concerning experimental group members, the results indicated no significant differences between pre-test and post-test (z = -1.807, p = .071), pre-test and follow-up 1 (z = -.530, p = .596), pre-test and follow-up 2 (z = -.527, p = .598), post-test and follow-up 1 (z = -.552, p = .581), post-test and follow up 2 (z = -.957, p = .339), and follow up 1 and follow up 2 (z = -.408, p = .683) RW scores. Similarly, concerning control group members, the results indicated no significant differences between pre-test and post-test (z = -.258, p = .796), pre-test and follow-up 1 (z = -.478, p = .633), pre-test and follow-up 2 (z = -.426, p = .670), post-test and follow-up 1 (z = -1.035, p = .301), post-test and follow up 2 (z = -.154, p = .877), and follow up 1 and follow up 2 (z = -.426, p = .670) RW scores.

Table 2.25. *The Results of the Wilcoxon Test for RW Scores of the Experimental and Control Group Subjects.*

	EXPERIMENTAL GROUP					CONTROL GROUP				
	N	Mean Rank	Sum of Ranks	z	*p*	N	Mean Rank	Sum of Ranks	z	*p*
Post-test – Pre-test										
- Ranks	1	2.00	2.00	-1.807	.071	4	6.25	25.00	-.258	.796
+ Ranks	5	3.80	19.00			6	5.00	30.00		
Ties	0					0				
Total	6					10				
Follow up 1- Pre-test										
- Ranks	3	2.67	8.00	-.530	.596	4	6.63	26.50	-.478	.633
+ Ranks	3	4.33	13.00			5	3.70	18.50		
Ties	0					1				
Total	6					10				
Follow up 2- Pretest										
- Ranks	3	2.67	8.00	-.527	.598	4	5.25	21.00	-.426	.670
+ Ranks	3	4.33	13.00			4	3.75	15.00		
Ties	0					2				
Total	6					10				
Follow up 1- Post-test										
- Ranks	2	3.25	6.50	-.552	.581	5	4.00	20.00	-1.035	.301
+ Ranks	2	1.75	3.50			2	4.00	8.00		
Ties	2					3				
Total	6					10				
Follow up 2- Post test										
- Ranks	4	3.75	15.00	-.957	.339	4	7.25	29.00	-.154	.877
+ Ranks	2	3.00	6.00			6	4.33	26.00		
Ties	0					0				
Total	6					10				
Follow up 2- Follow-up 1										
- Ranks	3	3.00	9.00	-.408	.683	4	3.75	15.00	-.426	.670
+ Ranks	2	3.00	6.00			4	5.25	21.00		
Ties	1					2				
Total	6					10				

Further, six analyses were conducted to evaluate the differences in the experimental group members, and six analyses were conducted to evaluate the differences in the control group members in LG scores. The results of these analyses are presented in Table 4.26.

As seen in Table 4.26, concerning experimental group members, the results indicated the only significant difference between the pre-test and post test LG scores ($z = -2.032$, $p = .042$). The LG scores of the experimental group members significantly increased between pre-test and post-test. The results indicated no significant differences between pre-test and follow-up 1, pre-test and follow-up 2, post-test and follow-up 1, post-test and follow up 2, and follow up 1 and follow up 2 LG scores of experimental group members.

As seen in Table 4.26, concerning control group members, the results indicated significant differences between the pre-test and follow-up 1 ($z = -2.395$, $p = .017$); post-test and follow-up 1 ($z = -2.254$, $p = .024$); and follow-up 1 and follow-up 2 ($z = -2.207$, $p = .027$) LG scores. LG score of control group members decreased significantly between pre-test and follow-up 1, and between post-test and follow-up 1, whereas their scores increased significantly between follow-up 1 and follow-up 2. The results indicate no significant differences between the pre-test and post-test, pre-test and follow-up 2, and post-test and follow-up 2 LG scores of the control group subjects.

Table 4.26. *The Results of the Wilcoxon Test for LG Scores of the Experimental and Control Group Subjects.*

	EXPERIMENTAL GROUP					CONTROL GROUP				
	N	Mean Rank	Sum of Ranks	z	*p*	N	Mean Rank	Sum of Ranks	z	*p*
Post-test – Pre-test										
- Ranks	0	.00	.00	-2.032	.042*	5	6.80	34.00	-1.371	.170
+ Ranks	5	3.00	15.00			4	2.75	11.00		
Ties	1					1				
Total	6					10				
Follow up 1- Pre-test										
- Ranks	1	1.50	1.50	-1.897	.058	7	5.00	35.00	-2.395	.017*
+ Ranks	5	3.90	19.50			1	1.00	1.00		
Ties	0					2				
Total	6					10				
Follow up 2- Pretest										
- Ranks	1	2.00	2.00	-1.490	.136	4	5.00	20.00	-.299	.765
+ Ranks	4	3.25	13.00			5	5.00	25.00		
Ties	1					1				
Total	6					10				
Follow up 1- Post-test										
- Ranks	3	2.00	6.00	-.949	.343	7	4.86	34.00	-2.254	.024*
+ Ranks	3	5.00	15.00			1	2.00	2.00		
Ties	0					2				
Total	6					10				
Follow up 2- Post test										
- Ranks	2	2.50	5.00	.000	1.000	2	6.75	13.50	-1.072	.284
+ Ranks	2	2.50	5.00			7	4.50	31.50		
Ties	2					1				
Total	6					10				
Follow up 2- Follow-up 1										
- Ranks	3	4.33	13.00	-.527	.598	2	3.00	6.00	-2.207	.027*
+ Ranks	3	2.67	8.00			8	6.13	49.00		
Ties	0					0				
Total	6						10			

*p < .05

Finally, six analyses were conducted to evaluate the differences in the experimental and control group members in PW scores. The results of these analyses are presented in Table 4.27.

As seen in Table 4.27, the results indicated no significant differences between pre-test and post-test, pre-test and follow-up 1, pre-test and follow-up 2, post-test and follow-up 1, post-test and follow up 2, and follow up 1 and follow up 2 PW scores of experimental group members. However, considering control group members, the results indicated a significant difference between pre-test and follow-up 1 PW scores ($z = -2.694$, $p = .007$). PW scores of the control group members decreased significantly between pre-test and follow-up 1. The results indicated no significant differences for the control group members between pre-test and follow-up 1, pre-test and follow-up 2, post-test and follow-up 1, post-test and follow up 2, and follow up 1 and follow up 2 PW scores.

Table 4.27. *The Results of the Wilcoxon Test for PW Scores of the Experimental and Control Group Subjects.*

	EXPERIMENTAL GROUP					CONTROL GROUP				
	N	Mean Rank	Sum of Ranks	z	*p*	N	Mean Rank	Sum of Ranks	z	*p*
Post-test – Pre-test										
- Ranks	4	3.50	14.00	-.755	.450	8	4.50	36.00	-1.615	.106
+ Ranks	2	3.50	7.00			1	9.00	9.00		
Ties	0					1				
Total	6					10				
Follow up 1- Pre-test										
- Ranks	4	3.38	13.50	-.632	.527	9	5.00	45.00	-2.694	.007*
+ Ranks	2	3.75	7.50			0	.00	.00		
Ties	0					1				
Total	6					10				
Follow up 2- Pretest										
- Ranks	2	2.50	5.00	-.677	.498	6	4.75	28.5	-1.476	.140
+ Ranks	3	3.33	10.00			2	3.75	7.50		
Ties	1					2				
Total	6					10				
Follow up 1- Post-test										
- Ranks	2	2.75	5.50	-.184	.854	5	6.20	31.00	-.364	.716
+ Ranks	2	2.25	4.50			5	4.80	24.00		
Ties	2					0				
Total	6					10				
Follow up 2- Post test										
- Ranks	1	2.00	2.00	-1.807	.071	4	3.50	14.00	.000	1.000
+ Ranks	5	3.80	19.00			3	4.67	14.00		
Ties	0					3				
Total	6					10				
Follow up 2- Follow-up 1										
- Ranks	1	4.50	4.50	-1.276	.202	3	2.83	8.50	-.938	.348
+ Ranks	5	3.30	16.50			4	4.88	19.50		
Ties	0					3				
Total	6					10				

4.3.1.3. Some Qualitative Findings Regarding the Participants' Evaluation of the AWP

An evaluation form (EF) was developed by the researcher for the purpose of obtaining further information about the process and personal outcomes of AWP. It included two Likert scale items and six open ended questions (see Appendix F) This evaluation form was given to the experimental group members in the last session of the AWP, together with other measurement instruments.

In the first question of the evaluation form, the subjects were asked to evaluate their effort to achieve their personal goals they determined at the beginning of the group process, on a 7-point Likert type scale ranging from (1) "not at all" to (7) "very much". The scores of the members ranged between 4 and 6 with a mean of 4.83, and a standard deviation of .75, indicating that subjects evaluated their own effort in a somewhat moderate degree.

When the members were asked about the benefits of AWP, some reported that they could devote more time to themselves and some others stated that they became more aware of some aspects of themselves than before. They acknowledged that especially by receiving feedback from the other group members they learned many things about themselves. They also stated that being acquainted with people who had the same or different concerns helped them to understand themselves and others better. One of the members reported that *"This group work provided a sincere, peaceful and supportive atmosphere. People who have different personalities and worldviews were together. This was a good opportunity for me to see, evaluate and compare myself with others"*. In addition, it was also reported that developing courage to confront some of their characteristics which they disliked was one of the most important benefits of the program. Finally, the members wrote that they were

pleased with the foods and beverages which were served in during the program.
The third question was about the parts of the group work they did like most. The main themes that appeared in the answers of the subjects were: art activities, positive outlook, self-awareness, receiving feedback from the other group members, foods and beverages, and the music used in the sessions. The excerpt below illustrates how one of the AWP participants described the benefits she gained from the group experience:

"We expressed our selves during this study. This was something which we had not done until now or something we were frightened of. Therefore, it was wonderful to express and understand ourselves. But the best thing was doing this by using different ways such as paintings or movements."

Another member reported that *"We need to share something with other people or to be listened by others. Here, everyone expressed his/her own thoughts and listened each other. Expressing oneself and listening to others are indeed useful. Sometimes we lose our ways in details. In this study we recognized ourselves better. We always say that we know ourselves. But never look at ourselves as having several parts as feelings and thoughts. Especially while drawing, we expressed some parts of ourselves unintentionally. It was really beneficial."*

The fourth question was related with the parts of AWP they liked less. The main theme that appeared in the answers of the subjects was related with the limited number of sessions of AWP. They suggested increasing the number of sessions to devote more time to their wellness. Although it was not directly related with the AWP, the members reported their complaints regarding their work load and tiredness. They reported that since they were too busy during the semester it was not possible for them to fully concentrate on this program.

Another question was about the members' ideas on participating in similar studies in the future. All of the members agreed on participating in similar activities in the future. However, consistent with their answers to the previous question, two of the

members added a note as *"But, if time and life conditions are appropriate"*.

Question six was about whether or not they suggest such a group work to their friends. All of the students gave positive answers by providing following the reasons: devoting time to ones' selves, understanding different people and different worlds, receiving feedback about ones' selves, hearing different viewpoints, examining one-self, increasing self-awareness, being at peace with oneself, self-expression, speaking, producing, and feeling relieved.

Members were also asked to make suggestions about the group process in order to develop the AWP program in the future. Most of the members suggested increasing the number of sessions. Only one of the members suggested focusing more on the cognitive dimension of wellness.

The last question of the evaluation form asked the members to rate the overall process of WI, on a 7-point Likert type scale ranging from (1) indicating "not at all" to (7) "very much". 4 of the members rated the overall group process as 7. The other two members rated 6. ($X = 6.67$, $SD = .52$). That is, all of the group members evaluated the group process positively. Overall, the analysis of the Evaluation Form revealed that the members' evaluation of the overall group experience was quite positive.

CHAPTER V

DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS

In this chapter, discussion regarding the results of the present study is presented by following the two phases of the study. The first section presents the discussions related to the results of the descriptive phase of the study. The second section introduces the discussion regarding the experimental phase of the study. Finally, the implications drawn from the results of the study and recommendations for future research are presented.

5.1. Discussion Regarding the Descriptive Phase of the Study

This section presents the discussion regarding the dimensions of wellness which were determined by exploratory and confirmatory factor analyses, and the predictors of wellness which were examined by stepwise multiple linear regression analysis.

5.1.1. Discussion Regarding the Dimensions of Wellness

The first purpose of the present study was to investigate the dimensions of wellness among METU students. In order to re-examine the factor structure of 103-item WI (Güneri, 2003) and provide further evidence for its validity and reliability, exploratory and confirmatory factor analyses were employed in the data. Results of

exploratory factor analysis did not verify the eight sub-dimensions (relational self, social interest and empathy, self-consistency, mastery orientation, physical wellness, humor, love, and environmental sensitivity) of the scale and yielded a new factor structure which was composed of 30 items measuring 4 dimensions of wellness (cognitive-emotional wellness, relational wellness, life-goal, physical wellness). The dimensions of this new 30-item WI were verified by confirmatory factor analysis and the results confirmed the four factor structure of the scale. The findings also indicated that WI with its four dimensions defined in the sample of the present study had satisfactory evidence for the reliability and validity of the scale.

As it was stated in the literature review section, several models of wellness have been developed over the years confirming the multidimensional nature of the construct. The examination of these models and the instruments developed based on these models seems to indicate that, although the numbers and names of dimensions may differ, there are some dimensions which are common in most of these models. Among these dimensions spiritual, cognitive-emotional, physical, and relational wellness seemed to be the most cited ones. Besides, there seems to be another tendency especially in the recent literature that the numbers of dimensions are becoming fewer and more self-related. For instance, the Original Multidimensional Wellness Model developed by Ardell (as cited in Ardell, 2001) included five wellness dimensions named responsibility, nutritional awareness, stress management, physical fitness, and environmental sensitivity. Then, revising this model in 1982, Ardell developed a model that consisted of five dimensions defined as nutritional awareness and physical fitness, meaning and purpose, relationship dynamics, emotional intelligence, and self-responsibility (as cited in Ardell, 2001). Finally, in 2001, he developed his third wellness model, which comprised three dimensions/domains (physical, mental, meaning and purpose) with fourteen skills classified under these three domains (exercise and fitness, nutrition, appearance, adaptations/challenges, lifestyle habits, emotional intelligence, effective decisions, stress management, factual knowledge, mental health, meaning and purpose, relationships, humor, and play). Similarly, the *Wheel of Wellness Model* of Myers, Sweney, and Witmer (2000) conceptualized wellness in five theoretical life tasks

(spirituality, self-direction, work and leisure, friendship, and love) and twelve subtasks of self-direction (sense of worth, sense of control, realistic beliefs, emotional awareness and coping, problem solving and creativity, sense of humor, nutrition, exercise, self-care, stress management, gender identity, and cultural identity). The *Wheel of Wellness Model* was then updated and named as *The Indivisible Self Model* (Hattie, Myers, & Sweeney, 2004; Ivey et al., 2005) covering Creative Self, Coping Self, Social Self, Essential Self, and Physical Self. However, the recent version of this model proposed a four factor structure, namely, cognitive-emotional, relational, physical, and spiritual components (Myers & Sweeney, 2005; Myers, Luecht, & Sweeney, 2004). From one perspective, these examples can be considered as the tendency of decreasing the number of dimensions in the conceptualization of wellness. But from another perspective, there seem to be a tendency to overcome the obstracles in measuring the construct which may lead to the reconceptualization of wellness. *The Indivisible Self Model* might be an example of reconstruction of wellness with its emphasis on self. In other words, although the basic philosophy behind the concept of wellness is the "wholeness of a human being", attempts to assess all the aspects inherent in wholeness might lead to some confusions not only in the measurement area but also in the conceptualization of the construct. All these studies seem to suggest that the number and the content of wellness dimensions may change depending on the instrumentation as well as the sample used in the study. However, there seem to be a trend to decrease the number of dimensions covered in the construct of wellness. Thus, the four dimensions of wellness identified in the present study might be considered as a support of the existent literature on wellness.

According to Sexton (as cited in Myers, Luecht, & Sweeney, 2004), in order to accurately assess wellness, theoretical or conceptual models defining the components of wellness should be developed and tested. In this process, the emergence of new models is both an anticipated and desired outcome. Thus, the new structure of wellness that appeared as a result of the present study is not unexpected but it is a desirable outcome which may lead to further understanding of the conctruct of wellness among Turkish university students. Below, some interpretations are

presented regarding the structure of wellness in the present study.

In the present study, the exploratory factor analysis showed that the factor loadings of most of the items in the original WI (Güneri, 2003) were below .40. For instance, all the items in the *humor* subscale of the original 103-item WI (Güneri, 2003) were excluded from the 30-item WI due to having factor loadings below .40. Thus, humor was not one of the dimensions of wellness in the present study. Although the contribution of humor to wellness is obvious in the literature, not all the wellness instruments included humor as a separate dimension. Humor took part in the "meaning and purpose" dimension of Ardell's Multidimensional model (as cited in Ardell, 2001). Likewise, it is a component of the "self-direction" dimension in Wheel of Wellness model (Myers, Sweeney, & Witmer, 2000), and a component of the "creative self" in Indivisible Self model of wellness (Ivey at al., 2005). In Turkish literature, there are some studies investigating the relationships between humor and some other variables such as popularity and academic achievement (Topuz, 1995), physical symptoms (Aydın, 1993), and coping strategies (Durmuş & Tezer, 2001) among Turkish adolescents. Although the results of these studies provide evidences for the relationship between wellness and humor, further studies are needed to discuss the role of humor in predicting wellness among Turkish university students.

Similarly, some of the items regarding *sexual life* and *romantic relationships* which were loaded on the love sub-scale; and items related with *physical exercise* and *self-care* which were loaded on the physical wellness sub-scale of the 103-items WI (Güneri, 2003) were not included in the 30-item WI. Likewise, although the 103-item WI did not include a separate dimension called *spiritual wellness* it included some items regarding spirituality which were loaded on other dimensions. However, in 30-item version of WI all these items were excluded as a result of the factor analyses, similar to the dimensions or items mentioned above. Additionally, the Life-Goal sub-scale emerged in the 30-item WI as a new dimension. It is a fact that different studies yielded different dimensions of wellness. The reasons of these differences might be the results of sample characteristics. One of the sample characteristics might be related with sub-cultural issues. METU students are coming from the different

regions of the country. Thus, the sample of the present study represents this heterogeneity. Therefore, in the following paragraphs, the absence of the sexuality, romantic relationships, physical exercise, self-care, and spirituality dimensions and the structure of the life goal dimension are interpreted witin a cultural framework.

In the present study, all of the items of the *love* subscale of the 103-item WI (Güneri, 2003) were eliminated from the scale since they had loadings below .40. These items were related with sexual life and romantic relationships. As stated by Medora, Larson, Hortaçsu, and Dave (2002), culture has an enermous impact on men and women regarding their sexual life and romantic relationships. Sexuality is one of the taboo concerns for Turkish society (İmamoğlu & Aygün, 1999). According to Goode (as cited in Medora et al., 2002) romantic love is valued and experienced more in industrialized and technologically advanced countries, while it is valued less in more collectivist, traditional, and less industrialized cultures. This is because of the familial and socio-cultural traditions and expectations which dictate a person's attitude and expectations and offer less freedom of choice with regard to mate selection and marriage. According to Kağıtçıbaşı (as cited in Sunar, 2002) Turkish culture is in a transition period in terms of romantic relationships through Westernization. This transition resulted in contradictions in the lives of Turkish people. While Turkish people seem to adopt Westernized values in terms of clothing, music, and life style, and women are free in terms of participating in division of labor which brings them economic freedom, the sexual behaviors of young people, especially young women, are still controlled by the family and the society. As stated by Sunar (2002), namus (honor) is still the dominant value in the Turkish cultural system and controlled by the men in the family. The findings of a study on the dating relationships and sexual life of Turkish college students revealed that there were gender differences in terms of perceived parental permissiveness toward premarital sexual behaviors in favor of male students, although there were no significant gender differences in terms of parental attitudes toward dating (Şahin, 2005). This finding is consistent with the findings of Akgün (2000) which revealed the predictor role of perceived parental attitudes on the sexual attitudes and experiences of Turkish adolescents. In addition, in a recent study which compares the attitudes toward

romanticism and preferences regarding the qualities in prospective mates in USA, India, and Turkey, Turkish university students were found as less romantic than American youth, but they expressesed more romantic beliefs than Indian youth (Medora et al., 2002). Based on these results, it can be concluded that Turkish culture is still in transition period in terms of romantic relationships and Turkish university students experience restrictions in their sexual life. The remaining items in the Relational Wellness (RW) subscale of the 30-item version of WI were composed of behaviors and communication skills which are basic for all good human relationships, and could be interpreted as measuring all close relationships, but not specific types of relationships such as family relationships, romantic relationships, or friendship.

The exclusion of the physical exercise items was another finding of the present study that might call for a sub-cultural and cultural interpretation. Although the literature suggested the most rapid reduction in physical activity levels occurs between the ages of 18 and 24 years (Stephens, Jacobs, & White, 1986), and participation in physical activities is not common at university years (Bray & Born, 2004), the research investigating the exercise preferences of Turkish university students is limited. The results of the present study showed that what students understand from the physical dimension of wellness covered the items regarding eating and sleeping habits.

Similar to the physical exercise items, spirituality items were also excluded by the exploratory factor analysis in the present study. According to the literature, spirituality is an "intrinsic human capacity" and it is one of the domains of human development (Benson, 2004; Benson, Roehlkepartain, & Rude, 2003; Cartwright, 2001; Mulqueen & Elias, 2000). Although some authors stated that spirituality emerges during early childhood, some others argued that it only emerges in adolescence and early adulthood (Benson et al., 2003). Spiritual development which involves "deriving meaning, purpose and direction in one's life"; and "developing a greater connectedness to self and others through relationships and union with community" (Love & Talbot, 1999) emerge or develop during adolescence, which is

a period of life including issues of meaning, purpose, vocation, relationships, and identity. Whenever it starts, spiritual development appears to be a potentially powerful resource for positive human development in the first two decades of life (Benson et al., 2003). A large body of literature supports the notion that individuals who are highly spiritual suffer fewer physical health problems, recover from illness more quickly, and experience less stress than those who are not (Koening & Cohen; as cited in Duffy, 2006; Thoresen, 1999).

Spirituality, as distinguished from religion, is a concept which has been discussed in higher education conferences and publications, since the end of the 1990s (Estanek, 2006). The spiritual life of college students have been investigated and discussed in several studies (Callichia, & Graham, 2006; Duffy, 2006; Estanek, 2006; Singleton, Mason, & Webber, 2004; Sokolov, 2006; Young, Cashwell, & Shcherbakova, 2000). However, despite the increased interest to understand the role that spirituality plays in healthy human functioning among psychologists and counselors in the world, the topic of spirituality is quite new for Turkish counselors waiting for examining. Indeed, Turkish culture is familiar with spiritual issues due to the Sufism traditions which go far back in history. However, there is no measurement tool for spirituality, and consequently no empirical research finding is reported regarding the spiritual lives of Turkish people thus far. Therefore, further studies investigating spirituality among Turkish people are needed to discuss spiritual wellness among Turkish university students.

Finally, the content of the Life Goal sub-scale of 30 item WI may be another result of this study which calls for a sub-cultural explanation. The Life Goal dimension of wellness in the present study was composed of behaviors such as setting and pursuing realistic goals etc. which were consistent with the literature (Myers, Sweeney, & Witmer, 2000). However, there were additional items such as interest in social and political events, coping with the workload in their school, and taking responsibility if required which could be suggested as a result of the characteristics of the university students sample.

To sum up, in the light of the results revealed in the first phase of the present study, it is obvious that further studies are needed in investigating the construct of wellness in Turkish culture. Actually culture is a considerable factor when wellness is in question. According to Christopher (1999), culture-free theories or measures are unattainable in defining and measuring wellness, since they have cultural assumptions and values. He indicates that a culture's notion of the self, the good or fulfilled life and normality and abnormality may differ from one culture to another. Thus, the concept of wellness has a risk of misinterpretaion and misunderstanding. While modern wellness advocates may bring in threads of eastern thought and religion into the models and discussions, there is an absence of a theoretical understanding of how the Western, mechanistic, dualistic roots may make an impact on the development of wellness paradigms (Depken, 1994). According to Christophner (1999), the understanding of wellness seems to be informed by the Western culture. In fitting with the positions of multiculturalists such as Pedersen and Ivey (1993) and Sue, Ivey and Pedersen (1996), it becomes a necessity to understand and analyze the dimensions of wellness in Turkish culture. Consequently, difficulties in defining the dimensions of wellness in the present study might appear because of the cultural definition of wellness in Turkey. Also the absence of some components such as humor, sexuality, romantic relationships, spirituality, and physical exercise might be significant findings which require further studies in Turkish culture.

5.1.2. Discussion Regarding the Predictors of Total and Sub-dimensions of Wellness

The second concern of the present study was to examine the role of the predictor variables (self-esteem, physical symptoms, art-self concept, and gender) on the dependent variables (total and sub-scale wellness scores). Five separate stepwise multiple linear regression analyses (SMLRA) were carried out to investigate any possible differences in the pattern of the predicting variables for overall wellness, cognitive emotional wellness, relational wellness, life-goal and physical wellness.

Results indicated that all the suggested independent variables (self-esteem, dummy-coded gender, physical symptoms and art self-concept) appeared as significant predictors of overall wellness. Additionally, self-esteem and physical symptoms appeared as significant predictors of cognitive emotional wellness; gender, self-esteem and art-self-concept appeared as significant predictors of relational wellness; self-esteem and art-self concept appeared as significant predictors of life-goal; and physical symptoms, gender, and self-esteem appeared as significant predictors of physical wellness. In conclusion, although all the selected variables have some contributions on total wellness or subscale wellness scores, self-esteem seems to be the best predictor of wellness among university students. In the following sub-sections, discussions regarding the findings of these analyses are presented.

5.1.2.1. Discussion Regarding the Predictors of Total Wellness

Results indicated that all the independent variables, self-esteem, dummy-coded gender, physical symptoms and art self-concept, used in this study were the significant predictors of overall wellness, explaining approximately 31 % of the total variance of the total wellness scores of the students. Self-esteem was the first variable entered into the equation and this variable alone accounted the 25 % of the variance. Gender, physical symptoms, and art self-concept explained for the 3 %, 3 %, and 1 % of the variance, respectively. Self-esteem and art self-concept were positively correlated with total wellness, whereas physical symptoms were negatively correlated.

Based on the results regarding self-esteem, female students who have higher self-esteem are expected to have a high level wellness. In the literature, *self-esteem* is one of the most frequently investigated variables in relation to wellness. Several empirical studies provided evidence that self-esteem is associated with some mental health characteristics such as depression (Rosenberg, et al., 1989); anxiety (Rosenberg, 1989); happiness (Perneger, Hudelson & Bovier, 2004); physical health including body image concerns and eating disorders (McVay, et al., 2002; O'dea, 2004; Stice, 2002); drug use (Hayes & Fors, 1990; Sullivan & Guglielmo, 1985;

Sullivan, et al., 1986); smoking, substance abuse, suicide, and pregnancy (Daane, 2003; Shirk, Burwell, & Harter, 2003); health values and behaviors (Torres & Fernandez, 1995), perceptions of vulnerability and health risk behaviors (Gerrard, et al., 2000), self-reported health (Axelsson & Ejlertson, 2002); academic life such as increased school performance and productive behavior (Leary, Schreindorfer, & Haubt, 1995), academic success (Spaights, Kenner, & Dixon, 1986); and socially related behaviors such as social integration in the community (Herrero & Gracia, 2004), leadership ability (Fox, 1992), dating (Leck, 2006), and loneliness (Haines, Scalise, & Ginter, 1993; McWhirter, 1997a; 1997b). All these studies provided strong supports for the present study regarding the role of self-esteem on wellness.

Gender, as being the second variable entered into the equation indicated that, although it explained the small portion of the variance, being female was the predictor of total wellness. In other words, those females who have higher self-esteem and art self-concept, and lower physical symptom are experiencing higher overall wellness. As it was outlined in the Review of Literature Chapter, the wellness literature frequently points out the gender differences in understanding various outcomes of wellness (e.g., Courtenay, 1998; 2000; 2003; 2004; Crose & Nicholas, 1992; Depken, 1994; Garret, 1996; Matheny, Ashby, & Cupp, 2005; Ryff & Heidrich, 1997; Steiner, Pavelski, Pitts, & McQuivey, 1998). However, results of several studies revealed contradictory findings regarding gender differences. Three categories of results were mentioned in the literature: (1) women experience less wellness than men (Myers & Bechtel, 2004; Myers & Mobley, 2004; Steiner, Pavelski, Pitts, & McQuivey, 1998) and they take less care of themselves than men (Lonnquist, Weiss, & Larson, 1992; Taeuber, 1991), (2) men experience less wellness than women (Oleckno & Blacconiere, 1990, Wagstaff, 1997), engage in fewer health-promoting behaviors, and in more risky behaviors (Courtenay, 1998, 2000), and (3) no gender differences between women and men in terms of wellness (Lee & Yuen-Loke, 2005).

Physical symptoms appeared as one of the significant predictors of total wellness in the present study. The negative relationship between having higher physical

symptoms and higher wellness is consistent with the previous literature (Belmaker, Espinoza, & Pogrund, 1985; Degges-White et al., 2003; Taylor, Szatmari, Boyle, & Offord, 1996). Actually, based on the wellness literature which emphasizes holism and the integrated nature of human fuctioning, it is easy to speculate that increased physical symptoms, an obvious evidence of poor physical wellness will result in negative affects in all other areas including total wellness of individuals.

Art self-concept was the last variable entered in predicting total wellness. Although no research has been found on the relationship between art self-concept and total wellness, some indirect evidence might provide a base to make further speculations. Since art self-concept is a component of overall self-concept, which is closely related with self-esteem, it was expected that art self-concept was a predictor of total wellness along with self-esteem. Although it was low, a relationship between self-esteem and art self-concept has been reported in a previous study (Duran-Oğuz & Tezer, 2005). Therefore, it could be speculated that having a higher art-self concept that resulted in having a higher self-esteem would predict wellness. In addition, employing oneself in art activities, which could be considered as a sign of art self-concept, has been shown to increase self-esteem in several studies (Berryman-Miller, 1988; Hietolahti-Ansten & Kalliopuska, 1991; Kalliopuska, 1991). Since the results of the present study regarding total wellness were in favor of females, the result that art self-concept predicts total wellness was also consistent with the findings of the previous literature in which sex differences in self-concept frequently emerge in stereotypical patterns. According to the literature, women score higher than men in verbal, artistic, moral, and social domains (Vispoel & Fast, 2000). In a previous study, Vispoel (1993) found that female students were better in music, dance, and dramatic art self-concepts than males. Likewise, Vispoel and Forte (1994) found that female students scored significantly higher than male students in both music and dance self-concepts; and Vispoel and Forte (1995) found that female students scored significantly higher than male students in music and dance.

5.1.2.2. Discussion Regarding the Predictors of Cognitive-Emotional Wellness

Results indicated that self-esteem and physical symptoms are the significant predictors of cognitive-emotional wellness, explaining approximately 52 % of the total variance of the cognitive-emotional wellness scores of the students. Self-esteem was the first variable entered into the equation and this variable alone accounted for the 50 % of the variance whereas physical symptoms explained the 2 % of the variance. Self-esteem was positively correlated with cognitive-emotional wellness, whereas physical symptoms were negatively correlated. That is, those students who have higher self-esteem and lower physical symptoms are experiencing a higher cognitive-emotional wellness.

The cognitive-emotional dimension of wellness which was predicted most strongly by self-esteem in the present study was a component of wellness composed of thoughts and feelings about oneself, coping with stressful or negative thoughts, feeling well psychologically, and having a self worth. Considering that self-esteem is a construct which refers to an individual's perceptions of his personal worth (Battle, et al., 1998) the relationship between cognitive emotional wellness and self-esteem is an expected result. This finding is consistent with the findings of other previously mentioned studies which suggested the association between self-esteem and many cognitive-emotional mental health indicators such as depression (Rosenberg, et al., 1989); anxiety (Rosenberg, 1989); and happiness (Perneger, et al., 2004).

Similar to the relationship between overall wellness and physical symptoms, the relationship between cognitive-emotional wellness and physical symptoms could be explained by the interplay between mind and body, which was first emphasized in the literature by Adler (as cited in Ansbacher & Ansbacher, 1956). That is, due to the integrated nature of human functioning, which was also revealed as a common tenet of wellness in several wellness models, having physical symptoms resulted in having problems in cognitive-emotional areas of functioning or vice versa.

5.1.2.3. Discussion Regarding the Predictors of Relational Wellness

In the present study, gender, self- esteem and art-self-concept appeared as

the significant predictors of relational wellness, explaining approxiametely 13 % of the total variance. Gender was the first variable entered into the equation and this variable alone accounted for the 7 % of the variance, self-esteem explained 4 % and art self-concept explained the 2 % of the variance. Both self-esteem and art self-concept were positively related with relational wellness.

The results of the present study indicated that gender was the most powerful predictor of relational wellness. That is, those females who have higher self-esteem and art self-concept are experiencing higher relational wellness. As it was previously explained, the items of the relational wellness subscale of WI was composed of items regarding behaviors and communication skills which are basic for all good human relationships. Literature strongly suggests that females are generally better than males in the basic qualities of good human relationships (Pakaslahti, Karjalainen, & Keltikangas-Jarvinen, 2002; Punyant-Carter, 2006). The existing literature on gender differences in close relationships also provides support for this result. For instance, several studies indicated that women and men differ in self-disclosure (Punyant-Carter, 2006), verbal and nonverbal communication styles (Helweg-Larsen, Cunningham, Carrico, & Pergam, 2004), prosocial behaviors (Pakaslahti, Karjalainen, & Keltikangas-Jarvinen, 2002), coping strategies (Matheny, Ashby, & Cupp, 2005; Yamasaki, Sakai, & Uchida, 2006), power strategy choices (Keshet, Kark, Pomerantz-Zorin, Koslowsky, & Schwartzwald, 2006), and conflict handling behaviors (Tezer & Demir, 2001).

Self-esteem also appeared as a predictor of relational wellness in the present study. Since self-esteem is a personality variable that influences many different aspects of human life and thus has been viewed as a requisite for healthy functioning, the predictor power of self-esteem on the relational dimension of wellness was expected. Regarding the relationship between self-esteem and social relationships, Rosenberg (1965) stated that individuals with low self-esteem lacked confidence and tended to avoid society. Consistently, Pope, Mchale and Craighead (1988) stated that positive self-esteem has an enormous impact on good social-emotional adjustment. Several research findings supported these beliefs, indicating that self-esteem has many

correlates which are closely related with positive or negative human relationships such as anger expression (Nunn, & Thomas, 1999), social skills (Riggio, Throckmorton & Depaola,1990), leadership ability (Fox, 1992), social integration in the community (Herrero & Gracia, 2004), minimal dating (Leck, 2006), and loneliness (Haines, et al., 1993; McWhirter, 1997a, 1997b). In addition, when the contribution of gender and self-esteeem on relational wellness is considered, the results of the present study are also consistent with the literature. For instance, in an earlier study, O'Brien (1991) reported that males are better in global self-esteem, competence, self-control, personal power, body appearance, and body functioning whereas females are better in lovability, likeability, moral self approval, and defensiveness. Furthermore, according to Josephs, Markus, and Tafarodi (1992), high self-esteem females are concerned with connecting with others while high self-esteem males are concerned with getting ahead of others.

Art-self concept was the last variable entered into the equation. Like the relationship betwen total wellness and art self-concept, although no research has been found on the relationship between art self-concept and relational wellness, some indirect evidence might provide a base to make further speculations. Since women score higher than men in verbal, artistic, moral, and social domains (Vispoel & Fast, 2000), and dramatic art self-concept (Vispoel, 1993) all of which can be accepted as requirements in establishing effective human relationship, it can be speculated that art self-concept influences females' relational wellness.

5.1.2.4. Discussion Regarding the Predictors of Life Goal

The results of the present study on the LG scores of the students revealed that self-esteem and art-self concept appeared as significant predictors explaining approximately 12 % of the total variance. These variables explained the total variance 11 % and 1 %, respectively. Both self-esteem and art self-concept were positively related with LG, meaning that students who have higher self-esteem and higher art self-concept tended to have life goals and more motivation to pursue these goals.

These findings are consistent with the findings of Zuckerman (1980) which indicated that self-concept and self-esteem predict life goals of college students. These results could also be interpreted in the light of the concept of "possible selves" which was theorized by the researchers based on a notion of the multiplicity of selves (Markus & Nurius, 1986; Nurius, 1986). Although in the past, self-concept has been conceptualized as a single, generalized avarage of self images which are stable over time, recently this perspective has changed with an understanding of self-concept including a diverse repertoire (collection of images and cognitions about self) of "possible selves" that individuals would like to become -the 'successful professional'self, the 'creative' self etc.- (Cantor, et al., 1988). Langan-Fox (1991) adopted this theoretical perspective of multiple selves to the field of interpersonal goals, assuming that goals are "future selves" or "possible selves", and thus linked the self-concept to motivation. She speculated that possible selves can be viewed as the cognitive manifestations of enduring goals. The literature on life goals also provides support to this view in the sense that some social and personal characteristics enable people to take part in life tasks, to have future goals (Cantor & Sanderson, 1999), and to make progress toward personal goals (Diener, & Fujita, 1995). Thus, it can be concluded that having higher self-esteem indicates having personal resources in achieving life goals.

Since this study wasconducted with university students, a considerable amount of the life goals of these students would be related with their academic life. Thus, considering the determined relationships between self-esteem and academic outcomes such as academic success (Leary, et al., 1995; Spaights, et al., 1986), another conclusion can be deduced that self-esteem predicts the life goals and thus the academic performance and success of students.

5.1.2.5. Discussion Regarding the Predictors of Physical Wellness

In this study, physical symptoms, gender, and self-esteem appeared as significant predictors explaining approximately 14 % of the total variance of the physical

wellness scores. Physical symptom was the first variable entered into the equation and this variable alone accounted the 5 % of the variance, gender explained 8 % and self-esteem explained for the 1 % of the variance. Physical symptoms were negatively related with physical wellness, whereas self-esteem was positively related.

Physical symptom was an expected predictor of physical wellness. The finding of the present study indicated that those females who have lower physical symptoms and higher self-esteem are experiencing higher physical wellness. In the literature it is reported that women rate their health more poorly than men, report more health problems and physical symptoms, take more sick days from work, make more physician visits, and take higher levels of medications (National Center for Health Statistics, 1994; Parks & Neutens, 1987; Verbrugge, 1985). It was also found that gender is an important variable in self-reported physical symptoms such as headaches, fatigue, dizziness, back and musculoskeletal pain, and gastrointestinal disturbances (Jones, et al., 2004).

Finally self-esteem was found as a predictor of physical wellness in the present study. That is, female students who have higher self-esteem are expected to be well physically. This result is also consistent with the literature indicating the relationships between self-esteem and self-reported health (Axelsson & Ejlertson, 2002), health values and behaviors (Torres & Frenandez, 1995), and body image concerns and eating disorders (McVay et al., 2002; O'dea, 2004; Stice, 2002). Similarly this finding was supported by the results of some emprical studies indicating the relationships between self-esteem and some variables which could be considered as the risk factors for physical wellness of individuals like drug use (Hayes & Fors, 1990; Sullivan & Guglielmo, 1985; Sullivan, et al., 1986), smoking, substance abuse (Daane, 2003; Shirk, Burwell, & Harter, 2003), and health risk behaviors (Gerrard, et al., 2000).

To sum up, this study generally replicates the previously documented associations between wellness and self-esteem, gender, and physical symptoms. In the present study, as expected, it was found that self-esteem has a superior predictive power in

predicting both the total and sub-scale wellness scores of the students. There is a positive relationship between wellness and self-esteem, meaning that students who have higher self-esteem are expected to be well in overall, cognitive-emotional, relational, life-goal, and physical dimensions of wellness. Gender appeared as a predictor of overall, physical and relational wellness scores of the female students, but it did not predict the cognitive emotional and life goal wellness scores. All the results of the present study indicated that gender differences were in favor of females. Physical symptoms were found as negatively related with wellness, predicting overall, cognitive emotional, and physical wellness scores of the students, meaning that students who have lower physical symptoms are expected to have higher cognitive-emotional and physical wellness. Finally, art self-concept, a special component of self-concept was found as a predictor of overall, relational and life goal wellness scores of the students. The relationship between wellness and art self-concept was positive.

5.2. Discussion Regarding the Experimental Phase of the Study (The Effectiveness of AWP on the Wellness)

One of the main purposes of this research study was to investigate the effect of AWP on the wellness level of METU students. Through the use of art tasks, journaling, self-expressions and group discussions, treatment group participants worked toward increasing their wellness levels. Significant increases in the post-test and follow-up 1 total wellness scores of the subjects who received AWP were found as sufficient evidence to claim that AWP was effective in significantly increasing the wellness scores of the students in the treatment group. That is, art is a successful therapeutic modality in improving wellness among university students. Significant improvements in cognitive emotional wellness of the subjects in post-test and follow-up 1; and in their life-goals in follow-up 1 were also received. In addition, qualitative data obtained from the evaluation form revealed several positive feedbacks from members regarding their experiences in treatment group.

In the literature, it is well documented that providing the people activities that help and equip them regarding improving their own wellness are efficient (Ansuini & Fiddler-Woite, 1996; Fowler, 1998; Galves, 1997; Hermon & Hazler, 1999; Light, 1995; Lee & Graham, 2001; McCalanahan, 1993; Omizo & Omizo, 1992; Peterson, 1996; Rybarczyk, et al, 2001; Shillinford & Shillinford-Macking, 1996; Wagstaff, 1997). Watt, Verma, and Flynn (1998) rewieved results of eleven wellness intervention studies and reported that all studies revealed some positive outcomes. Thus, the positive findings of the present study are in line with the findings of previous experimental research which report significant increases in the wellness scores of college students who received wellness education or wellness treatment programs.

The results of the experimental phase of the present study were also consistent with the previous literature which reveals that activity based wellness programs are more successful than the traditional cognitive-based or health education type programs (Fowler, 1998; McCalanahan, 1993); and art-based counseling and therapy are effective in motivating individuals to take increased responsibility for personal health and wellness (Maselli, 1998; Soden, 1998).

The results of the present study also revealed that, this program is *preventive* in its nature. It can be infered from the results that the wellness scores of the control group decreased over time, whereas the wellness scores of the experimental group increased. This result is fitting with the nature of prevention practices, which if are to work could not only confer something good or useful but also prevent something bad (Egan, 2002).

However, the results of the follow-up 2 unexpectedly indicated that, some of the scores increased in the control group whereas they did not increased in the treatment group More specifically, the results showed that total wellness, cognitive-emotional wellness and life goal scores of the control group members increased significantly between follow-up 1 and follow-up 2. Although there might be some several personal and/or situational reasons of such findings, yet such explanations might not

go beyond some speculations. For example, the end of the summer holiday when follow-up 2 was conducted might have some positive as well as negative affect on students' wellness. The effect of such factors are warrant for further studies.

There are two other unexpected results of the present study regarding the lack of effects of the program on relational and physical wellness. Physical wellness was particularly emphasized throughout the program by providing healthy foods and beverages to the participants in order to change their nutrition. However, the findings indicated no significant changes in this dimension. This might be the result of the living conditions of the university students. Although METU is one of the universities which provides several opportunities for the students, physical wellness may not only be related to the opportunities in the environment but also related with the habits gained throughout ones' life. In other words, taking care of ones' physical wellness should be taught in the families as a way of life which make the students to use these opportunities provided by a wellness environment and culture. As for the relational wellness, AWP yielded no significant effects in any of the measures of the treatment group. Considering that no changes were also obtained in the control group, the effect of the program in relational wellness might be evaluated in terms of students age characteristics. The affect of human relationships on students' life is so central and complex that might not be covered in the program. Besides, as it was explained in the discussion regarding the first phase of the study, the dimension of relational wellness included items measuring only general aspects of relationships. This might result in unexplained variations in relational wellness which should be considered both in the measurement of the dimension and in the intervention process.

5.3. Implications and Recommendations

The present study has some implications for both counseling research and practices. These implications with some recommendations are presented below by following the two phases of the study.

Fist of all, in the descriptive phase of this study the assessment of wellness appeared

as an important but difficult issue which should be considered in identifying its dimensions. The eight dimensions of wellness identified by Güneri (2003) did not verified by the results of the present study, althought both Güneri's study and the present study conducted on METU students in a short time interval. However, the results of this phase provides valuable information to show that wellness is a multidimensional concept, consisting of cognitive-emotional wellness, relational wellness, physical wellness, and life-goal dimensions. The psychometric properties of the 30 item version of WI (Güneri, 2003) were satisfactory to assess the wellness levels of university students. Thus, counselors who work in university campuses may use this instrument to identify the total, cognitive emotional, relational, life-goal and physical wellness scores of university students. In addition, considering the results of the present study which indicated that wellness has a multidimensional nature, consisting of cognitive emotional wellness, relational wellness, physical wellness and life goal, it could be recommended that college health and counseling centers should provide wellness programs which concentrate on all these dimensions of wellness (Grace, 1997).

Other results of the descriptive phase of the present study indicated that gender, physical symptoms and art self-concept are predictors of wellness among university students. However, self-esteem seemed to be the most significant predictor of overall and sub-dimensions of wellness. Thus, the results of this phase of the study may contribute to the researchers' understandings about wellness among university students. These findings may have several implications for counselors working with university students.

Results of the experimental phase of the present study showed that AWP was effective in improving the wellness level of university students. Thus, it is hoped that the findings of this study might encourage others to create art-enriched wellness programs at different school levels and agencies/settings. Taking this program as a starting point, future programs could be developed not only in schools, but also in work settings. Consequently, this would provide people with an opportunity to participate in positive, art-enriched wellness counseling programs in the community.

In addition, the experimental phase of this study provides information to show that AWP was not only successful in improving wellness among university students, but also has preventive functions in students' lives. For the present program (AWP) although the results revealed a positive effect on increasing the wellness of experimental group members, it could be possible to get more effective results and facilitate the maintenance of the treatment procedure by:

1. Controlling its effectiveness with a placebo control group; and by comparing AWP with alternative treatment procedures such as cognitive-based instructions and open-studio art programs.
2. Adding new issues and topics to AWP by considering the needs of the students.
3. Assuming a teamwork strategy (Grace, 1997) and collaborating with professionals in the community that are knowledgeable in wellness and healthy living by including them to the AWP procedure (Rayle, Dixon & Myers, 2004; Street, 1994).
4. Enriching the evaluation of wellness by including alternative evaluation strategies such as in-depth interviews, and alternative outcome measures such as health status, mental health status, and quality-of-life measures.
5. Testing the effectiveness of AWP with different and larger samples.
6. Conducting longitudinal studies to provide more insight into the long-term effects of AWP on the students, and
7. Using AWP as a part of a comprehensive campus-based intervention which aims to create and develop a *wellness environment and wellness culture* (Grace, 1997). *"Full-service schools",* which offer health and wellness programs and opportunities are in the agenda of a new world (Dryfoos, 1995). Moreover, the recent wellness literature expressed both intra-individual and contextual factors in improving wellness (Gruman, 1994). Environments as well as persons need to be targeted in wellness improvement studies (Schafer, 1998). As Wallack and Winkleby (as cited in Schafer, 1998) mentioned, a real preventive wellness paradigm requires creating a social and physical environment that promotes the establishment and maintenance of healthy lifestyle choices and

discourages health damaging choices. According to Gruman (1994), the view that wellness is exclusively the property of the individual, uninfluenced by the social environment, is not only wrong but also dangerous. It encourages people to attribute responsibility for factors outside their control. Pincus (1994; as cited in Schafer, 1998) agrees with Gruman (1994) either "blaming the victim" by ignoring context or "excusing the individual" by blaming the system can lead to unfortunate and misguided results.

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APPENDICES

APPENDIX A

COVER PAGE AND INFORMATION FORM

Değerli öğrenciler,

Bu ankette, sizin genel olarak yaşam biçiminiz ve sağlığınız ile ilgili konularda kendinizi nasıl gördüğünüzü anlamaya yönelik sorular bulunmaktadır.

Sizden beklenen, her bir bölümde verilen sorular için ilgili seçeneklerden size en uygun olanı çarpı (X) işareti koyarak belirlemenizdir.

Sorulara vereceğiniz yanıtlar kesinlikle gizli tutulacak ve araştırma dışında hiçbir amaçla kullanılmayacaktır.

Bu çalışmayla elde edilecek veriler ışığında daha sonra çeşitli, geliştirici etkinlikler düzenlenecektir. Bu etkinliklerde yer almak ya da ankete verdiğiniz yanıtlarla ilgili bilgi almak isterseniz "Kişisel Bilgiler" bölümünde ad ve soyadınızı ve size ulaşabileceğimiz e-posta (ve/veya posta) adresinizi yazmanız gerekmektedir. Bu çalışmanın sonuçlarıyla ilgili bilgi almak istemiyor ya da daha sonra yapılacak etkinliklere katılmak istemiyorsanız adınızı, soyadınızı ve e-posta adresinizi yazmanız gerekmemektedir.

Soruların doğru veya yanlış yanıtı yoktur. Lütfen her soruyu içtenlikle ve doğru olarak yanıtlayınız. Hiç bir soruyu boş bırakmamaya özen gösteriniz.

Yardımlarınız için çok teşekkürler.

Uzm. Psk. Dan. Nagihan OĞUZ DURAN
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Ofis tel: 210 40 42
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KİŞİSEL BİLGİLER

1. Ad soyad: .....
2. e-posta: .....
3. Posta (mektup) adresi: .....

3. Cinsiyet: ( ) K ( ) E
4. Yaş: .....
5. Bölüm/sınıf: .....
6. Daha önce ağır bir hastalık geçirdiniz mi? Hayır ( ) Evet ( )
   Lütfen yazınız.....
7. Halen önemli bir rahatsızlığınız var mı? Hayır ( ) Evet ( )
   Lütfen yazınız.....

APPENDIX B

WELLNESS INVENTORY *
(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 Katılmıyorum	**Katılmıyorum**	**Kararsızım**	**Katılıyorum**	**Kesinlikle Katılıyorum**
1. Her akşam o günün benim için ne ifade ettiğini düşünürüm.					
6. Dergi, gazete ve kitaplardan değişik konular hakkında bilgi edinirim.					
26. Genel olarak hayatımdan memnunum.					
37. Diğer insanlar ile yakın ve güvene dayalı ilişkiler kurabilirim.					
38. Hayattan zevk alırım.					
53. Diğer insanların gelişimleri ve iyi olmaları ile ilgilenirim.					
64. Sosyal ve politik olaylar ile ilgiliyimdir.					
65. Karşı cinsten bir kişi ile olumlu duygusal ilişki içindeyim.					
74. Stres düzeyimi kontrol edebiliyorum.					
75. Kalorisi yüksek ancak besleyici değeri olmayan gıdaları (cips, gofret, çikolata, bisküvi vb.) tüketmemeye dikkat ederim.					
77. Hocalarım tarafından takdir edilirim.					
88. Zamanımı iyi kullanırım.					
101. Yardıma ihtiyacı olanlara yardım ederim.					
102. Gelişmeme katkı sağlayacak değişiklikleri yapmaktan kaçınmam.					

* Ölçeğin tanıtımı amacıyla bazı örnek maddeler verilmiştir.

APPENDIX C
PHYSICAL SYMPTOM CHECKLIST
(FİZİKSEL SEMPTOM TARAMA LİSTESİ)

Aşağıda herkesin karşılaşabileceği genel bedensel rahatsızlıklar listelenmiştir. Bugün de dahil olmak üzere, geçen dört hafta içinde, sizin her bir maddede belirtilen problemleri veya rahatsızlıkları ne kadar hissettiğinizi öğrenmek istiyoruz. Lütfen, cevaplarınızı her maddenin karşısında verilen seçeneklerden size en uygun olan birine çarpı (X) işareti koyarak belirtiniz.

	Hiç	**Çok az**	**Orta**	**Oldukça**	**Çok fazla**
1. Uyku problemleri (uyuyamama, gece yarısı veya sabaha karşı uyuma)					
2. Kilo değişimi (dört hafta içinde 4-5 kg. veya daha fazla kilo alma veya verme)					
3. Sırt ağrısı					
4. Kabızlık					
5. Baş dönmesi (göz kararması)					
6. İshal					
7. Bayılma					
8. Sürekli yorgunluk					
9. Baş ağrısı					
10. Migren, baş ağrısı					
11. Mide bulantısı ve/veya kusma					
12. Midede kaynama veya hazım zorluğu					
13. Mide ağrısı (örneğin kramplar)					
14. Üşüme hissi					
15. El titremesi					
16. Aniden ateş basması					
17. Kalp çarpıntısı					
18. İştahsızlık					
19. Yorgunluğa bağlı olmaksızın nefes darlığı					
20. Bedenin bir bölümünde uyuşma veya karıncalanma					
21. Halsizlik					
22. Göğüste veya kalpte ağrılar					
23. Enerji azlığı					
24. Burun tıkanıklığı veya başta ağırlık hissi					
25. Bulanık görme					
26. Adale gerginliği veya ağrısı					
27. Adale krampları					
28. Aybaşı krampları (ağrılı kanama, kanamadan kesilme, aşırı kanama)					

29. Ergenlik sivilceleri					
30. Bedende nedensiz çürükler					
	Hiç	**Çok az**	**Orta**	**Oldukça**	**Çok fazla**
31. Burun kanaması					
32. Kaslarda çekilme veya gerginlik					
33. Eklemlerde çekilme veya gerginlik					
34. Soğuk algınlığı veya öksürük					
35. Mantar hastalıkları					
36. İdrar yolları iltihabı					
37. Diş/dişeti sorunları					
38. Kulak ağrısı					

APPENDIX D

ROSENBERG SELF-ESTEEM SCALE
(ROSENBERG BENLİK-SAYGISI ÖLÇEĞİ)

Aşağıdaki ifadelerin her birinin yanında yer alan seçeneklerden size en uygun gelen tek bir seçeneği çarpı (X) işareti koyarak belirtiniz.

	ÇOK DOĞRU	DOĞRU	YANLIŞ	ÇOK YANLIŞ
1. Kendimi en az diğer insanlar kadar değerli buluyorum				
2. Bazı olumlu özelliklerim olduğunu düşünüyorum.				
3. Genelde kendimi başarısız bir kişi olarak görme eğilimindeyim				
4. Ben de diğer insanların bir çoğunun yapabildiği kadar bir şeyler yapabilirm				
5. Kendimde gurur duyacak fazla bir şey bulamıyorum				
6. Kendime karşı olumlu bir tutum içindeyim				
7. Genel olarak kendimden memnunum				
8. Kendime karşı daha fazla saygı duyabilmeyi isterdim				
9. Bazen kesinlikle kendimin bir işe yaramadığını düşünüyorum				
10. Bazen kendimin hiç de yeterli bir insan olmadığını düşünüyorum.				

APPENDIX E

ART SELF-CONCEPT SCALE *
(SANAT BENLİK-KAVRAMI ÖLÇEĞİ)

Aşağıdaki ifadelerin her birinin yanında yer alan seçeneklerden size en uygun gelen tek bir seçeneği çarpı (X) işareti koyarak belirtiniz.

	Kesinlikle katılıyorum	Katılıyorum	Kararsızım	Katılmıyorum	Kesinlikle katılmıyorum
1. Sanata karşı doğal bir yeteneğim var.					
4. Sanat becerilerim diğer insanlarınkinden daha iyidir.					
10. Sanata dayalı işlerde performansım iyidir.					

* Ölçeğin tanıtımı amacıyla bazı örnek maddeler verilmiştir. Ölçeğin tamamına ulaşabilmek için araştırmacıyla iletişim sağlanabilir.

APPENDIX F

EVALUATION FORM

BÜTÜN OLARAK SAĞLIKLI YAŞAM PROGRAMINI VE KENDİMİ DEĞERLENDİRİYORUM

Yaşam stiliniz ve bütün olarak sağlıklı yaşamanız konusunda gelişmenizi hedefleyen bir programı tamamladınız ☺

Şimdi bu yaşantınızı değerlendirme ve önerilerinizi belirtme zamanı!

Lütfen, bütün olarak sağlığınızı geliştirme konusunda yaptığımız çalışmalarla ilgili aşağıda verilen soruları dikkatle okuyup yanıtlayınız.

Bu değerlendirmede isminizi yazmanız istenmemektedir. Yanıtlarınızın olabildiğince içten ve detaylı olması, bundan sonra yapılacak çalışmalara ışık tutması bakımından önemli olacaktır.

KOLAY GELSİN !
Uzm.Psk.Dan. Nagihan Oğuz Duran

1. Bu çalışma süresince, başlangıçta belirlemiş olduğunuz kişisel hedeflerinize ulaşmak için gösterdiğiniz çabayı nasıl değerlendiriyorsunuz? Aşağıdaki ölçek üzerinde işaretleyip, açıklayınız.

1.....2.....3.....4.....5.....6.....7

(HİÇ ÇABALAMADIM) (ÇOK FAZLA ÇABALADIM)

AÇIKLAMA:
.....
.....

2. Sizce bu çalışmanın size ne gibi yararları / katkıları oldu?
3. Bu çalışmanın en çok hangi yönlerini sevdiniz?
4. Bu çalışmanın en az hangi yönlerini sevdiniz?
5. Bundan sonra, benzer çalışmalara katılmakla ilgili düşünceleriniz nelerdir?
6. Başka arkadaşlarınızın benzer çalışmalara katılmalarını önerir misiniz? Neden?
7. Bu çalışmanın daha iyi bir hale getirilebilmesi için önerileriniz nelerdir?

8. Bu grup sürecindeki tüm yaşantılarınızı genel olarak nasıl değerlendiriyorsunuz?
1.....2.....3.....4.....5.....6.....7
(HİÇ İYİ DEĞİLDİ) (ÇOK İYİ BİR DENEYİMDİ)

APPENDIX G

ART-ENRICHED WELLNESS PROGRAM (AWP) *

SANAT ETKİNLİKLERİYLE ZENGİNLEŞTİRİLMİŞ İYİLİK HALİ GRUPLA PSİKOLOJİK DANIŞMA PROGRAMI (SEZİP)

SEZİP, üniversite öğrencilerinin iyilik halini arttırmak amacıyla, pozitif psikoloji, iyilik hali, danışandan hız alan yaklaşım ve sanatla psikolojik danışma literatürüne dayanılarak geliştirilmiş bir grupla psikolojik danışma programıdır. Tüm oturumların süresi 150 dakikadır. Genel olarak ilk 15 dakika üyelerin grup odasına yerleşmeleri, kendilerine ikram edilen sağlıklı yiyecek ve içecekleri yiyip içmeleri için kullanılır. Bunu, yaklaşık 15-20 dk. süren bir ısınma aşaması, 10-15 dk. süren yeni konunun ve etkinliğin tanıtılması aşaması, 40-45 dakikalık bir sanat etkinliği, 40-45 dakikalık bir paylaşım süreci ve 10 dakikalık bir sonlandırma süreci izler. Oturumlarda, her bir oturumun amacına uygun olarak çeşitli boylarda resim kağıtları, çeşitli boya kalemleri, oyun hamurları vb. malzemeler kullanılır. Ayrıca, her oturum, konuya uygun olarak araştırmacı tarafından belirlenen müzik eserleri eşliğinde yürütülür.

ÖN GÖRÜŞMELER

Bireysel veya grupla yapılabilir. Bu görüşmelerde üyelere grubun amacı, süresi, kuralları ve süreci açıklanır.

* Programın tanıtımı amacıyla oturumların ana hatları verilmiştir. Programın tamamına ulaşabilmek için araştırmacıyla iletişim sağlanabilir.

OTURUM 1: TANIŞMA-ORYANTASYON

Bu oturumda üyelerin birbiriyle tanışmaları, gruba ısınmaları; grubun amacını, kurallarını ve işleyişini anlamaları ; hedefleri netleştirmelari ve hedeflerine ulaşmada "sanat etkinliklerinin" rolünü kavramaları amaçlanır. grup odasındaki tüm malzemeler (çeşitli renk ve boyutlarda kağıtlar, kurşun kalemler, pastel ve kuruboyalar, kesme ve yapıştırma malzemeleri, oyun hamurları) ve "*Benim Hakkımda Bir Kitap*" (BHBK) dosyası kullanılır. Sürecin aşamaları aşağıdaki gibidir:

1. Grup liderinin kendini tanıtması ve grubun amacı, odada yer alan malzemeler, bunlarla yapılacak etkinlikler, ve grup kuralları hakkında açıklamalar yapması; üyelerin sorularını yanıtlaması (20 dk).
3. Isınma egzersizleri: *"İsim oyunları"* (15 dk).
4. Etkinlik: *"Ben kimim?"* çalışması. (40-45 dk)
5. Paylaşım (40-45dk)
6. Oturumun özetlenmesi; BHBK dosyalarının ve bu dosyalara gelecek hafta için eklenen ilk ödevin ("Ben kimim?) gruba verilmesi (10 dk).
6. *"Program sözleşmesi"*nin imzalanması (5 dk).

OTURUM 2: FİZİKSEL İYİLİK HALİ

Bu oturumda üyelerin fiziksel görünüm, beslenme, egzersiz ve öz-bakım alışkanlıklarıyla ilgili öz-değerlendirme yapmaları; bu alışkanlıkların birbirleriyle bağlantısını sorgulamaları; fiziksel iyilik-hallerini geliştirmek için neler yapılabileceklerini düşünmeleri ve bedenlerinin güçlü ve zayıf yönlerini kabul ve takdir etmelerini sağlamak amaçlanır. Büyük boy kağıtlar, resim kalemleri, kuruboya ve pastel boyalar, kolaj malzemeleri (besin, spor malzemeleri, hekim vb. resimleri), makas, yapıştırıcı, büyük boy bir ayna ve BHBK dosyası kullanılır. Sürecin aşamaları aşağıdaki gibidir:

1. Üyelerin bir hafta önce verilen ev ödevlerini tartışmaları (15-20 dk).
2. Liderin "fiziksel iyilik hali" konusuna giriş amacıyla bazı önemli noktaları gruba hatırlatması: (10-15 dk)

3. Isınma çalışması: *"Aynada bedenini izleme"* (10 dk)

4. Etkinlik: *"Beden Çizimi" (Beden konturu)* (40-45 dk).

5.Paylaşım (40-45 dk)

6. Oturumun özetlenmesi; gelecek hafta içinde "Bu soruları kendinize sordunuz mu?" ve "Bedenim" başlıklı ev ödevlerinin verilmesi (5 dk).

OTURUM 3: DUYGUSAL İYİLİK HALİ

Bu oturumda üyelerin duyum-duygu-düşünce-davranış ilişkisini farketmeleri; duyguların bedenle ilişkisini daha yakından görmek ve beden aracılığıyla duyguları daha iyi tanımaları; olumlu duygulardan keyif alabilmeleri ve olumsuz olanlarla baş edebilmeleri; "sen dili" ve "ben dili" kavramlarını tanımaları ve kullanmaya başlamaları ve "empatik anlayış"ın önemini kavramaları amaçlanır. Kağıt, kalem, ve BHBK dosyası kullanılır. Sürecin aşamaları aşağıdaki gibidir:

1. Üyelerin bir hafta önce verilen ev ödevlerini tartışmaları (15-20 dk).

2. Liderin, "duygusal iyilik hali" konusuna giriş amacıyla bazı önemli noktaları gruba hatırlatması: (10-15 dk)

3. Isınma çalışması: *"Nefes alıştırması"*(15-20 dk)

4. Etkinlik: *"Duygu Dansı"* (25dk).

5. Paylaşım (45-50 dk).

6. Oturumun özetlenmesi; Gelecek oturuma kadar okunacak hatırlatıcı notlar ve gelecek hafta içinde yaşadıkları bir duygularına daha yakından bakma konulu ev ödevlerinin dağıtılması (10 dk).

OTURUM 4: BİLİŞSEL İYİLİK HALİ

Bu oturumda üyelerin olumlu ve olumsuz düşüncelerini fark etmeleri; olumsuz düşüncelerini en aza indirmeleri ve müzik, gevşeme ve yönlendirilmiş imgeleme yoluyla bu düşüncelerini ifade etmelerini sağlamak amaçlanır. Oyun hamuru; çöp çubuklar, renkli kağıtlar ve BHBK dosyası kullanılır. Sürecin aşamaları aşağıdaki gibidir:

1. Üyelerin bir hafta önce verilen ev ödevlerini tartışmaları (15-20 dk).

2. Liderin *"*bilişsel iyilik hali" konusuna giriş amacıyla bazı önemli noktaları gruba hatırlatması: (10-15 dk)

3. Isınma egzersizi: *"Küçük bir yönlendirilmiş imgeleme çalışması"* (10 dk).
4. Etkinlik 1: *"Yönlendirilmiş imgeleme"* (20 dk).
5. Etkinlik 2: *"Hamurdan Heykeller"* (40-45 dk)
6. Paylaşım (40-45 dk).
7. Oturumun özetlenmesi; gelecek hafta için üyelerin yıkıcı düşüncelerini olumlu alternative düşüncelerle değiştirmelerine yönelik ev ödevinin verilmesi (10 dk).

OTURUM 5: SOSYAL İYİLİK HALİ

Bu oturumda üyelerin sosyal davranışların ve ilişki kurma biçimlerinin farkına varmaları; kendi ihtiyaçlarına ilişkin duygu ve düşüncelerini ifade etmeleri ve olumlu sosyal ilişkiler kurmanın iyilik halini artırıcı rolünü kavramaları hedeflenir. Büyük boy kartonlar, renkli kalemler ve BHBK dosyası kullanılır. Sürecin aşamaları aşağıdaki gibidir:
1. Üyelerin bir hafta önce verilen ev ödevlerini tartışmaları (15-20 dk).
2. Liderin , *"*sosyal iyilik hali" konusuna giriş amacıyla bazı önemli noktaları gruba hatırlatması: (10-15 dk)

3. Etkinlik: *"ADA"* (40-45 dk).
4. Paylaşım (40-45 dk).
5. Oturumun özetlenmesi; gelecek hafta için üyelerin bir ilişkilerine yakından bakarak bu ilişkide yaşadıkları mutlu veya mutsuz bir olay üzerinde duygu, düşünce ve davranışlarını incelemelerine yönelik ev ödevinin verilmesi (10 dk).

OTURUM 6: YAŞAM HEDEFLERİ

Bu oturumda üyelerin gelecekten beklentilerini belirlemeleri; yaşamın çeşitli boyutları ile ilgili kişisel hedefler oluşturmaları, bu hedefler doğrultusunda zamanlarını kullanmak ve hedefe ulaşmak için çaba sarfetmenin önemini kavramaları amaçlanır. Kağıt, kalem ve BHBK dosyası kullanılır. Sürecin aşamaları aşağıdaki

gibidir:

1. Üyelerin bir hafta önce verilen ev ödevlerini tartışmaları (15-20 dk).

2. Liderin *"*yaşam hedefleri" konusuna giriş amacıyla bazı önemli noktaları gruba gruba hatırlatması: (10-15 dk)

3. Etkinlik: *"Geleceğe yolculuk" – hayalleme ve yazma çalışması* (40-45 dk):

4. Paylaşım (40-45 dk).

5. Oturumun özetlenmesi; gelecek hafta için üyelerin bir aylık, bir yıllık ve beş yıllık yaşam hedeflerini ve bu hedeflere ulaşmak için neler yapabilecekleri düşünmelerine yönelik ev ödevlerinin verilmesi (10 dk).

OTURUM 7: BÜTÜNLÜK

Bu oturumda üyelerin fiziksel, zihinsel, duygusal ve sosyal boyutlarıyla bir bütün olmanın ve bu boyutların birbirleri üzerindeki etkisinin farkında olmaları; bu boyutlarda, aksayan, değişmesi ve gelişmesi gereken özelliklerin önceki oturumları da dikkate alarak yeniden fark etmelari; bütünlüğü sağlama konusunda etki gücüne sahip oluklarını fark etmeleri; bütünlük ile ilgili bir takdir duygusu, umut ve iyimserlik geliştirmeleri ve grubu sonlandırmaya hazırlamaları amaçlanır. Mandala çizimi için çeşitli boylarda daireler çizilebilecek plastik tabak veya kapaklar, pergel, kağıt, boya kalemleri ve BHBK dosyası kullanılır. Sürecin aşamaları aşağıdaki gibidir:

1. Üyelerin bir hafta önce verilen ev ödevlerini tartışmaları (15-20 dk).

2. Lider, *"bütünlü*i" konusuna giriş amacıyla bazı önemli noktaları gruba hatırlatması: (10-15 dk)

3. Etkinlik: *"Mandala"* (40-45 dk)

4. Paylaşım (40-45 dk)

5. Oturumun özetlenmesi (Gelecek hafta son oturum yapılacağından üyelerden, geride kalan yedi oturumluk grup süreci üzerinde düşünerek gruba gelmeleri istenir)(10 dk).

OTURUM 8: SONLANDIRMA

Bu oturumda grup sürecini değerlendirmek; bireysel amaçları ve gelişimi değerlendirmek; her üyenin için iyi oluşunu geliştirecek ve zenginleştirecek yeni amaçlar belirlemek; grubun sonlanması ile ilgili duyguları paylaşmak ve olumlu duyguları paylaşmak amaçlanır. Grup sürecinde üretilen tüm eserler, kağıt, kalem, katılım ve teşekkür belgeleri kullanılır. Sürecin aşamaları aşağıdaki gibidir:

1. Üyelerin bir hafta önce verilen ev ödevlerini tartışmaları (15-20 dk).
2. Liderin sonlandırma oturumuna uygun bir başlangıç konuşması yapması (10 dk).
3. Etkinlik 1: *"Tüm eserlerin gözden geçirilmesi"* (60 dk)
4. Etkinlik 2: *"Sevgi bombardımanı"* (40-50 dk).
5. Etkinlik 3: *"Grup fotoğrafı"* (hayali fotoğraf) (10dk.).
6. Üyelere, katılım ve teşekkür belgelerinin dağıtılması.
7. Son testlerin yanıtlanması.
8. Vedalaşılarak oturum sonlandırılması.

APPENDIX H
AN EXAMPLE FOR AWP INVITATION LETTERS

Değerli öğrenci,

Birkaç hafta önce, "yaşam biçiminiz ve sağlığınız" ile ilgili bir anket çalışmasına katıldınız ve doldurduğunuz anketin sonuçlarından ve bu konuda düzenlenecek etkinliklerden haberdar olmak istediğinizi belirtecek şekilde size ulaşabileceğim bir e-posta adresi verdiniz.

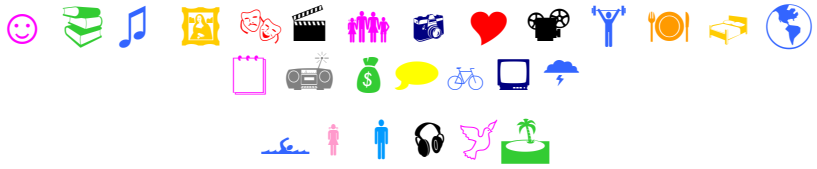
Anketleriniz değerlendirildi ve ihtiyaçlarınız doğrultusunda bir "kişisel gelişim grubu" programı hazırlandı.

Bu programa ktılıp katılmayacağınızı 30 Aralik Salı günü akşamına kadar aşağıda verilen e-posta veya telefonu kullanarak ya da belirtilen ofisi ziyaret ederek bildirmeniz gerekmektedir.

- ★31 Mart Çarşamba günü
- ★Saat: 15:45'te
- ★Eğitim Fakültesi, 1.kattaki grup odasında

bir toplantı yapılacak ve katılmak isteyenlere anket sonuçları ve programın içeriği hakkında daha ayrıntılı bilgi verilecektir.

"Düzenlenecek programın içeriği ne olacak?" diyenlere biraz ipucu:



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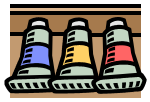
nagihan@fedu.metu.edu.tr
☎(ofis) : 210 40 42
Ofis no: 311

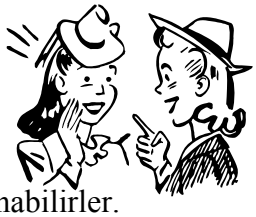
APPENDIX I
AWP GROUP RULES POSTER

GRUBUMUZUN KURALLARI

Çalışmalara zamanında gelinir.

1. Burada konuşulan ve yaşanan herşey gizli kalır.





2. Üyeler, bu odadaki tüm malzemeleri, ücretsiz olarak özgürce kullanabilirler. Ayrıca oturumlarda kullanmak üzere dışarıdan ek malzeme getirebilirler.

3. Burada ortaya çıkarılan tüm sanat ürünleri yapan kişiye aittir.

4. Kendine, diğer katılımcılara, yapılan eserlere ve odadaki eşya ve malzemelere saygı esastır. Üyeler, kendilerine, başkalarına ve materyallere kasıtlı olarak zarar vermezler; odanın temizlik ve düzeninden sorumludurlar. Aksi konusunda davet edilmedikçe, diğer katılımcıların eserleriyle oynamaz ve bunlara müdahalelerde bulunmazlar.

5. Üyeler, kendilerinin ve arkadaşlarının gelişimi için sorumluluk üstlenirler. Birbirlerini saygıyla dinlerler; birbirlerine yapıcı geribildirimler verir ve kendi duygularını da ifade ederler. Grup dışındaki zamanlarda, gruptan öğrendikleri üzerinde düşünmeye ve kendilerini geliştirmeye devam ederler.

6. Bu gruba ilk oturumdan sonra başka üye eklenmeyecektir. Ancak çeşitli nedenlerle ayrılmalar olup da üye sayısı 5'in altına düşerse, grup üyelerinin de onayı ile grup yaşantısının sürdürülebilmesi için gruba yeni üyeler alınabilir.

8. Üyelerin gruba geliş amaçları ile grubun amaçları arasındaki bağlantı başlangıçta çok açık olmayabilir. Buna bağlı olarak grubu bırakmayı düşünen üyeler olabilir. Böyle bir durum ortaya çıktığında, şimdiki durumda gruba katılmayı kabul eden bir üye olduğunuz için en az 4 grup oturumuna katılmış olmanız beklenir. Bu süre sonunda hala ayrılmayı istediğiniz takdirde sizden beklenen en az 2 oturum önce bu kararınızı gruba bildirmenizdir.

APPENDIX J

A BOOK ABOUT ME *

(BENİM HAKKIMDA BİR KİTAP)

* Benim Hakkımda Bir Kitap dosyasının tanıtımı amacıyla bazı örnek sayfalar verilmiştir. Dosyanın tamamına ulaşabilmek için araştırmacıyla iletişim kurulabilir.

Benim Hakkımda Bir Kitap

"Sağlıklı Yaşam Notlarım"

"... ve herkesin kendi yol hikayesi en önemlisidir."

Buket Uzuner

Ben .....

Bu çalışmaya,

**Güçlü ve zayıf yanlarımı keşfetmek*
ve
**gelişmeye devam etmek için gönüllü olarak katılıyorum.*

Bu çalışmadan en iyi şekilde yararlanabilmem için:

Yapılacak oturumlara eksiksiz katılacağıma,

Hem oturumlarda hem de oturum dışında, bu süreç boyunca, kendime ve arkadaşlarıma gereken saygıyı ve özeni göstereceğime,

Oturumlarda yaşadıklarımı, duygu ve düşüncelerimi açık bir şekilde ifade edeceğime ve diğer grup arkadaşlarıma onların gelişimine katkıda bulunacak geribildirimler vereceğime;

Kendimle ilgili öğrendiklerimden, grup arkadaşlarımın işine yarayacağını düşündüklerimi onlarla paylaşacağıma,

Bu dosyayı, kendimi ve yaşam stilimi keşfetme ve geliştirme serüvenimde yol arkadaşım olarak kullanacağıma ve her grup yaşantısından çıktıktan sonra, bir sonraki toplantıya kadar geçecek zamanda mutlaka uygun bir zaman bulup etkinliklere bakacağıma,

ve bu "kendime yolculuk" serüvenini kendim için bir fırsat kabul ederek ve olabildiğince zenginleştirerek yaşamaya çalışacağıma söz veriyorum.

İmza/Tarih _____ İmza/Tarih _____

BEN KİMİM?

- "Ben kimim?"
- Bu soruya pek çok küçük yanıtınız olabileceği gibi, bu küçük yanıtlarınızın birleşmesinden ortaya çıkacak büyük bir resiminiz de olacaktır.
- Verdiğiniz yanıtlara yenilerini ekleme, varolanlar yanıtlarınızı geliştirme ya da onlardan bir şeyler çıkarma hakkınız her zaman saklıdır.

Önümüzdeki hafta içinde...

"Ben kimim?" çalışmanız üzerinde düşünerek, istediğiniz ekleme, çıkarma ve değişiklikleri yapma hakkınızı kullanın.

Resminizde yaptığınız değişikliklerle ilgili aşağıdaki forma kısa notlar alın.

Kendi kendinize şu soruyu sorun:

- Bu alıştırmadan kendimle ilgili yeni neler öğrendim?

- **Eklediklerim:**
  .....
  .....
  .....
- **Çıkarttıklarım:**
  .....
  .....
  .....
- **Değiştirdiklerim:**
- .....
  .....
  .....

BU SORULARI KENDİNİZE SORDUNUZ MU?

Her bir soruyu kendinize sorup, olumlu cevap verdiklerinize bir ☺, üzerinde durmanız gerektiğini düşündüklerinize de ? işareti koyunuz.

☐YETERİNCE HAREKET EDİYOR MUYUM?

☐ **Özellikle kısa mesafelerde, kendime yürüme veya hareket fırsatları yaratıyor muyum?**

☐ Daha sağlıklı beslenmek için neler yapabilirim?

☐ **Yeterince banyo yapıyor muyum?**

☐ DOĞRU ŞAMPUANI KULLANIYOR MUYUM?

☐ **Güzel/temiz kokuyor muyum?**

☐ GİYİMİM NE KADAR TEMİZ VE ÖZENLİ?

☐ Dişlerim temiz ve sağlıklı mı? Dişlerime özen gösteriyor, diş bakımımı doğru yapıyor muyum?

☐ **ODTÜ'deki sağlık ve spor hizmetlerinden nasıl yararlanabilirim?**

☐ Sağlığımı riske atacak davranışlarım var mı? ("Bana bir şey olmaaaaaaaz!!"deyip, dikkatsiz ve özensiz davrandığım oluyor mu?)

☐ **Serbest zamanlarımda bedenimle ilgileniyor muyum?**

☐ UYKUMA DİKKAT EDİYOR MUYUM?

☐ **İçki, sigara, uyuşturucu maddeler, ilaçlar hayatıma giriyor mu?**

☐ Fiziksel, sosyal ve duygusal çevre kirliliğinden bedenimi nasıl koruyabilirim?

DÜŞÜNCELERİM

"Hayatımızı sık sık zincirlenmiş yaşarız, anahtarın bizde olduğunu bilmeden"

- Düşüncelerimiz de duygularımız gibi bizim önemli bir parçamızdır. Dünyayı anlamak, kararlar vermek, planlar yapmak için düşüncelerimizi kullanırız.
- Ayrıca düşüncelerimizi, acı verici duygularımızdan kaçmak, kendimizi korumak, yargılamak, haklı çıkartmak ya da korkutmak için de kullanırız.
- Çoğunlukla düşüncelerimiz, alışkanlıklarımızın bir sonucu olarak, otomatik bir biçimde ortaya çıkar.
- Birçok alternatif düşünce ortaya çıkarabilecekken, kendimizi bu otomatik olarak ortaya çıkan olumsuz düşüncelerimize teslim edip, üzülmeyi, öfkelenmeyi, acı çekmeyi, olumsuz düşüncelerimizin altında ezilmeyi seçebiliriz. Fakat aynı zamanda olanlarla **başetmemizde yardımcı olacak ve bizi güçlü kılacak başka, gerçekçi ve olumlu düşünceler geliştirmeyi de seçebiliriz.**
- Gevşemek ve yıkıcı düşüncelerinizden kurtulmak için, birlikte yaptığımız gibi **gevşeme ve nefes alma egzersizlerini** deneyebilir; olumsuz/yıkıcı düşüncelerinizi **daha işlevsel ve güçlü kılan yeni düşüncelerle değiştirebilirsiniz.**
- Yıkıcı düşüncelerinizi, sizi güçlü kılacak yeni yapıcı cümlelerle değiştirdiğinizde ya da sizin için zor olan herhangi bir şeyi yapmayı başardığınızda **"başardım!"** demeyi ve bununla **gurur duymayı** ihmal etmezseniz, böyle güzel deneyimleri yaşama olasılığınız artacaktır.

Önümüzdeki hafta içinde...

Yıkıcı düşünceler aklınıza geldiğinde onları savuşturmak ya da onların altında ezilmek yerine alternatif, sizi güçlü kılacak cümleler üretmeye çalışın. Aşağıdaki örneğe bakarak, bir yaşantınızı yazmaya çalışın.




İLİŞKİLERİM

Önümüzdeki hafta içinde...

Bir ilişkinize yakından bakın ve bu ilişkide yaşadığınız **mutlu veya mutsuz bir olayı** aşağıya kısaca yazın.

.....

.....

.....

.....

.....

.....

1) Yaşadığınız bu olay sırasında:

a) Neler düşündünüz?

.....

.....

b) Neler hissettiniz?

.....

.....

c) Nasıl davrandınız?

.....

.....

2) Bu ilişkinin daha iyiye gitmesi için yukarıdakilerden farklı olarak

a) Neler düşünebilir?

.....

.....

b) Neler hissedebilir?

.....

.....

c) Nasıl davranabilirsiniz?

.....

.....

APPENDIX K

CERTIFICATE

İYİLİK HALİ PROGRAMI
TEŞEKKÜR BELGESİ

Sayın .....

8 Hafta süren **"Bütün Olarak Sağlıklı Yaşam"** programına katılarak, bu belgeyi almaya hak kazandınız. Artık sağlıklı bir yaşam stilinin, duygu, düşünce ve bedenin bütün olarak sağlıklı olmasını sağlayan alışkanlıklardan oluştuğunu biliyorsunuz ve bütün olarak sağlıklı bir yaşam geliştirmeye adaysınız. Bu bilinçli çabanız için sizi tebrik eder, sağlıklı, mutlu, başarılı ve uzun bir yaşam sürmenizi dilerim.

Yaşasın hayat!

Uzm.Psk.Dan.
Nagihan OĞUZ DURAN

APPENDIX L

EXAMPLES FROM THE ARTWORK OF THE AWP GROUP MEMBERS*

Figure 1. Self Portrait

Figure 2. Self Portrait

* Bu eserler grup üyelerinden izin alınarak kullanılmıştır.

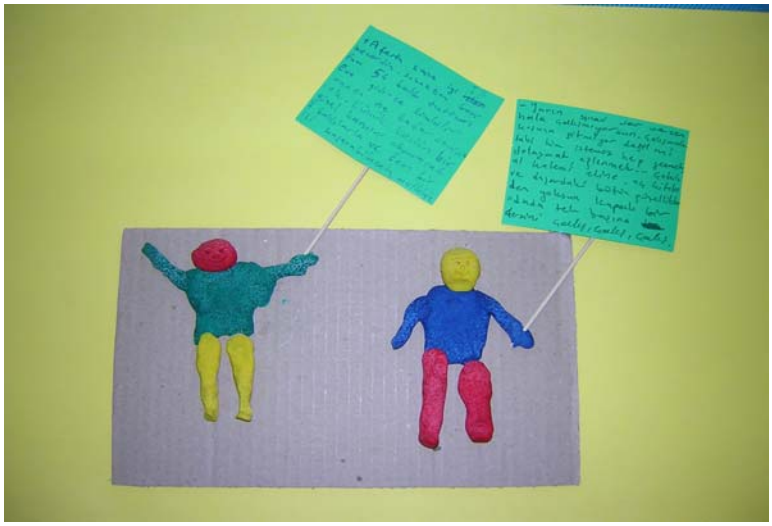


Figure 3. Positive and negative thoughts with play-doh

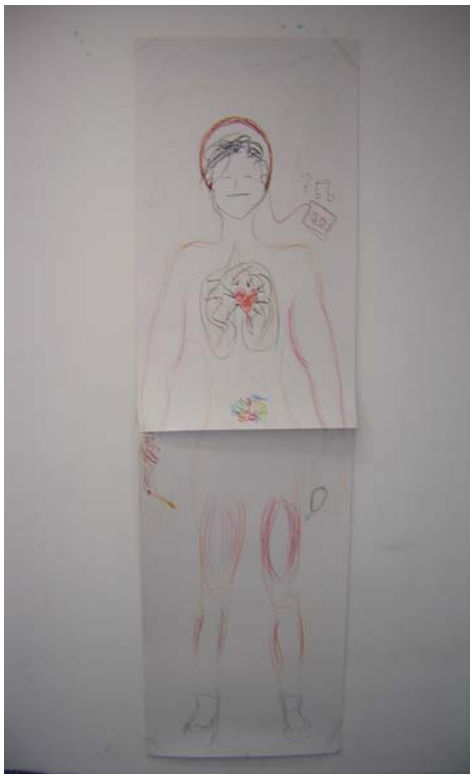
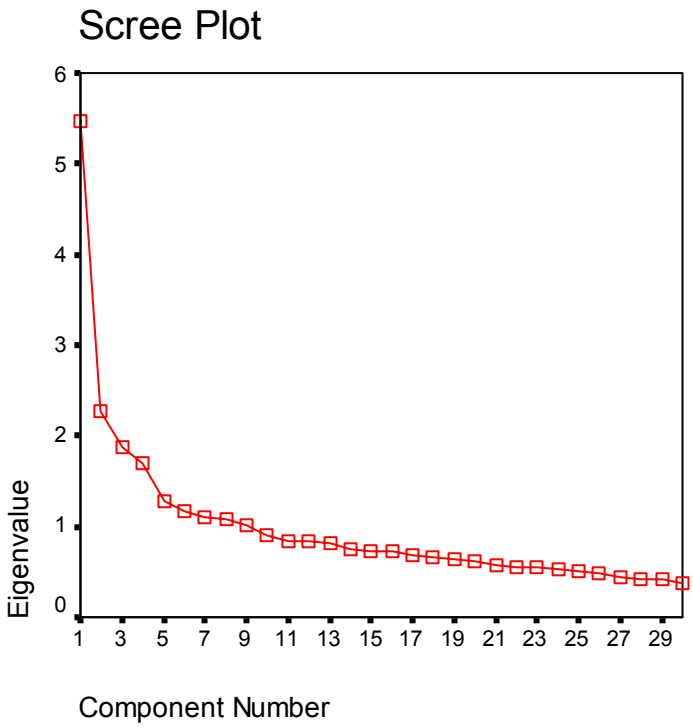


Figure 4. Example for “body contour”

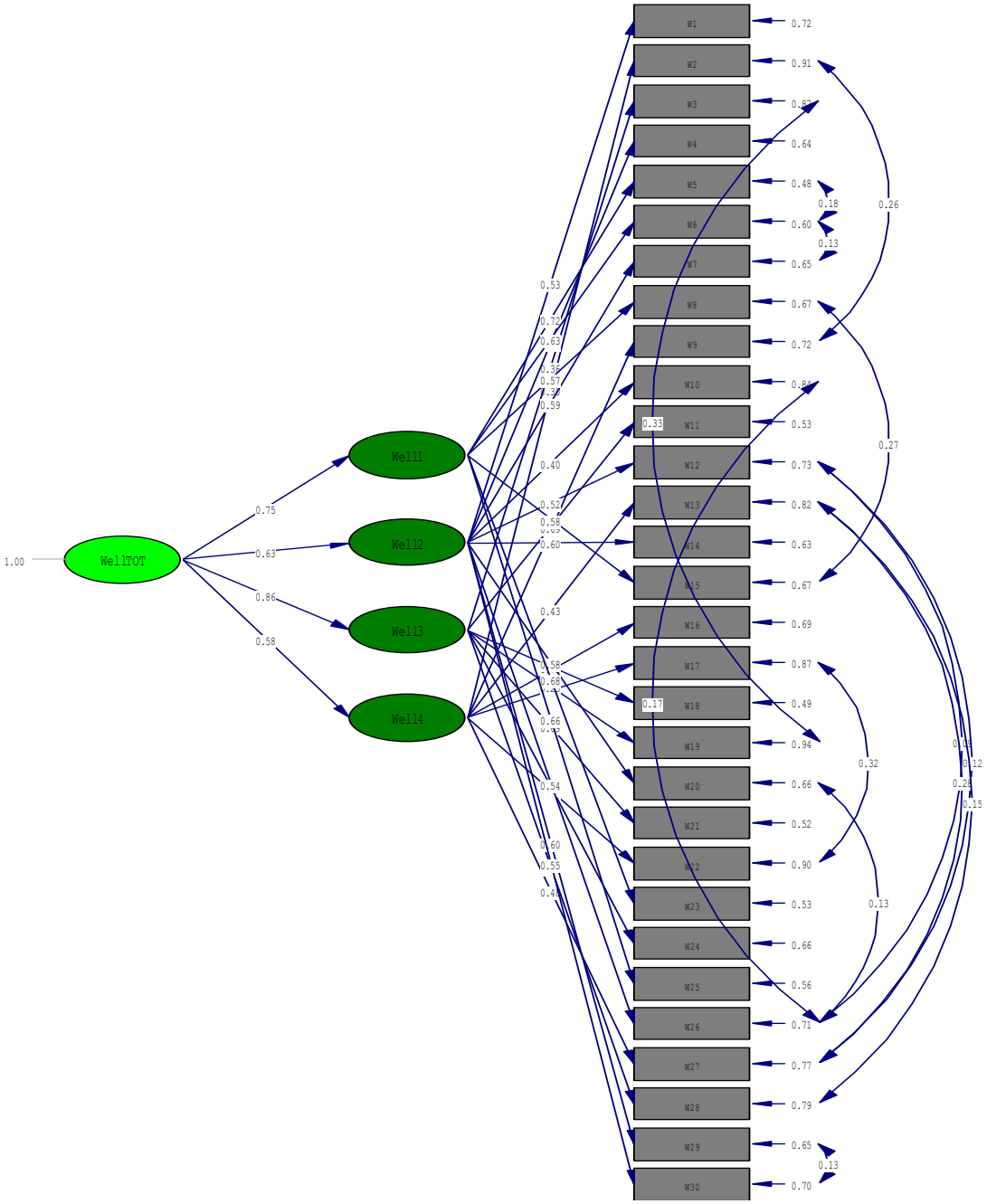
APPENDIX M
SCREE PLOT of WI



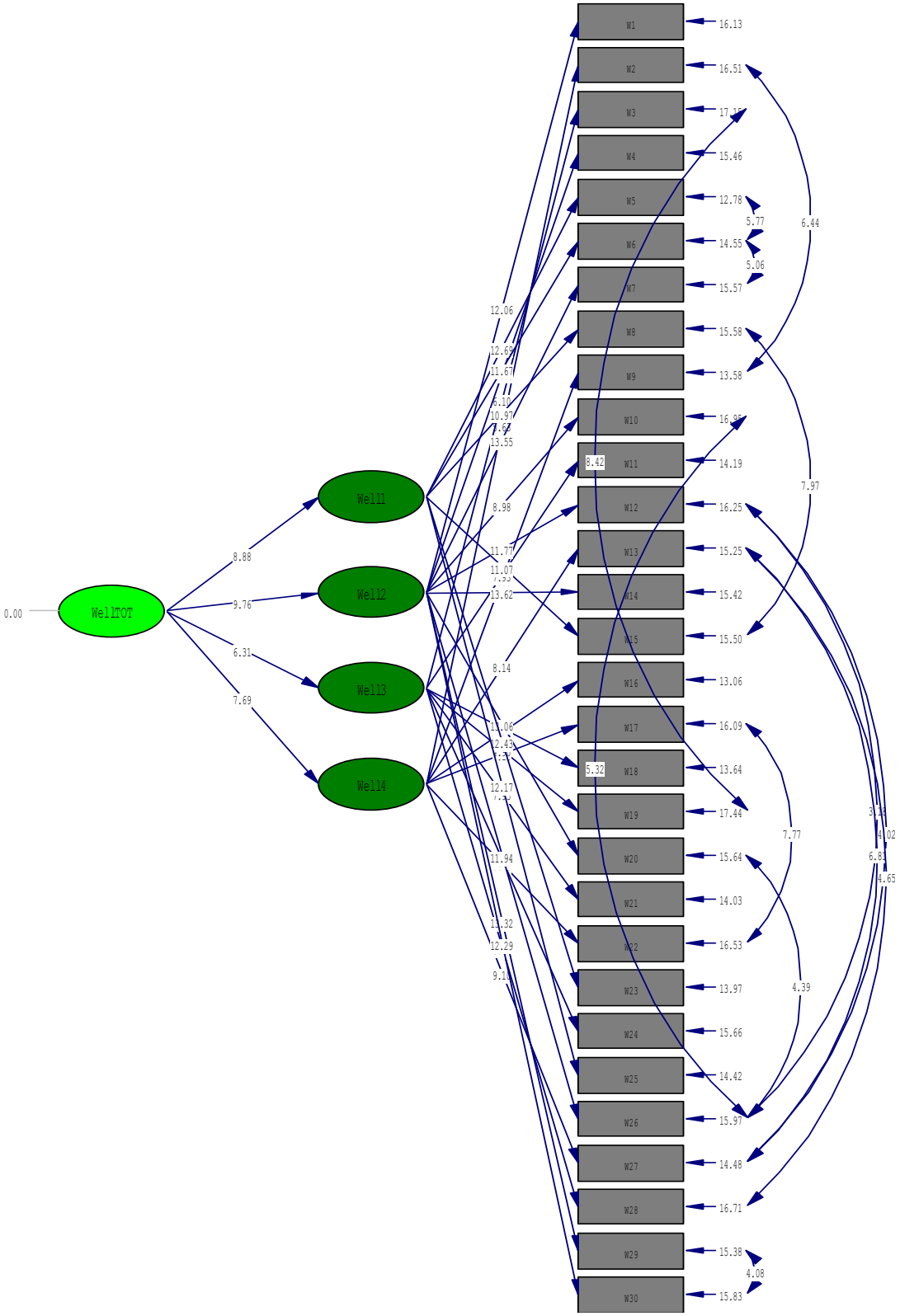
APPENDIX N

LISREL ESTIMATES OF PARAMETERS IN MEASUREMENT MODEL WITH COEFFICIENTS IN STANDARDIZED AND T-VALUES

N.1. LISREL Estimates of Parameters in Measurement Model of Wellness with Coefficients in Standardized Values



N.2. LISREL Estimates of Parameters in Measurement Model of Wellness with Coefficients in t-Values



APPENDIX O

TÜRKÇE ÖZET

ÜNİVERSİTE ÖĞRENCİLERİNİN İYİLİK HALİ: KAVRAMIN İNCELENMESİ VE SANAT ETKİNLİKLERİYLE ZENGİNLEŞTİRİLMİŞ İYİLİK-HALİ PROGRAMININ ETKİNLİĞİNİN TEST EDİLMESİ

1. GİRİŞ

İnsanoğlu binlerce yıldır kendisini tanıma ve nasıl daha iyi bir yaşam sürebilececeği üzerinde kafa yormaktadır. İnsanlık tarihi boyunca pek çok filozof ve bilimadamı insanın nasıl daha iyi olabileceği ve yaşamının nasıl daha yaşamaya değer hale getirebileceği üzerine sorular sormuş ve yanıtlar bulmuştur. 1990'lardan itibaren günümüzün en popüler kavramlarından biri haline gelen *iyilik hali* kavramı da modern dünya insanının kendi yaşam biçimini gözden geçirerek daha iyi ve sağlıklı nasıl yaşayabileceği konusunda bir yanıt bulma çabasının ürünüdür. İyilik hali kavramı, insanın bedensel, ruhsal ve sosyal olarak bir bütün olduğunu ve bu bütün içinde iyiliğini korumak, sürdürmek ve geliştirmek için kendi sorumluluğunu taşıdığı bir yaşam stilini vurgulamaktadır. Literatürde en iyi bilinen tanımlardan birine göre iyilik hali *"bireyin sosyal ve doğal çevresi içinde tam ve işlevsel olarak yaşaması için beden, zihin ve ruhun birleştiği optimal sağlık yönelimli bir yaşam biçimi ve iyi olma durumudur"* (Myers, Sweeney ve Witmer, 2000).

1961'de Halbert Dunn'un (1977) ilk olarak "üst-düzey iyilik hali" tanımıyla başlayan ve özellikle 80'li yıllarda pek çok kuramcı ve uygulamacının çalışmalarıyla hız kazanan iyilik hali hareketi içinde çok sayıda iyilik hali modeli ortaya çıkmış ve bu modellere dayanarak geliştirilen iyilik hali tanımları, iyilik hali ölçekleri ve iyilik halini geliştirme programları literatürde yer almaya başlamıştır. Bu anlamda, literatürde iyilik haliyle ilgili olarak yapılan çalışmaların genel olarak iki grupta yer aldığı görülmektedir. Bir grup çalışmada kavramın yapısı ve çeşitli değişkenlerle

ilişkileri incelenirken, başka bir grup çalışmada da iyilik halini geliştirmek üzere programlar geliştirilmiş ve bunların etkinliği test edilmiştir.

İyilik halinin kavramsal olarak incelendiği çalışmalar, çok boyutlu bir yapının vurgulandığı iyilik hali modellerine ışık tutmaları bakımından önem taşımaktadırlar. Literatürde en çok bilinen ve kabul gören iyilik hali modelleri arasında Ardel'in (1977, 1982 ve 2001; Akt., Ardell, 2003) *Çok Boyutlu İyilik Hali Modeli*, Hettler'in (1980) *Altıgen Modeli* ve Travis ve Ryan'ın (1988) *İyilik Hali Enerji Sistemi Modeli* yer almaktadır. Psikolojik Danışma alanında ortaya çıkan ilk iyilik hali modeli ise Witmer ve Sweeney'in (1992) *İyilik Hali Çember Modelidir*. Bu modellerin hepsinde iyilik hali fiziksel, duyuşsal, bilişsel, sosyal ve tinsel vb. boyutlardan oluşan çok boyutlu bir yapı olarak tanımlanmaktadır. İyilik hali modelleri, insanın bu çok boyutluluk içinde bir bütün olarak işlevsellik gösterdiğini ve boyutlardan birinin işlevselliğinde ortaya çıkacak bir değişimin diğerlerini de etkileyeceğini ifade etmektedir.

Literatürde ortaya çıkan farklı iyilik hali modelleri, iyilik halinin çeşitli boyutlarının saptanıp ölçülebildiği çeşitli ölçme araçlarının geliştirilmesini sağlamıştır (Palombi, 1992). En yaygın olarak kullanılan iyilik hali ölçekleri Hettler'in (1980) iyilik hali modeline dayanarak geliştirilen *Testwell* (National Wellness Institute, 1988) ve *Lifestyle Assessment Questionnaire* (LAQ; National Wellness Institute, 1983); Travis ve Ryan tarafından geliştirilen (1988) *Wellness Index* (Travis ve Ryan, 1988) ve Myers, Witmer ve Sweeney'in (1996) geliştirdikleri *The Wellness Evaluation of Lifestyle*'dir. Bu ölçme araçları üzerinde yapılan çeşitli araştırmaların bulguları, original modellerde ifade edilen yapılarda değişiklik yapılmasını gerektirecek şekilde yeni faktör yapıları ortaya koymaktadır (Palombi, 1992; Hattie, Myers ve Sweeney, 2004; Myers, Luecht ve Sweeney, 2004). Bu bakımdan, iyilik halinin boyutlarının ölçülmesi, literatürde iyilik hali kavramıyla ilgili olarak tartışılan önemli ve güncel konulardan biri olarak görülmektedir.

1.1. İyilik Halinin İlişkili Olduğu Çeşitli Değişkenler

İyilik hali kavramın araştırıldığı çalışmalardan bir kısmı da bu kavramın çeşitli değişkenlerle ilişkilerini saptamaya yöneliktir. Örneğin bazı araştırmacılar iyilik halinin çeşitli fiziksel özellikler ve fiziksel sağlıkla ilişkisini incelemiş ve iyilik halinin stress ve baş ağrısıyla (Degges-White, Myers, Adelman ve Pastor, 2003, 2003), fiziksel aktivitelere katılımla (Bray ve Born, 2004), sağlığı riske atan davranışlarda bulunmayla (Grace, 1997; Sussman ve ark., 1995) ilişkili olduğunu ortaya koymuştur. Genel olarak bu gruptaki araştırmalar, pasif bir yaşam biçimi sürdürme ve alkol, sigara, ilaç kullanma, riskli cinsel davranışlarda bulunma ve kötü beslenme alışkanlıklarına sahip olma gibi sağlığı riske atan davranışların iyilik halini olumsuz yönde etkilediğini vurgulamaktadır. Bu bulgulara parallel olarak, bazı araştırmacılar da fiziksel semptomlara sahip olmanın kişinin sağlıklı bir işlevsellik göstermesini olumsuz yönde etkilediğine dikkat çekmiştir. Örneğin, Tanaka ve arkadaşlarına (2005) göre, güçlü fiziksel semptomlar duygusal bazı sorunların habercileridir. Larsen ve Kesimatis'e (1991) göre fiziksel semptomların ortaya çıkması nerotizmle, bu semptomların süresi de saldırgan tepki gösterme özelliğiyle ilişkilidir. Benzer şekilde, daha az fiziksel semptoma sahip olan kişilerin daha iyimser (Aydın ve Tezer, 1991; Jones, O'Connel, Gound, Heller ve Forehand, 2004), daha az depresif (Herman ve Lester, 1994; Ring, Kadzielski, Fabian, Zurakowski, Malhotra ve Jupiter, 2006; Simon, VonKorff, Piccinelli, Fullerton ve Omel, 1999), daha fazla mizah duygusuna ve başarı beklentisine sahip ve içsel denetimli (Aydın, 1993) kişiler olduklarını gösteren çeşitli araştırma bulguları bulunmaktadır. Ayrıca, ergenlerde görülen fiziksel semptomların aile ve arkadaş ilişkileri içinde olumsuz psikolojik işlevsellikle (Rauste-von Wright ve Von Wright, 1992; Taylor, Szatmari, Boyle ve Offord, 1996), okul performansıyla (Garber, Walker ve Zeman, 1991), ve okula devam etmemeyle (Aro, Paronen ve Aro, 1987, Rauste-VonWright ve Von Wright, 1992) ilişkili olduğunu gösteren araştırma bulguları da bulunmaktadır

Bu bulgulara dayanarak, fiziksel semptomların yalnızca fiziksel iyilik haliyle değil, aynı zamanda psikososyal işlevselliğin çeşitli alanlarıyla da ilişkili olduğu söylenebilir. Bu araştırmada, öğrenciler tarafından rapor edilen fiziksel

semptomların iyilik halinin yordayıcılarından biri olduğu öngörülmüştür. Fiziksel semptomları fazla olan öğrencilerin iyilik hallerinde bir azalma olacağı varsayılmıştır.

Literatürde ayrıca iyilik halinin çeşitli psikolojik özelliklerle olan ilişkileri de araştırılmıştır. Bu araştırmalardan bazılarının bulguları iyilik halinin olumlu düşünceler ve iyimserlikle olumlu yönde (Adams ve ark., 2000); utangaçlıkla (Page, 1990) ise olumsuz yönde olduğunu göstermektedir. Ayrıca, iyilik hali kişinin yaşamda genel olarak ne tarzda hareket ettiğine ilişkin kişisel öncelikleriyle de ilişkili bulunmuştur. Buna gore başarıya yönelik olmak kişinin iyilik halini olumlu yönde etkilerken, bağlanamama ya da kaçınma ile iyilik hali arasında olumsuz bir ilişki bulunmaktadır (Britzman ve Main, 1990). İyilik halinin ilişkili olduğu psikolojik özellikler arasında benlik-saygısı en güçlü ve olumlu ilişkiyi gösteren değişken olarak öne çıkmaktadır (Abood ve Convay, 1992; Omizo,Omizo ve D'Andrea, 1992; Shillinford & Shillingford-Mackin, 1991). Literatürde iyilik hali ve benlik-saygısı arasındaki güçlü ilişkileri ortaya koyan araştırmaların bulgularına dayanarak, bu araştırmada, benlik-saygısı kişilik özelliklerinin önemli bir temsilcisi olarak kabul edilmiş ve iyilik halinin yordayıcılarından biri olduğu düşünülmüştür. Kişinin benlik-saygısı arttıkça iyilik halinin de olumlu yönde artması beklenmiştir.

Fiziksel semptomlar ve benlik-saygısının dışında, bu araştırmada sanat benlik-kavramı da iyilik hali ile ilişkisi araştırılan değişkenlerden biridir. Literatürde çok yeni bir kavram olan sanat benlik-kavramı, kişinin genel olarak sanat alanında kendisini nasıl algıladığını ifade etmektedir (Vispoel, 1993). Bir başka deyişle, sanat benlik-kavramı, genel benlik-kavramının parçalarından biridir. Literatürde, sanatın kişiyi zenginleştirici ve güçlendirici, örneğin benlik-saygısını arttırmadaki rolü (Berryman-Miller, 1988; Hietolahti-Ansten ve Kalliopuska, 1991; Kalliopuska, 1991) gibi çeşitli etkilerinden söz edilmekle birlikte, sanat-benlik kavramının kişinin iyilik haliyle olan ilişkisini doğrudan gösteren bir araştırma bulgusuna rastlanmamaktadır. Bu durum, bu araştırmada sanat benlik-kavramı ve iyilik hali arasındaki ilişkiye yönelik çeşitli varsayımların geliştirilmesine neden olmuştur. İlk

olarak, sanat etkinliklerine katılımı yüksek olan kişilerin iyilik halinin daha yüksek olacağı düşünülmüştür. Ayrıca, benlik-saygısı ve sanat benlik-kavramı arasındaki düşük fakat istatistiksel olarak anlamlı ($r = 0.15$, $p < .05$) ilişki göz önüne alındığında (Duran-Oğuz ve Tezer, 2005), sanat benlik-kavramı ile iyilik hali arasında olumlu yönde bir ilişki olabileceği düşünülmektedir. Son olarak, bu araştırmada, sanat benlik-kavramı ile iyilik hali arasında olumlu yönde bir ilişki bulunması halinde, bunun, bu araştırmanın bir parçası olarak geliştirilen iyilik hali programında sanat etkinliklerinden yararlanılması konusunda bir dayanak olacağı düşünülmüştür.

Bu araştırmanın ilk aşamasının amaçlarından biri de fiziksel semptomlar, benlik-saygısı ve sanat benlik-kavramı değişkenlerinin kişinin iyilik halini yordamadaki rollerini araştırmaktır. Literatürde cinsiyet değişkeninin iyilik haliyle ilgili olarak sıkça vurgulanan bir kontrol değişkeni olması (Depken, 1994; Garret, 1996). bakımından bu araştırmada ayrıca cinsiyetin iyilik halini yordamadaki rolü de araştırılmıştır.

1.2. İyilik Hali Programları

İyilik halinin kavramlaştırılması ve ilişkili olduğu değişkenlerin incelenmesine yönelik çalışmalar 1980'lerin sonundan itibaren iyilik hali programlarının geliştirilmesine yönelik çalışmalara hız kazandırmıştır (Millar ve Hull, 1997). İş dünyasında çalışanların sağlık harcamalarının azaltılması, verimliliğin arttırılması, çalışanların moralinin yükseltilmesi ve şirketlerinin imajlarının güçlendirilmesi amacıyla çeşitli iyilik hali programları geliştirilmiştir (Anderson, 1999, Anhaldt, 1994; Ginn ve Henry, 2003; O'Donnel, 1994; Kocakulah ve Joseforsky, 2002; Milligani, 2000). Okullarda da öğrencilerin yalnızca bilişsel gelişimlerinin değil bir bütün olarak gelişimlerinin sağlanmasına yönelik iyilik hali programları geliştirilmeye başlanmıştır (Pateman, 2004). Bu programların içeriğine yöneltilen en önemli eleştirilerden iyilik halinin bütüncül doğasına aykırı düşecek bir şekilde bilişsel yönelimli olmalarıdır (Conrad, 1987; Hollander ve Langerman, 1988; Roberts ve Harris, 1989). Bir başka eleştiri de iyilik hali programlarını yöneten

profesyonellerle ilgilidir. Örneğin, Myers (1991)'a göre, sağlık eğitimcileri, iyilik hali programlarında psikolojik danışmanların rolünü üstlenebilmektedir. Bu nedenle literatürde, psikolojik danışmanların ve psikologların iyilik hali programlarının geliştirilmesi ve uygulanmasında önemli roller üstlenmelerinin gerektiği önemle vurgulanmaktadır (Myers, 1991; Steiger, 1998; Street, 1994).

İyilik hali programlarının geliştirilmesi, uygulanması ve bu programların etkinliğinin test edilmesinde psikolojik danışmanların (1) iyilik halinin bütüncül ve çok boyutlu yapısına odaklanmaları ve (2) hizmet verdikleri grubun yaşlarına uygun teknikler kullanmaları önemlidir. Özellikle çocuklar ve ergenlere yönelik psikolojik danışma ve rehberlik hizmeti veren uzmanların, bu yaş grubundaki bireyleri konuya daha kolay çekecek, yaratıcı ve eğlenceli teknikler kullanmaları önerilmektedir (Linesh, 1998; Riley, 1994, 1998). Bu önerilere dayanarak, bu araştırmada, üniversite öğrencilerinde iyilik halini geliştirmeye yönelik bir programda sanata dayalı etkinlikler kullanmanın yararlı olacağı düşünülmüştür. Literatürde, sanatın akıl, beden ve ruha aynı anda ulaşabilme potansiyeli (Siegel, 1986, 1989) ve gençler için doğal, tehdit edici olmayan ve gelişimsel özelliklerine uygun bir ortam sağlayarak onların danışma sürecine katılımlarını güçlendirdiği (Mercedes-Ballbe, 1997; Graham, 1994; Linesh, 1998; Reynolds, 1990; Riley, 1994; Riley, 1999; Robertson, 2001) vurgulanmaktadır.

Literatürde sanatın iyilik halini arttırmada kullanılmasını destekleyen çok sayıda görüş bulunmakla birlikte, sanatın üniversite öğrencilerinin iyilik halini artırmaya yönelik bir psikolojik danışma programı içinde kullanıldığı herhangi bir araştırma bulgusuna rastlanmamıştır. Bu nedenle, bu araştırmanın son amacı, iyilik halini çeşitli boyutlarını kapsayan ve bütüncül, sanat etkinliklerine dayanan bir psikolojik danışma programı geliştirmek ve bu programın etkinliğini test etmektir. Bu programda sanat, kişinin kendini ifade etmesi ve kendisiyle ilgili içgörüsünün artmasını sağlaması amacıyla sürece yardımcı bir teknik olarak kullanılmıştır. Bu nedenle, katılan öğrencilerin sanatsal anlamda bir yeteneklerinin olması beklenmemektedir. Bunun yerine, programa katılan öğrencilerin sanatı bir araç olarak kullanarak kendilerini ifade etmeleri ve grup liderinin, üyelerin bu

ifadelerine empatik olarak yaklaşabilmesi süreç için en önemli beceriler olarak kabul edilmiştir (Coleman ve Farris-Dufrene, 1996).

1.3. Araştırmanın Amacı

Bu araştırmanın iki amacı bulunmaktadır. Araştırmanın birinci amacı, iyilik halinin Türk üniversite öğrencilerinde hangi alt boyutlarda görüldüğünü ortaya koymak ve öğrencilerin benlik-saygısı, fiziksel semptomlar, sanat-benlik-kavramı ve cinsiyetin iyilik halini ne ölçüde yordandığını ortaya koymaktır. Araştırmanın ikinci amacı ise Sanat Etkinlikleriyle Zenginleştirilmiş İyilik-hali Programının (SEZİP) geliştirilmesi ve bir grup ünivesrite öğrencisi üzerindeki etkinliğinin sınanmasıdır.

2. YÖNTEM

2.1. Örneklem

Bu araştırmanın birinci aşamasında, İyilik Hali Envanteri (İHE), Rosenberg Benlik-Saygısı Ölçeği (RBSÖ), Fiziksel Belirti Tarama Listesi (FBTL) ve Sanat Benlik-Kavramı Ölçeği (SBKÖ), ODTÜ Hazırlık Okulunda okumakta olan 415 (233 erkek, 162 kız, 20 cinsiyet bilgisi vermemiş) öğrenciye 2003-2004 öğretim yılı güz döneminde; ODTÜ Eğitim Fakültesinin birinci ve ikinci sınıflarında okumakta olan 214 (63 erkek, 139 kız, 12 cinsiyet bilgisi vermemiş) öğrenciye ise aynı öğretim yılının bahar döneminde uygulanmıştır. Böylece toplam 629 (297 erkek, 300 kız, 32 cinsiyet bilgisi vermemiş) öğrenciye ulaşılmıştır. Ölçeklerin uygulanması sırasında öğrencilere araştırmanın amacı açıklanmış ve bu araştırmanın iki aşamadan oluştuğu, araştırmanın ikinci aşamasına katılmak isterlerse araştırmacının kendilerine ulaşabilmesi için isim, adres, telefon ve e-posta adreslerini yazmaları istenmiştir.

Araştırmanın ikinci aşamasında ise üniversite öğrencilerinin iyilik-halini arttırmak amacıyla, araştırmacı tarafından Sanat Etkinlikleriyle Zenginleştirilmiş İyilik-Hali Programı (SEZİP) geliştirilmiştir. Bu programın etkinliği, ön-test son-test kontrol gruplu deneysel bir desenle 16 öğrenciden (deney grubu: 3 erkek, 3 kız;

kontrol grubu: 8 erkek, 2 kız) oluşan bir örneklemde test edilmiştir.

2.2. Kullanılan Ölçme araçları

2.2.1. İyilik Hali Envanteri (İHE)

Araştırmada iyilik hali, Güneri (2003) tarafından geliştirilen İHE ile ölçülmüştür. 103 maddeden oluşan ve 5'li Likert tipi bir ölçme aracı olan İHE'de bir toplam ve 8 alt boyut (ilişkisel benlik, sosyal ilgi ve empati, iç tutarlılık, başarı oryantasyonu, fiziksel iyilik hali, mizah, sevgi, ve çevresel duyarlılık) puanı heaplanabilmektedir. Ölçekten alınan yüksek puan, yüksek iyilik halini göstermektedir. Güneri (2003) ölçeğin tümü için hesaplanan alfa katsayısının .94 olduğunu, bu katsayıların alt ölçeklerde .88 (ilişkisel benlik), .76 (sosyal ilgi ve empati), .80 (iç tutarlılık), .91(başarı oryantasyonu), .76 (fiziksel iyilik hali), .59 (mizah), .72 (sevgi) ve .77 (çevresel duyarlık) olarak değiştiğini; ayrıca ölçeğin yeterli içerik ve yapı geçerliğine sahip olduğunu bildirmiştir.

Bu araştırmada, İHE'nin faktör yapısı, geçerlik ve güvenirliğini araştırmak üzere açıklayıcı ve doğrulayıcı faktör analizleri yapılmış, Cronbach alfa içtutarlık katsayısı ve halihazır geçerlik kanıtları elde edilmiş ve sonuçlar Bulgular bölümünde verilmiştir.

2.2.2. Fiziksel Belirti Tarama Listesi (FBTL)

Yorgunluk, öksürük, baş ağrısı, baş dönmesi vb. çok şiddetli olmayan fiziksel belirtilerin taranması için araştırmada Scheir ve Carver (1985) tarafından geliştirilen ve Aydın ve Tezer (1991) tarafından Türkçe'ye uyarlama çalışması yapılan FBTL kullanılmıştır. 38 maddeden oluşan FBTL, 38 ile 190 arasında değişebilen bir toplam puan vermekte ve ölçekten alınan yüksek puanlar belirtilen fiziksel semptomların daha sık ortaya çıktığını ifade etmektedir.

Bu araştırmada, FBTL'nin 629 ODTÜ öğrencisine uygulanmasıyla elde edilen veriler üzerinde yapılan analizde, ölçeğin Cronbach alfa iç tutarlık katsayısı .90 olarak bulunmuştur.

2.2.3. Rosenberg Benlik-Saygısı Ölçeği (RBSÖ)

Benlik-saygısını ölçmek amacıyla Rosenberg (1965) tarafından geliştirilen ve literatürde sıklıkla kullanılan RBSÖ'nün 10 maddelik kısa formu kullanılmıştır. RBSÖ'nün Çuhadaroğlu (1986) tarafından yapılan adaptasyon çalışmasında ölçek puanlarının psikiyatrik görüşmelerden alınan puanlarla korelasyonu .71 olarak bulunmuştur. Ölçeğin iç tutarlığıyla ilgili olarak Tuğrul (1994) tarafından rapor edilen Cronbach alpha katsayısı .86'dır.

Bu araştırmada, RBSÖ'nün 629 ODTÜ öğrencisine uygulanmasıyla elde edilen veriler üzerinde yapılan analizde, ölçeğin Cronbach alfa iç tutarlık katsayısı .87 olarak bulunmuştur.

2.2.4. Sanat Benlik-Kavramı Ölçeği (SBKÖ)

Öğrencilerin sanat alanında kendilerini nasıl gördüklerini ölçmek üzere Duran-Oğuz ve Tezer (2005) tarafından geliştirilen SBKÖ kullanılmıştır. 10 maddeden oluşan Likert tipi bir ölçek olan SBKÖ'den bir toplam puan elde edilmekte ve yüksek puan yüksek sanat benlik-kavramını ifade etmektedir. Ölçeğin RBSÖ (Rosenberg, 1965) ve Sosyal Beğenirlik Ölçeği (Kozan, 1983) ile arasında Duran-Oğuz ve Tezer tarafından rapor edilen korelasyon katsayıları sırasıyla $r = .15$, $p < .05$ ve $r = .03$, $p < .05$'dir. Ayrıca ölçeğin Cronbach alfa iç tutarlık katsayısı .92; 36 kişilik bir öğrenci grubuna bir ay ara ile iki kez uygulanmasından elde edilen test-tekrar-test güvenirlik katsayısı ise .74'tür.

Bu araştırmada, SBKÖ'nün 629 ODTÜ öğrencisine uygulanması sonucu elde edilen veriler üzerinde yapılan analizde ölçeğin Cronbach alfa iç tutarlık katsayısı .95 olarak bulunmuştur.

2.2.5. Değerlendirme Formu

Araştırmada, SEZİP'e katılan deney grubu üyelerinin program sonunda kendilerini ve genel olarak grup sürecini değerlendirmelerini sağlamak ve böylece programın etkinliğine ilişkin nitel bilgi elde edebilmek amacıyla araştırmacı tarafından geliştirilen ve Likert tipi iki ve açık uçlu 6 sorudan oluşan değerlendirme formu kullanılmıştır.

2.3. Sanat Etkinlikleriyle Zenginleştirilmiş İyilik Hali Programı

Bu araştırmada, İHE toplam puanları ile FBTL puanlarından ortalamanın bir standart sapma altında kalan öğrenciler seçkisiz yolla deney ve kontrol gruplarına atanan öğrencilerin iyilik-halini arttırmak amacıyla Sanat Etkinlikleriyle Zenginleştirilmiş İyilik Hali Geliştirme Programı (SEZİP) geliştirilmiştir. SEZİP'in geliştirilmesi sırasında iyilik hali ve sanatla psikolojik danışma literatürleri ve programa katılacak öğrencilerin içinde bulundukları gelişim döneminin özellikleri dikkate alınmıştır.

SEZİP oturumları haftada bir kez, 2.5 saat olmak üzere 8 hafta sürmüştür. Oturumlar ODTÜ Eğitim Fakültesi, Eğitim Bilimleri Bölümü, psikolojik danışma grup odasında gerçekleştirilmiştir. Program süresince her oturumda müzik kullanılmış, katılımcılara "sağlıklı" yiyecek ve içecekler sunulmuş ve katılımcıların "Benim Hakkımda Bir Kitap" isimli iylik hali günlüğünü tutmaları istenmiştir.

2.4. Verilerin Çözümlenmesi

Verileri çözümlenmesi süreci, araştırmanın aşamalarına uygun olarak aşağıda belirtilen aşamalarda sürdürülmüştür.

Araştırmada elde edilen verilerin analizine geçmeden önce, bu veriler hata bakımından temizlenmiş ve örneklemle ilgili genel bir bilgi edinmek için verilerin aritmetik ortalama, standart sapma ve yüzdelik değerlerine bakılmıştır.

Araştırmanın betimsel aşamasının ilk basamağı için, önce öğrencilerin İHE'den aldıkları puanların faktör analizine uygunluğu iki kriter kullanılarak test edilmiştir. Bunlar: (1) örneklemin büyüklüğü ve (2) maddeler arasındaki ilişkinin gücüdür. İlki için Tabachnick ve Fidell (1996)'in önerdiği "her madde için 5 kişi" formülü esas alınmış; ikincisi için ise Barlett's Testi ve Kaiser-Meyer-Olkin (KMO) ölçümüne bakılmıştır. Bu aşamada, İHE'nin boyutlarının saptanması ve geçerliğine ilişkin kanıt sağlanması amacıyla öğrencilerin İHE'den aldıkları puanlarla açıklayıcı faktör analizi (AFA) ve doğrulayıcı faktör analizi (DFA) yapılmıştır. İHE'nin bu faktör analizleri ile ortaya konan ve doğrulanan 30 maddelik hali üzerinden normal dağılımına yeniden bakılmıştır.

Betimsel aşamanın ikinci basamağında ise öğrencilerin İHE toplam puanları ve İHE alt boyut puanları bağımlı değişken alınarak, beş ayrı çoklu regresyon analizi yapılmıştır. Benlik-saygısı, fiziksel semptom, sanat benlik-kavramı ve cinsiyet bu analizlerde bağımsız değişken olarak kullanılmıştır.

Araştırmanın deneysel aşamasında, deney ve kontrol grubuna düşen kişi sayılarının az oluşu nedeniyle parametrik olmayan istatistikler kullanılmıştır (Pallant, 2001). Deney ve kontrol grubundaki öğrencilerin İHE'den aldıkları ön-test, son-test ve izleme puanları arasında anlamlı bir fark bulunup bulunmadığını kontrol etmek için Mann Whitney U testi; deney ve kontrol gruplarının ön-test, son-test ve iki izleme ölçümünde grup-içi anlamlı bir fark gösterip göstermediğini kontrol etmek için ise Wilcoxon İşaret sayıları testi kullanılarak bir dizi analiz yapılmıştır.

LISREL 8.30 programının kullanıldığı doğrulayıcı faktör analizi dışında, tüm analizlerde SPSS 11.5 paket programı kullanılmıştır. Tüm istatistiksel analizlerde anlamlılık düzeyi .05 alınmıştır.

3. BULGULAR

3.1. Ön Analizler

Araştırmada İHE, RBSÖ, FSTL ve SBKÖ'den elde edilen veriler öncelikle hata bakımında incelenmiş ve ölçeğin % 5'inden fazlasını boş bıraktığı belirlenen 7 kişi araştırma dışında bırakılmıştır. Geriye kalan öğrenciler için boş bırakılan değerlerin yerine her ölçek için ortalama puan hesaplanmıştır. Böylece, araştırmaya katılan toplam öğrenci sayısının 629 (297 erkek, 300 kız, ve 32 cinsiyet bilgisi vermemiş) öğrenciden oluştuğu görülmüştür. Bu öğrenci grubu için yaş ortalaması 18.96 ve standart sapması 1.47 olarak bulunmuştur.

3.2. Araştırmanın Betimsel Aşamasına İlişkin Bulgular

Bu aşamaya ilişkin bulgular, İHE'nin boyutları, geçerlik ve güvenirliğine ilişkin bulgular ve İH'nin benlik-saygısı, fiziksel belirtiler, sanat benlik-kavramı ve cinsiyetin değişkenleri tarafından ne ölçüde yordanabildiğine ilişkin regresyon analizi sonuçları olmak üzere iki bölümden oluşmaktadır.

3.2.1. İHE'nin Boyutları, Geçerliği ve Güvenirliğine İlişkin Bulgular

İHE için Açıklayıcı ve Doğrulayıcı Faktör Analizi Sonuçları: Güneri (2003) tarafından geliştirilen ve bu araştırmada kullanılan İHE'nin boyutlarının saptanması amacıyla öğrencilerin İHE'den aldıkları puanlara açıklayıcı faktör analizi (AFA) ve doğrulayıcı faktör analizi (DFA) uygulanmıştır. Faktör analizleri öncesinde verilerin bu analize uygunluğunun test edilmesi için saptanan iki kriter –(1) örneklemin büyüklüğü, (2) Barlett's Test = 23297.848 ($p < .05$) ve Kaiser-Meyer-Olkin (KMO) = .892 de verilerin faktör analizine uygun olduğunu göstermiştir.

AFA sonuçları ölçeğin 30 maddeden ve dört alt boyuttan oluşan bir yapı ortaya koyduğunu göstermiştir. Bilişsel-Duygusal İyilik-Hali (BDİH), İlişkisel İyilik-Hali (İİH), Yaşam-Hedefi ve Fiziksel İyilik Hali (FİH) olarak adlandırılan alt boyutlar

sırasıyla 6, 10, 7 ve 7 maddeden oluşmaktadır. Bu alt boyutlar toplam varyansın % 37.68'ini açıklamaktadır. Madde yükleri .743 ile .423 arasında değişmektedir. Ölçeğin bu yapısı DFA sonucunda elde edilen değerlerle de doğrulanmıştır (χ^2 /df = 2.57, RMSA = .05, GFI = .90, AGFI = .89 ve SRMR = .05.)

İHE'nin İç Tutarlık Güvenirliği: Ölçeğin Cronbach alpha formülü kullanılarak hesaplanan iç tutarlık katsayısı tüm ölçek için .82, BDİH alt boyutu için .79, İİH alt boyutu için .76, YH alt boyutu için .67 ve FİH alt boyutu için .63'tür. Bu değerler yüksek olmamakla birlikte iç tutarlık için yeterli görülmüştür.

İHE'nin Alt Ölçekler Arası Korelasyonları: İHE'nin alt boyutlarının birbirleriyle ilişkilerinin .24 ile .39 arasında, alt boyutların toplam ölçek puanıyla ilişkilerinin ise .66 ile .70 arasında değiştiği görülmüştür.

İHE'nin Uyum Geçerliği: İHE'nin RBSÖ ile arasındaki korelasyon katsayılarının yüksek olmamakla birlikte anlamlı düzeyde bulunması ölçeğin uyum geçerliğine ilişkin bir kanıttır (İHE toplam puanı için r = .499, p < .01; BDİH puanı için r = .705, p<.01; İİH puanı için r = .215, p < .01;YH puanı için r = .345, p < .01; FİH puanı için r = .180, p < .01). Benzer şekilde İHE ile FSTL arasındaki korelasyon katsayıları da bir geçerlik kanıtı kabul edilecek düzeyde bulunmuştur. İHE toplam puanı için r = -.236, p < .01; BDİH puanı için r = -.320, p < .01; FİH puanı için r = -.231, p < .01.

3.2.2. Çoklu Regresyon Analizine İlişkin Bulgular

Benlik-saygısı, fiziksel belirtiler, sanat benlik-kavramı ve cinsiyetin, İH'yi ne ölçüde yordadığını saptayabilmek için araştırmada beş adet çoklu regresyon analizi yapılmıştır. Elde edilen bulgular, İHE toplam puanı için benlik-saygısı, cinsiyet, fiziksel belirtiler ve sanat benlik-kavramının yordayıcı değişkenler olduğunu göstermiştir. Bu değişkenler toplam varyansın % 31'ini açıklamaktadır. Ayrıca BDİH için benlik-saygısı ve fiziksel belirtilerin; İİH için cinsiyet, benlik-saygısı ve sanat benlik-kavramının; YH için benlik-saygısı ve sanat benlik-kavramının; FİH

için ise fiziksel belirtiler, cinsiyet ve benlik-saygısının yordayıcı değişkenler olduğunu görülmüştür. Bu yordayıcı değişkenlerin her bir bağımlı değişken için açıkladıkları toplam varyanslar sırasıyla % 52, % 12, % 12 ve % 13'tür.

3.3. Araştırmanın Deneysel Aşamasına İlişkin Bulgular

Bu aşamada elde eldilen bulgular SEZİP'in etkinliğinin test edilmesi amacıyla deney ve kontrol grubu üyelerine ön-test, son-test, izleme 1 ve izleme 2 ölçümleri olarak verilen İHE'den elde edilen verilerin parametrik olmayan testlerle yapılan analizlerinden elde edilen nicel bulgular ve deney grubu üyelerine SEZİP'i tamamlamalarının ardından verilen değerlendirme formundan elde edilen nitel bulgulardan oluşmaktadır. Aşağıda bu bulgular üç bölüm halinde sunulmuştur.

3.3.1. Mann Whitney U Testlerinin Sonuçları

Deney ve kontrol grubu üyelerinin İHE'den aldıkları toplam puanlar arasında ön-test, son-test, izleme 1 ve izleme 2 ölçümlerinde anlamlı bir fark bulunup bulunmadığını test etmek amacıyla yapılan Mann Whitney U testlerinin sonucunda son-test ve izleme 1 ölçümlerinde deney grubu üyelerinin lehine anlamlı bir fark bulunmuştur.

Ayrıca, deney grubu üyelerinin son-test ve izleme 1 ölçümlerinde BDİH alt boyutunda ve izleme 1 ölçümünde YH alt boyutunda kontrol grubu üyelerinden anlamlı düzeyde daha yüksek puanlar aldıkları görülmüştür.

3.3.2. Wilcoxon İşaretli Sıra Sayıları Testlerinin Sonuçları

Wilcoxon İşaretli Sıra Sayıları testlerinin sonuçları, deney grubu üyelerinin İHE'den aldıkları toplam puanların ön-test ve son-test ve ön-test ve izleme 2 ölçümleri arasında; BDİH puanlarının ön-test ve son-test ile ön-test ve izleme 1 ölçümleri arasında; YH puanlarının ön-test ve son-test ölçümleri arasında anlamlı düzeyde arttığını; İİH ve FİH puanlarında ise anlamlı bir değişim görülmediğini ortaya koymuştur. Diğer taraftan, kontrol grubu üyelerinin İHE'den aldıkları toplam

puanların ise ön-test ve izleme 1 ile son-test ve izleme 1 ölçümleri arasında anlamlı bir düşüş gösterdiği görülmüştür. Benzer şekilde kontrol grubu üyelerinin BDİH puanları ön-test ve son-test ile ön-test ve izleme 1 ölçümleri arasında, YH ve FİH puanları da ön-test ve izleme 1 ile son-test ve izleme 1 ölçümleri arasında anlamlı düzeyde düşmüştür. Kontrol grubu üyelerinin BDİH, YH ve FİH puanlarının izleme 1 ve izleme 2 ölçümleri arasında ise anlamlı düzeyde arttığı görülmüştür. İİH puanları bakımından kontrol grubu üyeleri anlamlı bir değişim göstermemiştir.

3.3.3. Değerlendirme Formu Sonuçları

Yukarıda sunulan nicel bulgularla tutarlı olarak, SEZİP sonunda deney grubu üyelerine uygulanan değerlendirme formundan elde edilen nitel bulgular da öğrencilerin genel olarak programı kendi gelişimleri için olumlu ve yararlı bulduklarını ve süreci özellikle sanat etkinlikleri açısından etkin bulduklarını göstermiştir.

4. SONUÇ VE ÖNERİLER

Bu araştırmanın betimsel aşamasından elde edilen bulgular İH'nin bilişsel-duyuşsal İH, ilişkisel İH, yaşam hedefleri ve fiziksel İH alanlarından oluşan çok boyutlu bir kavram olduğunu göstermiştir. İH'nin boyutlarının araştırılması süreci, bu alanda var olan literatürü destekleyecek şekilde bu kavramı ölçmenin zorluğunu ortaya koymuştur. Bununla birlikte, bu araştırmanın betimsel aşamasından elde edilen bulgular benlik-saygısı ve cinsiyet değişkenlerinin hem toplam iyilik hali için hem de iyilik halinin boyutları için önemli yordayıcılar olduklarını, ayrıca sanat benlik-kavramı ve fiziksel semptomlarının da iyilik halini yordamada rol oynadıkları göstermesi bakımından önemli görülmektedir. Üniversite öğrencilerinin iyilik halini anlamak isteyen araştırmacılar ve üniversite öğrencilerine hizmet veren psikolojik danışmanların iyilik hali programları hazırlarken bu bulguları dikkate almaları önemlidir.

Ayrıca, bu araştırmanın deneysel aşaması, SEZİP'in üniversite öğrencilerinin iyilik halini artırmada etkili bir program olduğunu göstermiştir. Bununla birlikte, SEZİP'in etkinliğini arttırmak üzere bundan sonraki uygulamalarda aşağıdaki noktalara dikkat edilebilir:

1. SEZİP'in etkinliği bir placebo kontrol grubuyla veya bilişsel-temelli bir iyilik-hali eğitim programı, açık stüdyo sanat programı vb. alternatif iyilik hali programlarıyla karşılaştırılarak test edilebilir.
2. Programın uygulanacağı başka grupların ihtiyaçları doğrultusunda SEZİP'e yeni konular eklenebilir.
3. SEZİP bir takım çalışması biçiminden yeniden ele alınarak genişletilebilir ve iyilik hali ve sağlıklı yaşam konusunda uzman olan başka profesyonellerle işbirliği içinde yürütülebilir(Rayle, Dixon & Myers, 2004; Grace, 1997; Street, 1994).
4. SEZİP öncesinde ve sonrasında iyilik halinin ölçülmesi için alternatif değerlendirme stratejileri (görüşme teknikleri, alternatif fiziksel veya ruhsal sağlık ölçümleri veya yaşam kalitesi ölçümleri vb.) kullanılabilir.
5. SEZİP'in etkinliği farklı ve daha geniş örneklemlerde test edilebilir.
6. Boylamsal araştırmalarla, programın uzun dönemdeki etkileri araştırılabilir.
7. SEZİP, geniş çaplı bir "kampüs iyilik hali programı"nın parçası olarak kullanılabilir.

VITA

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