THE RELATIONSHIP BETWEEN COPING, DIMENSIONS OF PERFECTIONISM, PERCEIVED INTENSITY OF LIFE EVENTS AND DEPRESSIVE SYMPTOMS IN BOĞAZİÇİ UNIVERSITY STUDENTS: "A TEST OF COGNITIVE MODEL OF DEPRESSION"

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The Relationship between Coping, Dimensions of Perfectionism, Perceived Intensity of Life Events and Depressive Symptoms In Boğaziçi University Students: "A Test of Cognitive Model of Depression"

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APPROVAL PAGE

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Could I have finished this thesis without…

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Believing that in the future we will know much more about depression and through preventive studies, less people will suffer because of it…

ABSTRACT

The Relationship between Coping, Dimensions of Perfectionism, Perceived Intensity of Life Events and Depressive Symptoms in Boğaziçi University Students: "A Test of Cognitive Model of Depression"

by

Selin Şen

This study investigated the direct or indirect effect of and association between coping in terms of styles and strategies, and perfectionism on the relationship between the perceived intensity of life events in terms of their stressfulness and depressive symptoms; as well as investigating the different categories of depressive symptoms in terms of perceived intensity of life events, coping styles and strategies, and perfectionism dimensions among Boğaziçi University undergraduate students.

The five variables of this study were: perceived intensity of life events in terms of their stressfulness, coping styles, coping strategies, perfectionism and depressive symptoms.

Six instruments were used for data collection: Demographic Information Form (DIF), Life Events Inventory for University Students (LEIU), Coping Styles Inventory (CSI), Rosenbaum's Learned Resourcefulness Schedule (RÖGÖ), Multidimensional Perfectionism Scale (MPS), and Beck Depression Inventory (BDE). Data analysis was done through SPSS and Structural Equation Modeling, in AMOS software statistics program.

The results showed that coping styles, coping strategies and perfectionism by themselves did not have a significant effect on the relationship between perceived

intensity of life events and depressive symptoms. However, when both coping styles and strategies and perfectionism are entered into the model, perfectionism acted as a mediator and caused coping, in terms of styles ($\beta = -.46$, $p < .001$) and strategies ($\beta = -.23$, $p < .001$), to have a significant effect on the relationship. The results also showed that coping styles accounted for 21% of depressive symptoms whereas coping strategies accounted for only 5% of depressive symptoms. In addition, a difference still existed between those showing no depressive symptoms and those in different categories of depressive symptoms according to all the variables of this study.

ÖZET

Boğaziçi Üniversitesi Öğrencilerinde Başetme,

Mükemmelliyetçi Kişilik Özelliği ve Yaşam Olayları Algısının

Depresif Belirtilerle İlişkisi:

"Bilişsel Modelin İncelenmesi"

Selin Şen

Bu araştırma Boğaziçi Üniversitesi lisans öğrencilerinin, başetme tarzları ve stratejileri, ve mükelmelliyetçi kişilik özelliğinin, yaşam olaylarının ne boyutta stres verici olarak algılandığı ile depresif belirtiler arasındaki ilişki üzerindeki doğrudan veya dolaylı ve birleşik etkilerini; ve farklı kategorilerde depresif belirtiler gösterenlerin yaşam olayları algıları, başetme tarzları ve stratejileri, mükemmeliyetçi kişilik boyutları alanlarında farklılık gösterip göstermediklerini incelenmiştir.

Araştırmanın beş değişkeni vardır: yaşam olaylarının ne kadar stres verici olarak algılandığı, başetme tarzları, başetme stratejileri, mükemmeliyetçi kişilik özelliği, ve depresif belirtilerdir.

Bu araştırmada altı farklı ölçek veri toplama için kullanılmıştır. Bunlar, Demografik Bilgi Formu (DBF), Üniversite Öğrencilerine Yönelik Yaşam Olayları Ölçeği (ÜÖYO), Stresle Başa Çıkma Tarzları Envanteri (SBTÖ), Rosenbaum'un Öğrenilmiş Güçlülük Ölçeği (RÖGÖ), Çok Boyutlu Mükemmelliyetçilik Ölçeği (ÇBMÖ) ve Beck Depresyon Envanteri (BDE)'dir. Toplanan veriler SPSS ve yapısal denklem modelleme (structural equation modeling) yöntemi ile AMOS istatistik programında analiz edilmiştir.

Sonuçlar göstermiştir ki başetme tarzları ve stratejileri ve mümemmelliyetçi kişilik özelliği değişkenleri, tek başlarına yaşam olaylarınını algı ile depresif belirtiler arasındaki ilişkiyi doğrudan etkilememiştir. Ancak SEM modeline başetme tarzları ve stratejileri ile mükemmelliyetçi kişilik özelliği aynı anda girildiğinde, mükemmeliyetçi kişilik özelliğinin yordayıcı bir rolü olduğu ve başetme tarzlarının (β= -.46, $p<.001$) ve stratejilerinin (β= -.23, $p<.001$) yaşam olaylarını algı ile depresif belirtiler arasındaki bağlantı üzerinde "anlamlı" bir ilişkisi olmasını sağlamıştır. Aynı zamanda başetme tarzlarının, yaşam olaylarının ne boyutta stress verici olarak algılandığı ile depresif belirtiler arasındaki ilişkiyi %21 açıkladığı ancak başetme stratejilerinin sadece %5 açıkladığı bulunmuştur. Bu sonuçlara ek olarak, depresif belirtiler göstermeyenler ile farklı kategorilerde depresif belirtiler gösterenler bu çalışmadaki diğer tüm değişkenlerde anlamlı bir farklılık göstermiştir.

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I - INTRODUCTION

It is noteworthy that depressive disorders are among the highest ranking mental problems among the general population (Wolman & Stricker, 1990). Each year, the number of people suffering from depression and depressive disorders is more than one hundred million all over the world (Clark et al., 1999). Everybody feels a little depressed from time to time for many different reasons, which may last for varying lengths of time. However, depressive disorders are likely to take place when a person's coping abilities are not effective or are outweighed.

Depressive symptoms have come to be one of the common problems of modern age through multiple and conflicting time demands, competition in every aspect of life, and increasing requirements of rapid change (Sayar, 2004; Miars, 1996). Literature shows that there is scientific evidence supporting a significant relationship between depression and stress (Baltaş & Baltaş, 2004; Sayar, 2004; Miars, 1996; Hobfoll, 1988; Elliot & Eisdorfer, 1982). People are exposed to stressors during every moment of their lives; however what determines the quality of their lives is how they respond to stress (Kutash et al., 1980). No individual is identical to another; and consequently the same stressors, which include specific events and environmental conditions, are likely to affect different people in different ways and to different degrees (Cooper, 1983).

Researchers have concentrated on depression and stress, specifically centering on psychopathology (Hobfoll, 1988; Elliot & Eisdorfer, 1982). What has been overlooked for some time is the fact that some stressors may lead to positive changes instead of causing elevated depressive symptoms (Elliot & Eisdorfer, 1982). In the light of supportive view of Lazarus & Folkman (1984) and Elliot & Eisdorfer (1982), the literature on stress reactions shows that not every individual who is

exposed to a stressor will be depressed. The question at hand then becomes why some people do not become depressed by stressors while others become severely depressed and what moderates and/or mediates the effect of stressors, such as life events, on people.

In addition, as a consequence of findings, an important question which is addressed by research is why some people are resilient to stress while others are especially vulnerable to it (Elliot & Eisdorfer, 1982).

Through research, it has been found that what determines the type and degree of response to stress is the "perception of the stressor by the individual" and coping methods (Cooper, 1983). In addition, personal dispositions are also determinants of the reaction to stressors (Elliot & Eisdorfer, 1982). Thus it can be stated that life events, how the person perceives them, the personality traits of the individual, and how they cope according to the resources that they have, are important moderating and/or mediating factors for depressive symptoms (Elliot & Eisdorfer, 1982).

Beck has tried to investigate this issue and formulated The Cognitive Theory of Depression (Clark et al., 1999). In the Cognitive theory, it is recognized that depression is caused by a combination of factors that are within the biological, genetic, familial, developmental, personality and social domains (Clark et al., 1999). The Diathesis-Stress Model of Cognitive Theory of Depression states that all individuals inherit certain physical and psychological predispositions that leave them vulnerable to problems that may or may not appear, depending on what kinds of events they confront (Clark et al., 1999).

One of the important factors of depression is how people cope, since studies by Lazarus and Folkman (1984), showed that, unsuccessful coping may lead to

depression and in turn, depression is characterized by particular styles and types of coping. It is also stated that personal characteristics are viewed as antecedents for coping efforts (Elliot & Eisdorfer, 1982). Striving for excellence, or in other words; perfectionism, is one of the personality traits that may have an influence on how much a person is affected by a certain event and how s/he reacts (Hobfoll, 1988).

This study aims to examine the cognitive theory of depression, specifically focusing on the psychological aspect of diathesis-stress model, to investigate the effect of coping skills and strategies and perfectionism on the relationship between perception of life events and depressive symptoms on undergraduate Boğaziçi University students. Among other variables of vulnerability, perfectionism has been chosen because of its prevalence among university students (Flett & Hewitt, 2002). In addition, university life has a high frequency of events experiences and how the students perceive these events and how they cope has an important effect in understanding depressive symptoms (Flett & Hewitt, 2002).

For the purpose of the study, "Beck Depresyon Envanteri" (Beck Depression Inventory) for assessment of depressive symptoms, "Üniversite Öğrencilerine Yönelik Yaşam Olayları Ölçeği –ÜÖYO" (Life Events Inventory for University Students) for the assessment of perception of life events, "Stresle Başa Çıkma Tarzlar Envanteri –SBTÖ" (Coping Styles Inventory – CSI) for assessing coping styles, Rosenbaum's Learned Resourcefulness Schedule (RÖGÖ) for assessing coping strategies, and Multidimensional Perfectionism Scale (ÇBMÖ) for assessment of perfectionism were chosen.

II - REVIEW of LITERATURE

This study investigated the effect of coping styles and strategies, as well as perfectionism on the relationship between perceived intensity of life events in terms of their stressfulness and depressive symptoms. In addition, differences among students who fall in different depressive symptom categories in terms of perceived intensity of life events, coping styles and strategies, and perfectionism were also investigated.

First of all, in this part, general background information will be presented, followed by detailed literature about the variables of the study. Depressive disorders are said to be the disease of the modern age which affect the quality of life (Sayar, 2004). It is one of the most common psychological conditions which is experienced both by clinical and nonclinical populations, affecting and in return being affected by the functioning of the individual (Bradley, 1994; Lewinsohn et. al., 1984).

The Dictionary of Psychology describes "depression" as "1. in the normal individual, a state of despondency characterized by feelings of inadequacy, lowered activity, and pessimism about the future. 2. In pathological cases, an extreme state of unresponsiveness to stimuli, together with self-depreciation, delusions of inadequacy, and hopelessness" (Chaplin, 1985, p.122).

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 2000) describes "major depressive disorder" as:

> "The essential feature of a Major Depressive disorder is a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities. The individual must also experience at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep and psychomotor activity; decreased energy; feeling of worthlessness or guilt; difficulty thinking, concentrating or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. The episode must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning."(p.349)

Each year, nearly 100 million people worldwide are affected by depressive disorders (Clark et al., 1999). According to the Social Science Encyclopedia (Kuper & Kuper, 1996), the prevalence of depressive disorders is relatively high, with a lifetime incidence of 15-30%. In addition, women are thought to be twice as more affected by depressive disorders than men. This finding is supported by studies: the ratio of females to males in prevalence of depression has been found as 2:1 and this ratio has also been found consistent across cultures (Smith & Weissman, 1991). It is important to note that showing some depressive symptoms does not mean that a person is clinically depressed; it means that they are experiencing depressive symptoms.

There is scientific evidence which support that there is a link, or in other words, relationship between stressful events and depressive symptoms (Jenaway & Paykel, 1997). Since 1960s, the relationship between life events and depressive symptoms has been a topic that has been paid attention to, as the self and the environment are in a continual contact. It has been found that there's a strong and complex link between them (Jenaway & Paykel, 1997). Sometimes depressive symptoms occur after a major change in a person's life, such as death (Flach, 1974). Other than specific life events, another stressor is the daily events which are called daily hassles (Miars, 1996). Daily hassles are constant daily tensions and conflicts which are usually unrecognized, compared to crises and identifiable stressors (MacNab, 1986). Studies have shown that daily hassles not only have the potential to cause stress, but also an even stronger role to cause stress compared to traditional life event stressors (Miars, 1996, p.134).

Reactions to stressors are not the same for everyone; they vary widely and unpredictably since when faced with stressors, people use different ways of coping

(MacNab, 1986; Williams, 1984). However, when stressors become more than one can cope with, depressive symptoms and depressive disorders become inevitable.

The fact that everyone reacts differently to stressors is explained by the Diathesis-Stress Model of Cognitive Theory of Depression. According to Beck, the specific stresses which are responsible for depressive symptoms are people's specific vulnerabilities (1974b). According to the Diathesis-stress model, it is stated that all people inherit certain physical and psychological predispositions that leave them vulnerable to problems which may or may not appear, based on what kinds of situations people are faced with (Clark et al., 1999). Literature supports the fact that some personality characteristics might be antecedents to depressive symptoms, and cause the person to be vulnerable to depression (Hirschfeld et al., 1997, p.327).

In addition, one of the main beliefs of cognitive theory of depression is that perceptions always mediate an event and the emotional response to that event (Wolman & Stricker, 1990). On the other hand, studies by Lazarus and Folkman (1984) showed that one of the important factors of depressive symptoms is how people cope, since results showed that, unsuccessful coping may lead to depressive symptoms, and in turn, depressive disorders are characterized by particular styles and strategies of coping. It is also stated that personal characteristics are viewed as antecedents to coping efforts (Elliot & Eisdorfer, 1982).

People experience depressive symptoms for many reasons and the duration and severity can vary. According to Steptoe & Appels (1989), the origins of depression are based upon two factors, which are vulnerability and provoking factors. Vulnerability factors can be described as relatively long-term attributions of the individual and the social environment of the person which affect the individual's susceptibility to depression. Provoking factors, on the other hand, are relatively

short-term attributes of the individual and the life events or difficulties which activate or provoke depressive symptoms. The important feature in these definitions is the interaction of the provoking and vulnerability factors, since depressive symptoms are experienced by people who have vulnerabilities and are exposed to provoking factors.

According to Cognitive Theory of Depression, the vulnerabilities of individuals include personality traits and results of research show that perfectionism is one of the personality traits that affect how much people are affected by certain events and how they react (Hobfoll, 1988).

Sometimes stressors facilitate performance, sometimes they impair it, and sometimes they increase variability among individuals (Lazarus et al., 1952). Characteristics of the stressor, the person's resources, the task required and the nature of the surrounding environment all affect this relationship. According to Elliott & Eisdorfer (1982), whether a stressful event leads to growth, temporary difficulty or trauma is probably a function of the stressors' pervasiveness and persistence; the time of the event; the personal resources available to react to the stressor; whether it is possible to act on the environment, and the personal meaning of the experience.

Depressive disorders among college students are very common (Flett & Hewitt, 2002). In fact, depressive symptoms and depression are accepted as the leading psychological disorder in colleges (Vredenburg et al., 1988). In a study by Vredenburg, O'Brien & Krames (1988), it was found that depressive symptoms among university students represent a serious problem, although mild in intensity. The results revealed that three quarters of depressed students had been depressed for more than three months and that half of them thought about suicide. In addition, the

study examined the nature of university students' depression and its relation to personality variables and to experiences unique to university life, and no gender difference was found for depressive symptoms. In addition a larger proportion of depressed subjects (.63) were found to feel pressure from their families to achieve success than nondepressed students. The results of the study also suggested that depression experienced by university students is not just related to either a personality trait or a life event but rather both factors seemed to have significant implications.

Common stressors in college life include adaptation to a new environment, a period of transition, greater academic demands, financial responsibilities, changes in social life, exposure to new people, ideas and temptations, awareness of sexual identity and preparing for life after graduation.

Boğaziçi University Guidance and Psychological Counseling Center's (BÜREM) ("Boğaziçi Üniversitesi Öğrenci Rehberlik ve Psikolojik Danışmanlık Araştırma ve Uygulama Merkezi") annual reports show that depressive symptoms are common among Boğaziçi University students. During the 2002-2003 academic year, depressive symptoms are the third most frequent reason for application for counseling by 14.10% (96 students out of 283); while during the 2001-20002 academic year, depressive symptoms is the most frequent reason for application for counseling by 15.80% (75 out of 242); during the 2000- 2001 academic year depressive symptoms is the fourth most frequent reason for application for individual counseling by 12% (26 out of 222) and during the 1999-2000 academic year, depressive symptoms is the second most frequent reason for application for counseling (32 out of 292).

The main aim of this study, in the light of literature, was to investigate the effect of coping styles and strategies, and perfectionism on the relationship between the perceived intensity of life events and depressive symptoms. Life events in this study are taken as the daily hassles that each university student is likely to experience instead of traumatic life events.

A- The Cognitive Theory of Depression: The Diathesis- Stress Model

According to the cognitive model of depression, cognitive structures are accepted to be predisposing or vulnerability factors for depressive symptoms. In the cognitive theory of depression, it is proposed that schemas which consist of maladaptive attitudes, beliefs, and assumptions about the self, the world, and future might be related with increased vulnerability to depression (Beck, 1967; Beck et al, 1979, cited in Clark, Beck & Alford, 1999). It is important to distinguish that in cognitive therapy, it is not claimed that depressive symptoms are caused by negative cognitions; rather it is recognized that depressive symptoms are caused by a combination of factors within the biological, genetic, familial, developmental, personality and social domains. In addition, the activation of maladaptive schemas is considered to be an integral mechanism for the development of depressive symptoms (Clark, Beck & Alford, 1999).

During 1960s and 1970s, cognitive vulnerability to depression was viewed in terms of schemas that involved beliefs, attitudes and assumptions individuals held about themselves and the world around them (Clark et al., 1999). These schemas, which can also be referred to as predisposing factors, are not active until faced with external or internal stimuli that are congruent to the predisposing factors. When activation takes place, maladaptive schemas become effective, which may lead to

biased negativity. In return, biased negativities result in the use of less constructive modes of thinking. This biased negativity is an integral part of experiencing depressive symptoms (Clark et al., 1999).

During the mid-1980s, in the cognitive theory of depression's view of vulnerability, there was a shift of emphasis from "specific idiosyncratic negative schemas or assumptions" to "more general superordinate personality constellations or modes" (Clark et al., 1999, p.263). Possible vulnerability factors were identified as personality constructs: specifically sociotropy and autonomy (Beck, 1983, cited in Clark, Beck & Alford, 1999). However, in the cognitive model, it is not assumed that sociotropy and autonomy or other maladaptive schemas are the only contributors to the development of depressive symptoms. There are other vulnerability factors in the formation of depressive symptoms such as dependency, self-criticism, negative attributional style, low self-esteem, hopelessness, pessimistic explatory style, neuroticism, etc.; among which perfectionism is one (Hewitt & Flett, 1993). When these constructs interact with the maladaptive schemas of a person, then depressive symptoms may be formed. In addition, predepressive personality of a person, as proposed by cognitive theory, also contributes to the formation of depressive symptoms (Clark et al., 1999). Some people have characteristic ways of thinking about negative life events, themselves and the future, and this depressogenic cognitive style increases the risk of experiencing depressive symptoms. In other words, personal attributes and key personality traits have an influence on how people react to events that they experience (Hobfoll, 1988).

An important part of cognitive theory of depression is that personality traits just by themselves are not predisposing contributors to depressive symptoms; they increase the likelihood of risk for depressive symptoms. Any combination of genetic,

biological, personality and environmental factors may be necessary to activate a person's information system characterized by negativity (Clark et al., 1999). The probability of experiencing depressive symptoms is increased if maladaptive schemas and their connections are activated. In other words, an increased vulnerability to depressive symptoms occurs when a stressor matches a congruent maladaptive personality aspect (Clark et al., 1999).

The cognitive theory of depression has identified several hypotheses related to the vulnerability formulation, which is an important part of the theory (Clark et al., 1999). There are nine hypothesis of the Cognitive Model of Depression. Among these nine hypotheses, the first three are: Stability, Depression Onset and Depression Recurrence. These three hypotheses are about the cognitive constructs and processes which play an important role in the predisposition and maintenance of depression. Research on the vulnerability aspects of the cognitive model concentrates on these three hypotheses. The remaining 6 hypotheses of Cognitive Model of Depression are the following: Self-Evaluation, Congruent-Processing, Relationship, Differential Coping, Symptom Specificity and Differential Treatment. However, of relevance to this study are two hypotheses, which are Depression Onset and Differential Coping since this study is interested in coping, perfectionism, and life events.

The Depression Onset Hypothesis states that: "a negative event that matches the content of the prepotent self-schemas and maladaptive personality constellation associated with the primal loss mode will lead to a heightened risk of depression onset in people with no previous diagnosable depression" (Clark et al., 1999, p.268). The Differential Coping Hypothesis states that: "maladaptive coping responses and compensatory strategies will play a more significant role in depression when personality-event congruence is present than when personality-event incongruence is

present" (Clark et al., 1999, p. 268). These hypotheses are related to personality traits, life events, and coping.

There are some important issues related to these hypotheses. First one is the fact that the occurrence of life events by themselves is not enough; rather it is the perception; meaning how individuals appraise or evaluate events, that can form a depressive response. Actually, perception is a critical mediating factor between the personality and the depressive property of the stressor. In the diathesis-stress model, it is stated that the meaning an event has for a person, is what determines the potential of a stressor to elicit depressive symptoms (Clark et al., 1999). Another important issue is that for each personality dimension, there are adaptive as well as maladaptive characteristics. In other words; when a person experiences a stressor which is negative, susceptibility to depression takes place if the individual has a maladaptive schema. On the other hand, if an individual who experiences a negative stressor has more adaptive schemas, then the individual will show resistance to depression (Clark et al., 1999). Thirdly, in the cognitive model it is stated that the only pathway to depression is not just the interaction of a congruent event and a present cognitive vulnerability. According to cognitive theory of depression, depressive symptoms are formed by any combination of biological, genetic, stress or personality factors; or in other words, by multiple causal factors.

In addition, it should be stated that according to the cognitive model, a cognitive vulnerability or diathesis is considered to be a "moderator" variable in the relationship between negative life events and depression (Clark et al., 1999). Baron and Kenny (1986) (cited in Clark et al., 1999, p. 294) define a moderator as:

> "… qualitative (e.g., sex, race, class) or quantitative (e.g., level of reward) variable that affects the direction and / or strength of the relationship between an independent or predictor variable and a dependent or criterion variable"

The concept of a moderator and mediator is defined as follows: a moderator affects the causal relation between two variables but a mediator, on the other hand, accounts for the relationship between a predictor and the criterion variable (Clark et al., 1999). A mediator can be defined as a psychological factor that may change the significance of a specific activator that has potential to cause depressive symptoms. Mediators help to explain why some people seem to experience many potential stressors without having any consequences, while others experience many consequences (Elliot & Eisdorfer, 1982). To provide an example, Kwon and Oei (1992, cited in Clark, Beck & Alford, 1999) tested a model in which dysfunctional attitudes act as a moderator between life events perceived as negative and depression, whereas negative automatic thoughts act as a mediator. They have found that, dysfunctional attitudes as a moderator interact with negative life events to affect the occurrence of depressive symptoms, and negative automatic thoughts mediate or transmit the impact of negatively perceived life events to affect the occurrence of depressive symptoms (Clark et al., 1999).

Research has shown that both mediating and moderating effects have been found for coping and perfectionism (Flett & Hewitt, 2002; Clark et al., 1999; Folkman & Lazarus, 1984).

As a summary, it can be stated that certain vulnerability factors play an important role in the development of depressive symptoms according to the diathesis-stress model of Cognitive Theory of Beck (Muris et al., 2001).

B- Life Events

According to cognitive theory of Beck (1969, p.275), during their lives, people develop a variety of concepts and attitudes about themselves and the world

around them. Some of these concepts and attitudes are based on reality and these help the individual to form a healthy adjustment. However, some of these concepts and attitudes are not based on reality and they cause vulnerabilities to possible psychological disorders (Beck, 1969). The people who become sensitive to certain types of life events become prone to depression. In other words, according to Beck (1969), it can be said that some people who are more likely than others to experience depressive symptoms have vulnerabilities/dispositions that result from their enduring negative attitudes about themselves, about the world and also about their future.

According to Beck (1969), whether a person will become depressed or not actually depends on whether at a given time he necessary conditions exist to activate the "depressive constellation" the person has, which are stressors such as life events.

Every individual is unique. No two people are the same. As a result, people show different reactions to similar events and reach different conclusions. However, each individual shows consistencies in the way s/he reacts to similar events (Beck, 1969). According to the Cognitive Theory, people who are prone to depressive symptoms or to depression have certain cognitive patterns of thinking (Beck, 1969). These patterns of thinking may become activated if certain events which place stress upon the vulnerabilities of the individual take place. When these cognitive patterns become activated, they are likely to dominate the thinking process of the individual and lead to depressive symptoms (Beck, 1969).

As a summary, in the Diathesis-Stress Model of Cognitive Theory, the importance of congruent stressors in the activation of vulnerabilities, which is an integral part of the theory, is stressed (Clark et al., 1999).

Individuals who experience stressful events have an increased risk of developing a physical or mental disorder (Elliot & Eisdorfer, 1982). However,

although it is generally accepted that life events, are likely to result in experiencing depressive symptoms, a debate in literature continues to exist about the strengths and weaknesses of the major approaches in the assessment of depressive symptoms (Steptoe, A & Appels, A., 1989). However, a large body of research has established an important link between the occurrence of stressful major life events and the onset of depressive disorders. Stressors play an important role in both the onset and the course of depressive symptoms (Clark et al., 1999).

Most life event researchers agree that cognitive factors play an important mediating role in the life event-depression relationship; which means that the meaning individuals attach to a stressful event will determine its impact on the individual (Hammen, 1985, cited in Clark, Beck & Alford, 1999).

Stress research on personal attributes has focused on the self in relation to the environment and it has been found that negative life events have an impact on almost all people; yet personality factors may affect how long the effects of these events last for. Overall, results of research investigating the aspects of the self in relation to the environment indicate that the way individuals view themselves, or in other words perception, in interaction with the environment, affect the resistance of people to stress (Hobfoll, 1988). People who perceive life events negatively appear to be more prone to experiencing further stressful circumstances (Hobfoll, 1988).

It should be noted that according to the diathesis-stress model of depression, the occurrence of life events by itself does not provide a sufficient explanation for the onset or reoccurrence of depressive symptoms. More recent research has been directed towards investigating possible predisposing factors or diatheses that may interact with life events to explain individual differences in susceptibility to depression (Clark et al., 1999).

C- Coping

Coping behavior is described as "the characteristic manner in which the individual deals with his social and physical environment, particularly as he mobilizes his resources to handle stress" in the Dictionary of Psychology (1985).

Stress and coping are a part of everyday life (Endler & Parker, 1990). When a person experiences negative and/or stressful life events, what determines psychological well-being is the coping styles or strategies that s/he uses (Endler & Parker, 1990). In the past, coping was viewed as a defense mechanism. However, in later literature coping is viewed as a response to stressful or negative life events (Lazarus & Folkman, 1984). Studies showed that unsuccessful coping may lead to depressive symptoms and depressive symptoms are characterized in turn by particular styles of coping.

During the last decade, Folkman and Lazarus have been active researchers in the field of coping (Endler & Parker, 1990). They define coping as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Hobfoll, 1988; Folkman & Lazarus, 1984). According to them, coping serves two main functions and as a result, a two-part distinction of coping has been formulated. These are emotion-focused coping and problem-focused coping. Emotion-focused coping includes efforts to regulate emotional reactions to stressors cognitively. Problem-focused coping, on the other hand, consists of those efforts aimed at directly managing or altering the source of distress (Endler & Parker, 1990; Lazarus & Folkman, 1984; Hobfoll, 1988). Other researchers have formed different categorizations of coping. Yet, if it can be said that a consensus in coping literature

exists, then it exists in the area of the distinction between emotion-focused coping and problem-focused coping (Endler & Parker, 1990).

Until around 1999s, the cognitive theory did not place importance on the role of coping strategies in the formation of depressive symptoms (Clark et al., 1999). According to the diathesis-stress model of depression, coping plays a secondary but significant role in the cognitive predisposition to depression (Clark et al., 1999).

In the Cognitive Theory of Depression, "states versus traits" is an important topic of debate in personality dysfunction research (Hirschfeld, 1997). Cognitive theory is interested in two levels of coping. The first one is automatic compensatory strategies. These are related to responses to basic needs and goals of the individual such as survival, independence, sociability, intimacy and mastery and become active through threats to these needs and goals. These strategies are named as compensatory strategies by the Cognitive Theory, and whether a compensatory strategy is adaptive or maladaptive will depend on the personality trait and the schemas of the individual (Clark et al., 1999). The second level of coping is coping style, which just like compensatory strategies, is linked to schemas and personality traits of the person and is activated by stressors that are congruent. Compared to automatic compensatory strategies, coping styles are much more conscious, voluntary, and requiring effort and the application of a coping style includes the perception of a problem and cognitive effort. As a summary, coping style can be described as the intentional and deliberate problem-solving strategies people use to deal with a life event (Clark et al., 1999).

According to the Differential Coping Hypothesis of Diathesis-Stress Model, individuals are more likely to use compensatory strategies and coping responses to highly significant negative and/or stressful life events that are congruent to their

schemas and vulnerabilities (cited in Clark, Beck & Alford, 1999). Research carried out until now on differential coping styles in cognitive and personality vulnerabilities to depressive symptoms are not enough to have consistent conclusions. There is some evidence that different intentional coping styles may characterize sociotropy and autonomy, but the stability of these response styles across time, situations, and mood state is unknown. It is also likely that the presence of a congruent life stressor will greatly influence whether adaptive or maladaptive coping responses are evoked. The relationship between dysfunctional attitudes and coping style also remains uncharted by depression researchers (Clark, Beck & Alford, 1999).

Research on coping suggests that coping has a mediating role between stressful life events and its outcomes, such as depressive symptoms, anxiety and psychological distress (Endler & Parker, 1990; Folkman & Lazarus, 1984).

A study by Erseven Yılmaz (1993), aimed to investigate the relationship between stress, psychopathology and coping strategies with a "normal" or in other words nonclinical sample of university students. Rosenbaum's Learned Resourcefulness Schedule (RLRS) was used to assess coping strategies, whereas Global Symptom Index (GSI) was used to assess psychopathology. The results showed that there was a significant negative correlation between the scores of RLRS and GSI.

A study by Muris et al. (2001) was carried out to investigate the role of various protective and vulnerability factors in the development of depressive symptoms. The results showed that among other factors, depressive symptoms were accompanied by passive coping, and by low levels of active coping. In general, coping styles are accepted to be a protective factor for mental health, based on the assumption that they help the person to overcome stressful life events. However,

some coping styles do not help to protect people; rather they enhance people's vulnerabilities to psychological disorders (Muris et al., 2001). Literature supports the view that depressive symptoms are accompanied by higher levels of passive coping and lower levels of active coping (Muris et al., 2001; Folkman & Lazarus, 1984). In addition, depressive symptoms are negatively associated with problem-focused coping, but positively associated with emotion-focused coping (Muris et al., 2001; Folkman & Lazarus, 1984).

A study by Ravindran et al. (2002), investigated the relationship of stress, coping, uplifts and quality of life. The results showed that depressive symptoms are associated with increased stress perception and use of emotion-focused coping styles. The depressive groups were found to have higher perceptions of daily hassles and reliance on emotion-focused coping style. In addition, among the depressive group, the hassles, and coping styles were related to symptom severity.

In 1995-1996, Zeynep Tokay-Özdamar, Derya Şayan and Süheyla Zubaroğlu conducted a large scale research for BÜREM, with a sample of 1833 Boğaziçi University students using stratified sampling technique. Their observation was that majority of students getting psychological help from BÜREM were mainly coming with two psychological states: depressive symptoms and anxiety. Suicidal tendencies, low self-esteem, nonassertiveness, financial difficulties, fear of failure both academically and socially were the reasons of referral by approximately 50% of the students. The aim of the study was to identify the psychological symptoms and stressors for the students and their ways of coping with these stressors. Based on their observations the authors especially addressed the high depression and anxiety groups. In addition they examined the difference of high depression and anxiety groups from the low depression and anxiety groups in terms of coping styles. Two

instruments and a demographic form were used for this study. The instruments used were Brief Symptom Inventory (BSI) (Turkish adaptation by Şahin and Durak, 1994) and Coping Style Scale (CSS) (Shortened Turkish form by Şahin and Durak (1995) from the ways of coping Inventory from Folkman and Lazarus (1980)). The CSS has five subscales which are optimism, self-confidence, submission, helplessness and seeking social support. The nine subscales of BSI are somatization, obsessive-compulsiveness, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiet1y, paranoid ideation, and psychotism. In addition, high and low depression and anxiety groups were formed by distinguishing the students falling in the first 25 percentile and the fourth 25 percentile of depression and anxiety scales.

The results of the study showed that the highest mean was found for obsessive –compulsiveness followed by depression and hostility on BSI. On CSS, the highest mean was for self-confidence, followed by optimism. The lowest mean value was found for helplessness subscale.

Analysis of variance in terms of demographic variables for the low depression group showed that no significant differences were found for gender. However, analysis of variance in terms of demographic variables for the high depression group showed that significant differences were found for gender. It was found that males showed less depressive symptoms compared to females. Pearson Product Moment correlations for the low depression group showed significant ($p<.05$) but low positive correlation with helplessness (.1525) and negative correlation with optimism (-.1127) and self-confidence (-.1236). For high depression group, there are significant ($p<.05$) positive correlations with submission (.1173) and helplessness (.3376) and negative correlations with optimism (- .2110) and self-confidence (- .2465). In addition, the low depressed group was found to be less

submissive and helpless while being more optimistic and self-confident according to the results of CSS.

As a summary, it can be stated that female students seem to be more depressed than male students as for the high depression groups; the depression scores of females are higher than males. Another important result of the study was that high and low depression groups made use of different coping styles.

D- Perfectionism

Studies have found that perfectionism is associated with psychological distress (O'Connor & O'Connor, 2003; Flett & Hewitt, 2002). It can be said that perfectionism is a factor in "predisposing, precipitating, and prolonging" depressive symptoms and depression among university students and other populations (Flett & Hewitt, 2002; Hewitt et al., 2003). In addition, perfectionism is a personality construct that has shown some evidence of diathesis-stress effects in predicting depressive symptoms (Dunkley et al., 2000).

The construct of perfectionism has been receiving a good deal of attention recently and literature agrees that perfectionism should be accepted as a multidimensional concept (O'Connor & O'Connor, 2003; Flett & Hewitt, 2002). Yet, there is considerable debate concerning which components of perfectionism increase the risk of psychopathology.

Perfectionism has been conceptualized as a multidimensional construct, with both adaptive and maladaptive aspects (Wei, Mallinckrodt, Russell & Abraham, 2004; Flett & Hewitt, 2002). Adaptive perfectionism is about setting high but achievable personal standards. It can be described as a desire to achieve more and to be better with a motivation to achieve positive rewards, in addition to preferring

order and organization. Maladaptive perfectionism, on the other hand, involves unrealistically high standards. It can be described as an intense concern over mistakes, perceived pressure from others to be perfect. Usually it is accompanied by a sense of large discrepancy between one's performance and personal standards, compulsive worry about one's actions, and also a motivation to avoid negative consequences (Enns & Cox, 2002).

Hewitt & Flett (1991) proposed a multidimensional model of perfectionism. The model consists of three dimensions which are: "self-oriented" perfectionism, "other-oriented" perfectionism and "socially-prescribed" perfectionism. "Self-oriented" perfectionism can be described as the need to attain high self-standards which are based on achievement. The other dimensions are based on an interpersonal orientation. "Other-oriented" perfectionism can be described as the need for others to be perfect, and "socially-prescribed" perfectionism can be described as the belief that other people expect perfection from one's self.

Perfectionism is positively associated with depressive symptoms. "Self-oriented perfectionism" has been found to show a specific interaction with negative achievement events in predicting depressive symptoms. In addition evidence, although less consistent, has been found between "socially-prescribed" perfectionism and negative interpersonal events (Hewitt & Flett, 1993; Hewitt, Flett & Ediger, 1996, cited in Clark, Beck & Alford, 1999). However, "other-oriented perfectionism" has been found to be uncorrelated with depressive symptoms as its focus is not on the deficiencies of oneself, but rather it has an external focus (Hewitt & Flett, 1993, cited in Clark, Beck & Alford, 1999).

How coping style interacts with perfectionism to predict depressive symptoms has been an area of interest for the last decade. First of all, literature

suggests that some of the vulnerability associated with perfectionism may only be activated by the presence of moderating factors, such as stress (Hewitt & Flett, 1993; O'connor et al., 2002; Rice & Lapslye, 2001; cited in O'connor & O'connor, 2003). Such hypotheses drive from the diathesis-stress literature that argues psychological vulnerabilities, when activated by stress, result in depression, hopelessness and suicide ideation. Coping styles, the behavioral and cognitive responses that individuals use when they encounter stressors, have also been shown to have moderating effects. There are studies that support the relationship between "maladaptive" coping responses and psychological distress. However, there are only a few studies that have investigated how coping and perfectionism interact to predict psychological stress (cited in O'connor & O'connor, 2003). Dinç (2001) investigated the predictive role of perfectionism on depressive symptoms and anger, negative life events as the moderator on a sample of university students in Turkey. It was found that life events were positively correlated with socially-prescribed perfectionism.

The evidence suggests that certain dimensions of perfectionism are associated with maladaptive coping, whereas other dimensions are related to adaptive components. In 1995, Hewitt et al. assessed 121 psychiatric in-and-out patients from a large psychiatric hospital on measures of perfectionism, coping and depression. The results suggested that self-oriented perfectionism and emotion-oriented coping were positively associated with depressive symptoms. In addition it was found that emotion-oriented coping interacted with self-oriented perfectionism to predict depressive symptoms.

Some other studies have found that perfectionism and coping predicted emotional adjustment but have not found evidence for moderating effects. Another study with college students did not find any interaction between coping and

perfectionism. However, O'connor & O'connor (2003) found that the dimensions of perfectionism are predictive of hopelessness and psychological distress, and that these relationships are moderated via coping styles. To sum up, in the study evidence was found that the relationship between perfectionism and distress was moderated by coping style.

O'Connor & O'Connor (2003) carried out a study to investigate a model that involved the relationship between perfectionism and coping to predict changes in hopelessness and general psychological distress among university students. The results indicated that changes in psychological well-being of university students were predicted by socially-prescribed perfectionism. In addition, under certain conditions, self-oriented perfectionism was shown to be maladaptive in addition to the findings that indicate the adaptive effects of cognitive reconstruction coping. Finally, evidence was found that the relationship between perfectionism and distress was moderated by coping style.

Hewitt and Flett (2002) argued that perfectionism could serve as a moderator, as well as mediator, between insecure attachment and depressive mood. Several studies have found that specific dimensions of perfectionism, specifically socially-prescribed perfectionism, hers to be perfect) interacted with stress to predict increased depressive symptoms. In other words, more depressive symptoms were experienced by people who experienced both higher levels of perfectionism and perceived stress. In addition, in other studies reported that specific dimensions of perfectionism interacted with specific stressors to predict higher levels of depression. Hewitt and Flett (1993) found that perfectionism, particularly in the form of perceived pressure from others to be perfect, interacted with interpersonal stressors to predict depressive symptoms. The results imply that maladaptive perfectionism

could serve as a potential moderator of the relationship between general or specific stressors and psychological distress caused by these stressors (Wei, Mallinckrodt, Russell & Abraham, 2004).

Literature has shown that how people perceive stressors, how they cope and the personality traits they have all effect whether they experience depressive symptoms as the Cognitive theory of Depression states. As supported by research, among university students'experinces of depressive symptoms, perception of life events, coping styles and strategies and perfectionism play an important role.

III- STATEMENT OF THE PROBLEM AND RESEARCH QUESTIONS

This study's aim was to analyze the different categories of depressive symptoms in terms of perceived intensity of life events, coping styles and strategies, and perfectionism dimensions; the effect of coping in terms of styles and strategies, as measured by SBTÖ and RÖGÖ respectively, on the relationship between the perceived intensity of life events in terms of their stressfulness and depressive symptoms; the effect of dimensions of perfectionism on the relationship between the perceived intensity of life events in terms of their stressfulness and depressive symptoms, as well as to analyze the effect of coping in terms of styles and strategies as measured by SBTÖ and RÖGÖ respectively, and dimensions of perfectionism on the relationship between perceived intensity of life events in terms of their stressfulness and depressive symptoms, among B.U. students.

The research questions are:

1) Is there any difference between students who are not depressed and as well as those in different categories of depressive symptoms as measured by BDE in terms of perceived intensity of life events (as measured by ÜÖYO-Y), coping styles (as measured by SBTÖ), coping strategies (as measured by SBTÖ), and perfectionism dimensions (as measured by ÇBMÖ)?
2) Does the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms change according to

   A- coping styles as measured by SBTÖ?

   B- coping strategies as measured by RÖGÖ?

3) Does the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms change according to dimensions of perfectionism as measured by ÇBMÖ?
4) Does the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms change according to
   A- coping styles as measured by SBTÖ and dimensions of perfectionism as measured by ÇBMÖ?
   B- coping strategies as measured by RÖGÖ and dimensions of perfectionism as measured by ÇBMÖ?

IV –METHODOLOGY

A-Sample

The target population of this study was 2004-2005 Academic Year, second semester students of B.U. The total number of students was based on 2004-2005, first semester student statistics. There are six faculties that the students of B.U. can attend, which are Faculty of Arts and Sciences, Faculty of Education, Faculty of Engineering, Faculty of Economics and Administrative Sciences, Faculty of Applied Sciences and School of Foreign Languages (English Preparatory Division). English Preparatory Division is made up of three levels, which are: Beginner, Intermediate and Advanced. The total number of students and their distribution according to faculties and gender is given in Table 1.

Table 1: *Distribution of B.U. Students according to Faculty and Gender*

	Females		Males		Total number
FACULTIES	*n*	*%*	*n*	*%*	*n*
Education	873	53.40	763	46.60	1636
Arts & Sciences	1251	62.50	752	37.50	2003
Economics & Administrative Sciences	470	32.50	978	67.50	1448
Engineering	422	22.00	1494	78.00	1916
Applied Disciplines	285	36.60	494	63.40	779
School of Foreign Languages (English Preparatory Division)	717	45.60	854	54.40	1571
Total	4018	43	5335	57	9353

During the 2004-2005 academic year, first semester, B.U. had a total number of 9,353 undergraduate students. In addition, 1571 students were from English Preparatory Division. However, information acquired from the university more

recently (personal contact with the Director of English Preparatory Division, April 2005) has shown that only 1127 students in the English Preparatory Division continued their education in preparatory class during second semester. Table 2 shows the distribution of English Preparatory Division students according to English adequacy level; in terms of Beginner, Intermediate and Advanced.

Table 2: *Distribution of Attending Students from English Preparatory Class according to Levels*

English Preparatory Class	*N of Students*
Beginner	354
Intermediate	560
Advanced	213
Total	1127

Stratified sampling procedure was employed. The aim was to reach 10% of the students from each faculty. Although attempted, all faculties of the university could not be represented proportionally as some of the teachers contacted did not approve collection of data in their classes based on time or schedule constraints. As a result, some faculties were underrepresented and some overrepresented.

For this study, students were asked to fill out a questionnaire and data was gathered from 1142 participants. Among these 1142 questionnaires, some had too many missing items. For participants with less than 10% missing items for a measure, their mean has been calculated and missing items have been replaced with the mean value. However, the data from students whose number of missing items exceeded tolerance level (over 10% of missing variables in a measure) were eliminated. As a result, data from 53 participants were eliminated and data from 1089 participants were statistically analyzed for this study. Participants were students from

English preparatory class (beginner, intermediate, advanced), first, second, third, fourth and fifth year students.

Table 3 shows the planned frequency distribution of participants according to stratified sampling and faculties, compared to frequency of actual data.

Table 3: *Distribution of Participants according to Faculties Based on Stratified Sampling*

	Planned		Actual	
FACULTIES	*n*	*%*	*n*	*%*
Education	164	10	425	25.97
Arts & Sciences	200	10	90	4.49
Economics & Administrative Sciences	145	10	44	3.03
Engineering	192	10	137	7.15
Applied Disciplines	78	10	107	13.71
School of Foreign Languages (English Preparatory Division)	157	10	286	18.20
Total	936		1089	

As can be seen from the table, Faculty of Economics and Administrative Sciences (3.03%), Faculty of Arts and Sciences (4.49%), and Faculty of Engineering (7.15%) have been underrepresented while Faculty of Applied Disciplines (13.71%), School of Foreign Languages (18.20%), and Faculty of Education (25.97%) were overrepresented.

In addition, although the aim was collecting data from 936 participants to represent 10% of the whole population, data from 1089 participants were collected during the study. In other words, 11.64% of the population was represented in this study.

The frequency and percentage distribution of participants according to grade level can be seen in Table 4. A total number of 285 participants were from English Preparatory Division, followed by 263 second grade participants, 212 third grade, 185 first grade and 140 fourth grade participants.

Table 4: *Distribution of Participants according to Grade Levels*

GRADE LEVEL	*n*	*%*
Prep- Beginner	107	9.80
Prep- Intermediate	109	10.00
Prep- Advanced	69	6.30
Freshman (1st year)	185	17.00
Sophomore (2nd Year)	263	24.20
Junior (3rd Year)	212	19.50
Senior (4th Year)	140	12.90
Fifth Year	4	0.40
Total	1089	100

During data collection, demographic information was gathered from participants by the Demographic Information Form (See Appendix A). The characteristics of the sample are presented in this section. As can be seen in Table 5, 52.20% of the participants were female, and 47.80% were male, whereas 43% of the target population is female and 57% is male. In this study, females have been overrepresented and males have been underrepresented.

Table 5: *Distribution of Participants according to Gender*

GENDER	*n*	*%*
Female	568	52.20
Male	521	47.80
Total	1089	100

The mean age of the total sample was 21.1, with a range from 17 to 39. The median was 21, the mode being 21 and standard deviation 1.983. Most of the subjects' age was 21 (23.30%). The number of participants who were 21 years old was 256, followed by 201 participants at the age of 19; 191 participants at the age of 22; 164 participants at the age of 20; 120 participants at the age of 23; 51 participants at the age of 24 and 50 participants at the age of 18.

Regarding nationality, 95.20% of the participants were from Turkish nationality, whereas 4.80% of the participants were from other countries.

In terms of high schools that the participants graduated from, the highest percentage belonged to Anatolian High Schools and Anatolian Teacher High Schools both by 28.20%. These two types of schools are followed by Science High Schools with 10.70%. The frequency and percentage distribution can be seen in Table 6.

Table 6: *Distribution of Participants according to Type of High School They Graduated from*

High School	*n*	*%*
Anatolian High School	307	28.20
Private Foreign College	31	2.90
Lycee	54	5.00
Vocational School	63	5.80
Anatolian Teacher High School	307	28.20
Religious High School	4	0.40
Technical School	15	1.40
Private Turkish High School	72	6.60
Science School	116	10.70
Super School	50	4.60
Secondary Education High School	3	0.30
Others	65	6.00
Total	1097	100

In terms of parent education, as can be seen in Table 7, the most frequent level of education for fathers is university education (30.50%), followed by primary school (23.20%), and high school (20.90%) ; whereas for mothers, the most frequent educational level is primary education (34.10%), followed by high school (23.10%) and university education (17%).

Table 7: *Distribution of Parent Education*

	Father Education		Mother Education	
Parent Education Level	*n*	*%*	*n*	*%*
Illiterate	4	0.40	58	5.40
Literate (not Primary School graduate)	19	1.80	51	4.70
Primary sc. Graduate	250	23.20	367	34.10
Secondary sc. Graduate	105	9.70	84	7.80
High sc. Graduate	225	20.90	248	23.10
Vocational sc. Graduate	83	7.70	64	6.00
University graduate	328	30.50	183	17.00
Master's Degree	40	3.70	15	1.40
Doctorate Degree	23	2.10	5	0.50
Total	1077	100	1075	100

In addition, the participants were asked to state their income sources in terms of the type of source and to rank their first three sources of income. Table 8 shows the frequency of income sources in terms of how many sources the students are using as means of income. According to results, 48% of students are getting financial help from two sources followed by 42.40% from one source, and 9.60% from three sources. As the first source of income, out of 1076 participants, 876 (81.40%) stated getting financial help from family, followed by 173 (16.10%) participants stating scholarship and 24 (2.20%) stating self-employment. As the second source of income, out of a total number of 627 participants, 490 (78.10%) stated scholarship, followed by 105 (16.70%) participants stating self-employment, and 16 (2.60%) stating financial help from relatives. As the third source if income, out of 104 participants, 73 (70.20%) stated self-employment, followed by 28 (26.90%) stating financial help from relatives.

Table 8: *Distribution of Participants according to Number of Income Sources*

Number of Income Sources	*n*	*%*
0	13	1.20
1	449	41.20
2	523	48.00
3	104	9.60
Total	1089	100

In terms of residence, Table 9 shows that 38% of the participants lived in the dormitories of Boğaziçi University, followed by living with family (28%), and sharing a house with friends (22.30%). Of the 408 participants who lived in the dormitories of Boğaziçi University, 58.30% resided in North Campus dorms, 14.20% in the South Campus dorms, 8.80% in Superdorm, 7.40% in Kilyos, 6.10% in Uçaksavar, 2.70% in private dorms, and 2.50% in government dorms.

Table 9: *Distribution of Participants according to Residence*

Place of Residence	*n*	*%*
With family	301	28.00
With a family member or relative	56	5.20
Alone	28	2.60
With friends	240	22.30
Private dormitory	28	2.60
B.U. Dorm	408	38.00
Other	13	1.20
Total	1074	100

When asked if they received any psychological help themselves, 86.60% of the participants reported that they did not receive any professional psychological help, whereas 13.40 % stated that they did. In addition, 87.60% of the participants

stated that none of their family members received any psychological help while 12.40% stated that their family members received psychological help (See Table 10).

Table 10: *Distribution of Participants according to Getting Professional Psychological Help: for Themselves or by Family Members*

Psychological Help	YES		NO		Total	
	n	*%*	*n*	*%*	*n*	*%*
Myself	144	13.40	932	86.60	1076	100
My Family Members	133	12.40	941	87.60	1074	100

The frequency distribution of receiving psychological help for self and psychological help received by family members can be seen in Figure 1.

Fig. 1: D*istribution of Participants according to Receiving Psychological Help for Self and the Reception of Psychological Help by Family Members*

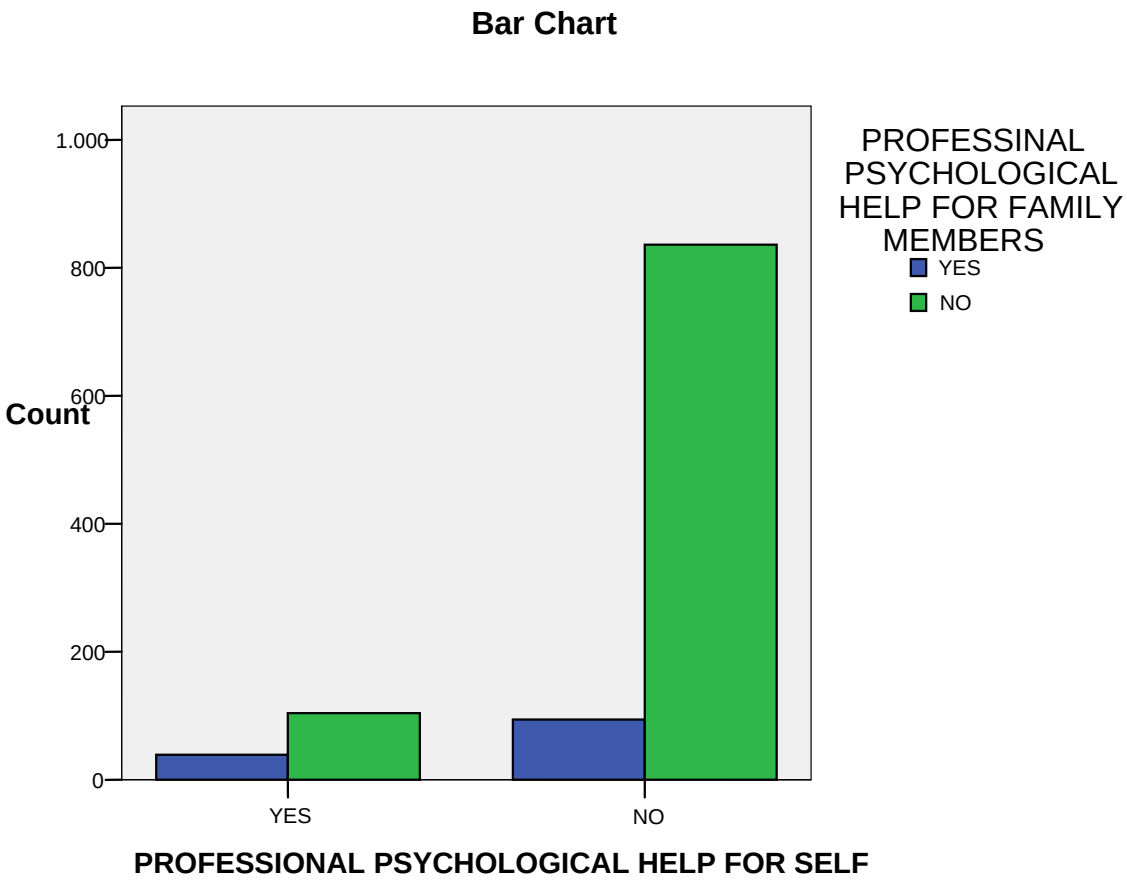


Table 11 shows the crosstabulation for receiving psychological help, in terms of participants themselves and the family members of the participants. As can be seen from the table, the families of 27.30% of the participants received psychological help while the participants also received psychological help; whereas the families of 72.70% of the participants did not receive psychological help while the participant did. In addition while the participant did not receive any psychological help, 10.10% of the family members did and 89.90% of the family members did not. The results show that the likelihood of students, who are coming from families “receiving

psychological help" to receive professional psychological help is almost three times more likely than students not coming from families receiving psychological help.

Table 11: *Crosstabulation for Receiving Professional Psychological Help by Participants Themselves and by Family Members*

			Family Members Receiving Psychological Help		
			YES	NO	Total
Receiving Psychological Help for myself	YES	*n*	39	104	143
		%	27.30	72.70	100
	NO	*n*	94	836	930
		%	10.10	89.90	100
	Total	*n*	133	940	1073
		%	12.40	87.60	100

In addition, the correlation between receiving psychological help for self and family members receiving psychological help is .18 ($p < .01$).

Table 12: *Correlation between Receiving Psychological Help for Self and Family Members Receiving Psychological Help*

	Receiving Psychological Help for Self *r*	Receiving Psychological by Family Members *r*
Receiving Psychological Help for Self	1	.18****
Receiving Psychological Help by Family Members	.18****	1

****p<.001

B- Instruments

1) Demographic Information Form (DIF) (Demografik Bilgi Formu - DBF) (*See Appendix A*): Demographic Information Form was prepared by the present researcher, with the help of the thesis committee, to get demographic information about the participants such as gender, nationality, age, high school, faculty, department, grade level, parental education, sources of financial support, place of residence, and whether professional psychological help had been received by the participant and his/her family members.

The data was used to define the characteristics of the participants.

2) Life Events Inventory for University Students (LEIU) (Üniversite Öğrencilerine Yönelik Yaşam Olayları Ölçeği -ÜÖYO) *(See Appendix B)*: The original form of LEIU (ÜÖYO), developed by Oral in 1999, was developed for a master's thesis ("The relationship between dimensions of perfectionism, stressful life events and depressive symptoms in university students, "a test of diathesis-stress model of depression") and measured daily stresses of university students, especially the frequency of specific hassles and life events experienced by students. It was a 49-item 5 point Likert type scale, with 1 representing 'never' and 5 representing 'always'. Oral reported that the stress factors for university students of this measure also overlapped with findings of other studies, and also with the items of Daily Hassles Scale (Oral, 1999).

Factor analysis was carried out to see the factor structure of ÜÖYO and to differentiate between different categories of events such as: interpersonal, achievement, etc. However, the results showed that it was not possible to

differentiate the events into categories. As a result, in the end it was decided to use the scale as a homogeneous measure to assess life events of university students.

With item-total correlation coefficients ranging between .19 and .64, and internal consistency of .90, ÜÖYO was found to be a reliable measure. In terms of validity, the scale was found to have high validity with a correlation of .52 ($p<.01$) between Beck Depression Inventory and the scale.

Oral stated that an important limitation of the measure was that with this inventory, it was not possible to adequately test the diathesis-stress model of depression (Oral, 1999, p.61). The measure assessed the frequency of life events experienced by university students; yet, it did not measure the perception of events by the subjects. For diathesis-stress model, the perception of events as stressful is an important concept. Just experiencing an event does not mean that a person will be stressed by that event. Consequently, in Oral's study, the frequency of events was measured whereas Oral also wanted to assess the distress caused by encountering those events. Following the statement of this limitation, Oral suggested that instead of developing a new scale, ÜÖYO could be revised to assess the perception of subjects. She suggested, distress multiplied by frequency of events could be used to measure the stress value of events. With the suggested change, Oral believed that ÜÖYO could be used as a stress measure for university students.

In 2002, Yasemin Dinç, in her master's thesis "Predictive role of perfectionism on depressive symptoms and anger: negative life events as the moderator" modified ÜÖYO according to Oral's suggestions. Intensity scores of the life events were used in Dinç's study instead of frequency scores. In addition, several items were added to the original form, where some domains were underrepresented. The items added were item numbers 32, 50, 51, 52 and 53. Also item number 54 was

changed from “being unable to adapt to Ankara” to “being unable to adapt to the place that I live in” (Dinç, 2001). With Dinç’s work, ÜÖYO now has 54 items and the answer format has two sections. First section asks the subjects their perception of the intensity of the event as stressful and the second part asks the subjects their perception of the frequency of the stressful event. The minimum score for a section is 54, and the maximum is 270.

The factor analysis of ÜÖYO in Dinç’s study yielded two internally reliable factors. The first factor was “achievement related life events” and the second was “social life events”.

Reliability studies for the scale showed that for the total scale, the Cronbach alpha value was 90.77, whereas for the achievement-related events Cronbach alpha was 88.33 and for social life events it was 86.14 (Dinç, 2001).

3) Beck Depression Inventory (Beck Depresyon Envanteri- BDE) *(See Appendix C)*:

Beck Depression Inventory (BDI) is a self-report depression inventory that is among the most frequently used in assessing depression (Williams, 1992, p.79). It was developed by Aaron T. Beck in 1961, first as an interview scale. The interviewer used to read each sentence aloud to the patient while the patient had his own copy and gave his choice. Now, BDI is used as a self-rating scale (Williams, 1992, p.79).

BDI consists of 21 clinically derived items; each item representing a symptom-attitude category or in other words, each describing a particular manifestation of depression. The subject chooses the statement that best describes his/her present state. Each item has four self-evaluative statements that are ranked in varying degrees of severity. The statements are ranked from 0 to 3 to indicate the severity of the symptom and attitude.

The 21 symptom-attitude categories are: “mood”; “pessimism”; “sense of failure”; “lack of satisfaction”; “guilty feelings”; “sense of punishment”; “self-dislike”; “self accusations”; “suicidal wishes”; “crying spells”; “irritability”; “social withdrawal”; “indecisiveness”; “distortion of body image”; “work inhibition”; “sleep disturbance”; “fatigability”; “loss of appetite”; “weight loss”; “somatic preoccupation”; and “loss of libido” (Beck, 1969, p.189).

The minimum score that can be obtained is 0, and the maximum score is 63. The subjects’ total score on BDI represents a combination. It is the combination of the number of symptom categories and the severity of the particular symptoms (Beck, 1969, p.189). However, the cut-off points of the scale are somewhat arbitrary and different researchers report different cut-off points. An important dimension in this issue is the characteristics of the target population as Beck (1974a) stated that the specific cut-off scores depend upon the characteristics of the sample and the purpose of the study. Beck’s original system is as the following: 0-13: not depressed; 14-24: medium level of depression; and 25≥ : severely depressed. Other researchers found different cut-off points. Rush et al. (1981) and Murphy et al. (1984) used the following classifications for severity: 0-9: “not depressed”; 10-15: “mildly depressed”; 16-24: “moderately depressed”; 25+: “severely depressed”. According to Psychology Department of Norwich Area Health authority, the cut-off scores are: 0-9: “normal”; 10- 19: “mild-moderate”; 19-30: “moderate-severe”; 30-63: “severe”.

Reliability of the BDI was analyzed through two methods for evaluating the internal consistency. The split-half reliability is around .90, and the test-retest reliability is .75. In addition, BDI has been consistently found to correlate well with clinicians’ ratings of depression severity, as well as with other scales of depression (Williams, 1992, p.79). For the validity of the inventory, concurrent and construct

validity were used and BDI was found to correlate .65 with clinicians' ratings (Beck, 1969, p.197). The relationship between BDI and Hamilton Rating Scale was evaluated and Spearman Rank correlation coefficient of .75 was found between the measures. In distinguishing between depression and anxiety, BDI was also found to be effective. In a study done by Beck, it was found that BDI scores correlated .59 (Pearson r) with clinical ratings of depression and .14 with clinical ratings of anxiety (Beck, 1969).

Compared to other scales, BDI has been reported to have the advantage of being useful across a great range of severity levels and in clinical, subclinical and student populations.

After the revision, studies to determine cut-off points of BDI were carried out again. Meites, after a study with university students in 1980, determined the cut-off points for revised version of Beck Depression Inventory as: 0-10: "mild depression"; 11-20: "moderate depression"; 21> "severely depressed"; whereas Bryson (1984), also after a study with university students, determined the cut-off points as: 0-9: "not depressed"; 10-15: "mildly depressed", 16-23: "moderately depressed"; 24-63: "severely depressed".

The Turkish adaptation of the original Beck Depression Inventory was carried out by Teğin (1980) who conducted a study to determine the reliability and validity of BDI for the Turkish Population. Teğin, with a 15 day interval, found a test-retest reliability value of .65 for 40 normal undergraduates. The internal consistency of the inventory was found through split-half correlations: for undergraduates it was .78 and for depressive patients it was .61. Concurrent validity was determined and patients who were previously identified as "depressive" were correctly identified with the inventory (Teğin, 1980).

Hisli-Şahin (1988) translated the revised version of the Beck Depression Inventory in 1984 with a different name, “Beck Depresyon Envanteri “contrary to Teğin’s “Beck Depresyon Ölçeği” adaptation. “Beck Depresyon Envanteri” was accepted as a reliable and valid instrument, for both clinical and nonclinical samples, after studies carried out to test the reliability and validity of the inventory.

Both adaptations are widely used in Turkey. Fatma Zengin, in 1999, investigated both of the adaptations in a study in terms of reliability and validity on the same sample for her master’s thesis: “Beck Depresyon Ölçeği- BDÖ” adapted from the original Beck Depression Inventory- BDI by Teğin (1961) and “Beck Depresyon Envanteri- BDE” adapted from the revised BDI (1978) by Hisli-Şahin (1984-89). In addition, Zengin also reanalyzed the items of the short form of the BDI that were derived from the revised one, from the data of the BDE as a preliminary step for the adaptation of the BDE- Kısa Form, BDE- KF. The sample consisted of 100 female and 61 male students adding up to a total number of 161 university students. Different test orders were used during the study: half of the participants took the tests in the order of the BDE, MMPI-D, and BDÖ while the other half took the tests in reverse order.

As a result of the study, it was found out that in terms of internal consistency, item-total correlations, correlations with the MMPI-D and factorial discrimination of symptom groups reported by Beck, BDE, BDÖ and BDE-KF were all reliable and valid instruments. However, although the mean scores of the BDE were almost the same in both test-taking orders, the mean scores of BDÖ changed significantly. As a result of the test-taking order in the paired and independent sample, sample t-tests of corresponding items in the BDÖ had more items that were significantly different.

Zengin (1999), according to research findings, concluded that in addition to being the adaptation of the revised BDI, BDE is more stable and consistent across different test-taking orders. Because of these reasons, it is recommended that BDE should be preferred.

In the light of Fatma Zengin's findings, for this study BDE was used. The cut-off points were determined according to certain criterion: this study was carried out with university students, the cut-off points were to be chosen among studies done with university students and a classification that distinguishes the depression levels more accurately was chosen. As a result, Bryson's (1984) scoring was used as criterion to assess levels of depression. Specifically; 0-9: "not depressed"; 10-15: "mildly depressed", 16-23: "moderately depressed"; 24-63: "severely depressed".

4) Coping Styles Inventory (CSI) (Stresle Başa Çıkma Tarzlar Envanteri -SBTÖ) *(See Appendix D)*: Coping Style Inventory (CSI) was developed by Şahin and Durak in 1995, derived from the Ways of Coping Inventory of Folkman and Lazarus. Coping processes are measured by Ways of Coping Inventory (WAYS). The WAYS can assess and identify thoughts and actions that individuals use to cope with the stressful events of everyday living. It has 8 subscales which are: "confrontive coping", "distancing", "self-controlling", "seeking social support", "accepting responsibility", "escape-avoidance", "planful problem solving", and "positive reappraisal". (Folkman & Lazarus, 1980; Folkman & Lazarus, Ways of Coping Questionnaire Manual). The scale has 67 items and it is a 4 point Likert type scale (0= "Not used", 1= "used somewhat"; 2= "used quite a bit"; 3= "used a great deal"). The subjects are asked to choose a situation first and then to read each item and

circle the most appropriate category for them; to what extent they use this in the situation they have just described (Lazarus & Folkman, 1984, p.328).

The adaptation of the Ways of Coping Inventory into Turkish was done by Siva in 1991. Some changes were done in the question format during the process. In addition, Siva added eight new items relevant to Turkish culture. As a result, the final measure had 74 items.

Desiring to form an inventory that measures coping styles, not strategies; Şahin and Durak formed the SBTÖ (Şahin & Durak, 1995). SBTÖ is intended to measure the coping styles of university students which are related to depression, loneliness and other psychological measures.

SBTÖ is a 30 item 4-Likert type scale (1= 0% applicable, 4= 100% applicable). The scale has a five factor and two dimension structure. The dimensions are: "problem oriented/effective style" and "emotion oriented/ineffective style". The factors are, "self-confidence" (items 8, 10, 14, 16, 20, 23, 26), "optimistic" (items 2, 4, 6, 12, 18), "submissive" (items 5, 13, 15, 17, 21, 24), "helpless" (items 3, 7, 11, 19, 22, 25, 27, 28) and "seeking of social support" (items 1, 9, 29, 30; 1 and 9 are the reversed items). Each factor is calculated by separately taking their average (Şahin & Durak, 1995).

Şahin and Durak (1995) carried out a pilot study to develop the inventory, and used Ways of Coping Inventory (WCI), Beck Depression Inventory (BDE), UCLA- Loneliness Scale, Stress Indicators Scale (Stres Belirtileri Ölçeği), and Scale for Stress-Related factors (Stresle İlişkili Faktörler Ölçeği). In the end, several items of Ways of Coping Inventory were deleted, the number of items being reduced to 30.

Three studies with different samples and purposes, which also made use of different instruments, were carried out to investigate the reliability, validity and

factor structure of SBTÖ (Şahin & Durak, 1995). The five factors of the CSI were identified as a result. For the three studies, the reported internal consistency coefficient ranged between .45 to .80. In addition results showed that the lowest reliability was found for “seeking social support” factor (mean alpha=.46) whereas the highest was found for “self-confidence” factor (.62 to.80, mean alpha= .73), followed by “helpless” (mean alpha=.68), “submissive” (mean alpha=.63), and “optimistic” factors (mean alpha=.61) (Kublay, 2001).

The five factors were classified into two dimensions after studies done to test construct validity, with different university samples. The dimensions were; “problem-oriented / effective style” and “emotion-oriented / ineffective style”. “Problem-oriented / effective style” includes “self-confidence” and “optimistic” factors whereas “emotion-oriented / ineffective style” includes “submissive” and “helpless” factors. The last factor, which is “seeking social support”, was considered to be belonging to both dimensions.

Şahin and Durak (1995) also compared the SBTÖ with BDI to test criterion-related validity. At the end of the analyses, the following correlations were found: between BDI and “optimistic” factor, a correlation coefficient value of - .18; “self-confidence” -.25; “helpless” .41; and “submissive” .19 (Şahin & Durak, 1995, p.64).

In the end, the results indicated that ”People who had more psychological symptoms used more “emotion- oriented coping” styles, while the ones who had less psychological symptoms used more “problem-solving oriented coping” styles” (Şahin & Durak, 1995, p.70).

Also, gender comparisons revealed that females were more inclined than males to seek social support (Şahin & Durak, 1995, p.56).

5) Rosenbaum's Learned Resourcefulness Schedule (RLRS), Turkish Form (Rosenbaum'un Öğrenilmiş Güçlülük Ölçeği- RÖGÖ) *(See Appendix E):* Developed by M.A. Rosenbaum in 1980, RLRS assesses how effective a person can cope with stress evoking life events; or in other words, the level of cognitive strategies used by a person to cope with stress and the skill to control yourself (Savaşır & Şahin, p.86).

According to Rosenbaum, learned resourcefulness is a reflection of a person's mainly cognitively learned repertoire of behaviors and skills that are used by the person to cope with internal stimuli such as emotions, cognitions, or pain. While the measure was developed, variables were chosen among techniques used to train people to cope better with stress (Savaşır & Şahin, p.10). What is measured by RLRS is: a) the use of cognitions to control unpleasant emotional and physical reactions; b) application of problem-solving strategies; c) ability to delay gratification; d) self-efficacy about self-control (Williams, 1992, p.82).

RÖGÖ is a self-report questionnaire, which can also be used with groups. It is suitable for people older than 17 who have at least graduated from secondary-school. There is no time limit for the measure. However, the estimated time it takes to fill the measure is 15 minutes.

It is a 36 item, Likert type scale, with scores ranging from 1 to 5, from "very uncharacteristic of me" to "very characteristic of me" ("very uncharacteristic of me"= 1, "a little"= 2, "good enough"= 3, "well"= 4, "very characteristic of me"= 5). The subjects respond to "How well does this sentence represents you?" by choosing the option that best describes him on the 5 point scale. In the original form, RLRS, the scores ranged from –3 to 3. However, because of the complexity of the system, it has been changed to scoring between 1 and 5.

There are reverse items in the measure which are item numbers: 4, 6, 8, 9, 14, 16, 18, 19, 21, 29, and 35. The minimum score of RÖGÖ is 36, whereas maximum score is 180.

Studies done with the original thirty-six item scale show that higher scores on this measure have been found to be a predictor of good response to cognitive therapy. In addition another finding is that low scores predicted a good response to antidepressant medication (Williams, 1992, p.82).

The Cronbach alpha value for the original RLRS range between .48 to .82. Test-retest reliability values range between .77 and .86. In terms of reliability, at the lowest level .51 internal consistency has been found.

Higher scores represent better skills to control oneself, or in other words, higher scores mean that the coping skills represented by the measure are more frequently used.

Siva has translated the Schedule into Turkish. After that, RLRS has been adapted to Turkish by Siva and Dağ, under the name of Rosenbaum's Öğrenilmiş Güçlülük Ölçeği (RÖGÖ) (Siva, 1991; Dağ, 1991).

The Cronbach alpha internal reliability score for RÖGÖ was .78 as found in a research carried out with a sample of 532 people. Item-total correlation has been found to range between .11 and .51, each being significant. 5th and 21st items have been found significant at the $p<.01$ level, whereas other items have been found significant at the $p<.001$ level in the study of Dağ in 1991. Siva has found the Cronbach alpha level as .79 in a study with a sample of 100 people. Test-retest reliability has been found to be .80.

In terms of concurrent validity, it was found that RÖGÖ correlated significantly with Rotter Internal-External Inventory (r=-.29; $p<.01$). For construct

validity, factor analysis was carried out and 12 factors were found to explain 58.20% of the variation (*n*=532). These 12 factors are: acting with a plan ("planlı davranma"); mood control ("ruh hali denetimi"), controlling unwanted thoughts ("istenmeyen düşüncelerin denetimi"), controlling impulses and acting planned ("dürtü denetimi ve planlı davranma"); self-adequacy and calming yourself ("yeterli olma ve kendini yatıştırma"), pain control ("ağrı denetimi"), delaying ("erteleme"), seeking support ("yardım arama"), being optimistic ("iyiye yorma"), directing concentration ("dikkati yönlendirme"), changeable planning ("esnek planlama"), controlled seeking ("denetleyici arama").

Siva found that RÖGÖ scores and BDI scores were negatively correlated; as learned resourcefulness increased, depressive symptoms lessened. In another study done by Dağ in 1991, it was hypothesized that lower scores on learned resourcefulness scale would be related to higher psychopathological symptoms. As a consequence, scores of learned resourcefulness and "general symptoms" scores of Symptom Screening List (Belirti Tarama Listesi) (SCL-90 R) have been analyzed only to be found negatively correlated, with a moderate magnitude (r= -.28).

6) Multidimensional Perfectionism Scale (Çok Boyutlu Mükemmelliyetçilik Ölçeği-ÇBMÖ) *(See Appendix F):* Hewitt and Flett (2002) consider perfectionism a multidimensional construct, with both personal and interpersonal aspects and identified dimensions directed towards either the self or others, as well as a third dimension which is based on the belief that other people are imposing unrealistic demands on self (Flett & Hewitt, 2002).

In 1989, Hewitt and Flett developed the Multidimensional Perfectionism Scale (MPS) which measures three dimensions of perfectionism: "self-oriented

perfectionism", "other-oriented perfectionism" and "socially-prescribed perfectionism" (Hewitt & Flett, 1989).

Initially, MPS was developed in relation to university students, but later studies were carried out with different populations and they proved the reliability and validity and structure of the scale for both normal and clinical samples (Hewitt & Flett, 1991). MPS is a 45 item, 7 point Likert type scale; with points ranging from disagree to agree. There scale has reverse items which are: 2, 3, 4, 8, 9, 10, 12, 19, 21, 24, 30, 34, 36, 37, 38, 43, 44 and 45. Each subscale of MPS has 15 items and can range from 15 to 105. Higher scores on each scale represent greater levels of perfectionism. "Self-oriented perfectionism" is represented by items 1, 6, 8, 12, 14, 15, 17, 20, 23, 28, 32, 34, 36, 40, 42; "other-oriented perfectionism" by items 2, 3, 4, 7, 10, 16, 19, 22, 24, 26, 27, 29, 38, 43, 45; and "socially-prescribed perfectionism" by items 5, 9, 11, 13, 18, 21, 25, 30, 31, 33, 35, 37, 39, 41, and 44.

Hewitt and Flett (1991), for undergraduate students' samples, reported the internal reliability coefficients for the three dimensions as: for "self-oriented perfectionism" .86; for "other-oriented perfectionism" .87 and for "socially-prescribed perfectionism" as .82.

Also, item subscale and subscale coefficients were found to vary between .51 and .73 for "self-oriented" items, between .43 and .64 for "other-oriented" items and between .45 and .75 for "socially-prescribed" items. The factor structure of the MPS showed that all of the items of "self-oriented perfectionism" were converged under the first factor with item loading between .45 and .66. The items of "socially prescribed perfectionism" were converged under the second factor with item loading between .39 and .69 and 13 items of "other-oriented perfectionism" were converged under the third factor with factor loading between .38 and .63. Two items of this

dimension had factor loadings between .24 and .32 on “socially-prescribed perfectionism” factor but slightly higher factor loading on the second factor.

Construct and discriminant validity of the scale has been shown in large scale studies. The scale has been compared with other related personality variables such as narcissism, irrational beliefs, self-blame, locus of control, irrational beliefs, fear of negative evaluation, dysfunctional attitudes, sociotrophy, autonomy, and with different psychopathological conditions (Hewitt & Flett, 1991). They have also found that scores of subjects were not influenced by response biases, or social desirability and the dimensions were found to be observable to others.

Muradiye Oral, in 1999, translated MPS into Turkish for her thesis “The Relationship between dimensions of perfectionism, stressful life events and depressive symptoms in university students: a test of diathesis model of depression”, under the name of “Çok Boyutlu Mükemmelliyetçilik Ölçeği (ÇBMÖ)”. A pilot study was carried out first to test the factor structure and the reliability of the translated MPS with Turkish university students.

Based on the results obtained from the pilot study, Oral (1999) made some modifications on the translations and used the scale in her study. Just like Hewitt & Flett (1991), Oral found three dimensions for ÇBMÖ. These dimensions matched the dimensions of MPS. The three factors Oral found explained 37% of the variance in the study of Oral with 333 METU students. The alpha coefficients were found to be .91 for “self-oriented perfectionism”, .73 for “other-oriented perfectionism” and .80 for “socially-prescribed perfectionism” (Oral, 1999).

In 2001, Yasemin Dinç, in her thesis “Predictive role of perfectionism on depressive symptoms and anger: negative life events as the moderator” used ÇBMÖ as one of her instruments. Dinç also carried out a factor analysis study for the scale

and found a three-factor solution. The three factor Dinç found explained 66.46% of the variance. The obtained factor structure was found to be similar to both the original scale and the results of Factor Analysis of MPS in Oral's study.

The Cronbach alpha values for "self-oriented perfectionism" was found to be 90.13, for "other-oriented perfectionism" it was 74.09, and "socially-prescribed perfectionism" it was 83.47 (Dinç, 2001).

C- Procedure

First of all, permission was obtained from the President of Boğaziçi University to apply the questionnaire to Boğaziçi University students. Teachers were contacted both by email as well as personally by phone to give information about the research and to get permission for data collection in class.

Data was gathered in three different ways. According to the time constraints and permission of the faculty member, data was collected either during class hours, or by distribution of the questionnaires to students at the beginning of the class and collecting them next class hour or asking them to be returned to the researcher. Last method was true only for a limited number of questionnaires, which involved the distribution of the questionnaires in the dormitories and collection after 45 minutes, by students who were residing in dorms and were trained by the researcher. Data was collected during the month of May, mainly during class hours as explained above. The time to fill out the questionnaire varied according to participants, with a minimum of twenty-five minutes to a maximum of one hour. All the participants were informed about the main aim of the study and provided information about their right to refuse to fill the questionnaire and their rights to privacy. No names were taken and they were informed that the information gathered would only be used for

research purposes. In addition, instructions about how to fill the questionnaire were also provided to students at the beginning of administration both orally and also in written format. The students were also asked to answer all questions in the questionnaire and to be honest about their answers. Three students declined to fill the questionnaire while the rest of the students volunteered.

D-Design

This study is a field survey, which uses a cross-sectional approach. There is one dependent variable in the study which is depression as assessed by BDE. The independent variables are coping in terms of "problem-oriented/effective style" and "emotion-oriented/ineffective style" as measured by SBTÖ and coping strategies as measured by RÖGÖ; dimensions of perfectionism in terms of "self-oriented", "other-oriented" and "socially-prescribed" perfectionism; and perceived intensity of life events in terms of their stressfulness. The interrelationships of these variables are investigated by using Structural Equation Modeling (SEM) on a sample that consisted of Boğaziçi University undergraduate students

SEM is a statistical methodology aiming to investigate causal relationships through causal modeling, which is mostly used in non-experimental research. In this study, it was used to investigate three types of relationships between the variables. The types of relationships are: 1) direct effect of designated variables on the dependent variable; 2) indirect effect of designated variables on the dependent variable; 3) the association between variables.

SEM argues for the plausibility of postulated relations and takes a confirmatory approach. It is used effectively with data analysis process for inferential purpose (Eryiğit, 2004 & İlimsever Başarır, 2002).

SEM has two components, the measurement model and the structural model. Measurement model is the component of the general model, in which latent variables are prescribed. In other words, it is the link between latent and observed variables. On the other hand, structural model is the component of the general model that prescribes relations between latent variables, or in other words, the link among the latent variables. Pictorially, variables in ellipses are latent variables, which mean unobserved ones. They are measured through the factors of each variable. In the models, this kind of a relationship is shown by the single headed arrow which goes from latent variable to its factor (measurement component of the model). Variables in rectangular shape show these factors, which is measured variables (Eryiğit, 2004, p.36-7).

Fig. 2A represents the structural component of the hypothesized general model of this study; in terms of coping styles as measured by SBTÖ. It explores the direct effect of coping styles, dimensions of perfectionism, perceived intensity of life events in terms of their stressfulness on depressive symptoms, as well as the indirect effect of coping styles and dimensions of perfectionism on the relationship between perceived intensity of life events in terms of their stressfulness and depressive symptoms.

Fig. 2B represents the structural component of the hypothesized general model of this study; in terms of coping strategies as measured by RÖGÖ. It explores the direct effect of coping strategies, dimensions of perfectionism, perceived intensity of life events in terms of their stressfulness on depressive symptoms, as well as the indirect effect of coping strategies and dimensions of perfectionism on the relationship between perceived intensity of life events in terms of their stressfulness and depressive symptoms.

Fig. 2A: *Hypothesized General Model- Structural Component, according to SBTÖ*

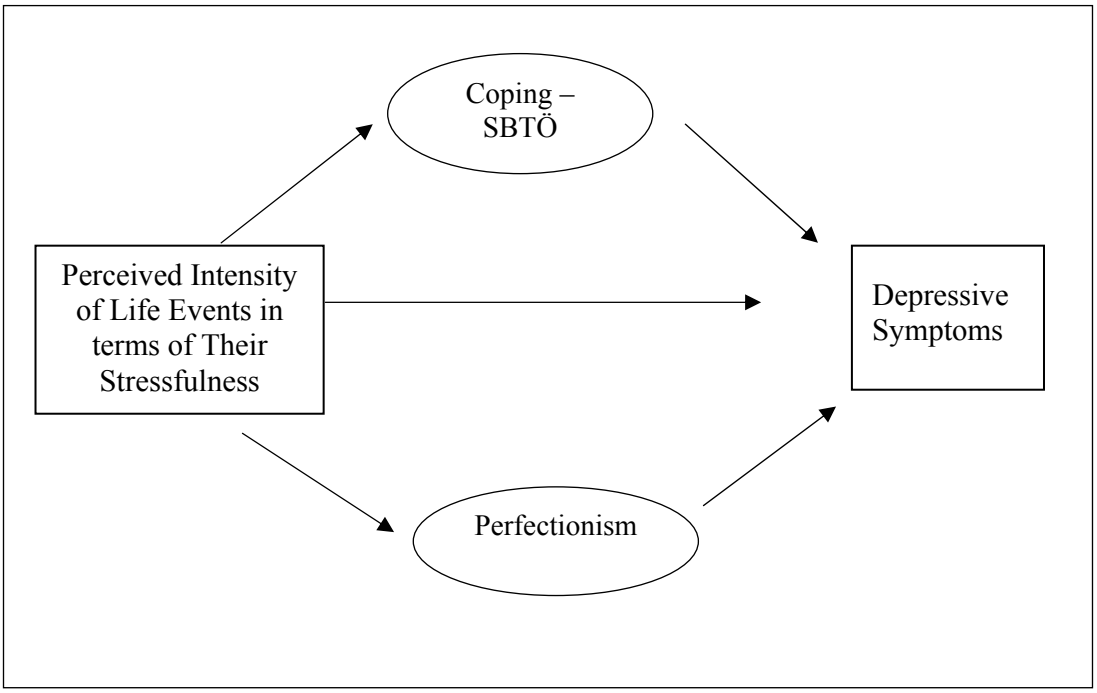


Fig. 2B: *Hypothesized General Model- Structural Component, according to RÖGÖ*

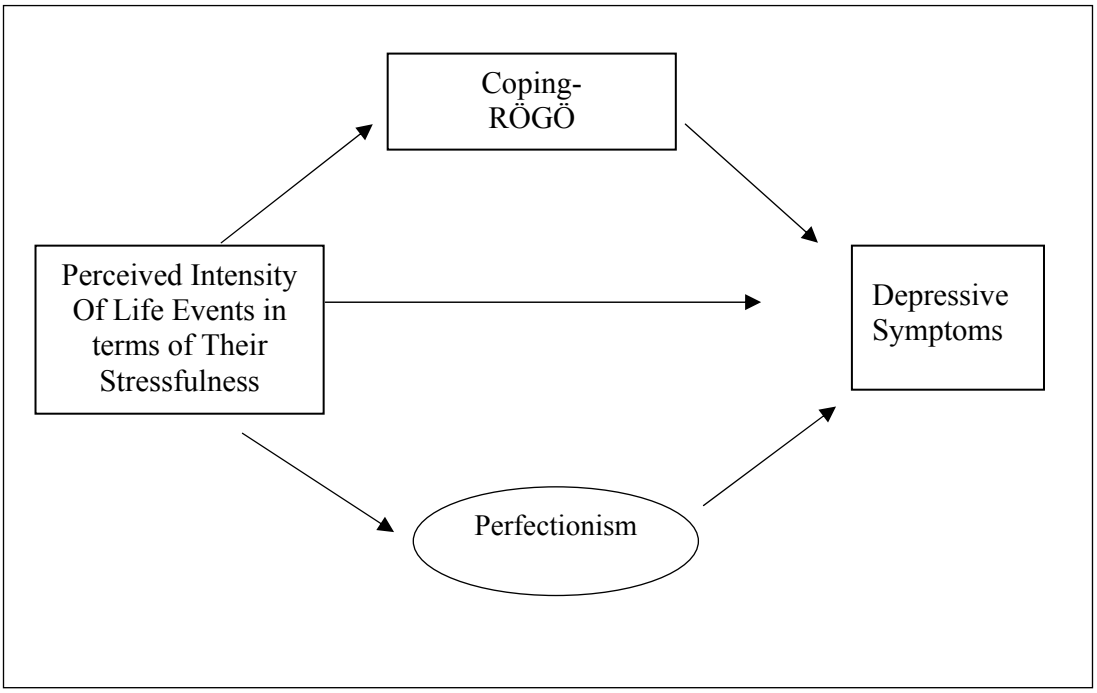


Fig. 3A shows the hypothesized general model including both measurement and structural components. In this model, depressive symptoms is the endogenous

variable (dependent variable). The exogenous variables (independent variables) are coping styles, as measured by SBTÖ, and its dimensions of "problem-oriented/effective style" and "emotion-oriented/ineffective style"; perfectionism and its dimensions of "self-oriented", "other-oriented" and "socially-prescribed"; and perceived intensity of life events in terms of their stressfulness.

Fig. 3A: *Hypothesized General Model, according to Coping Styles*

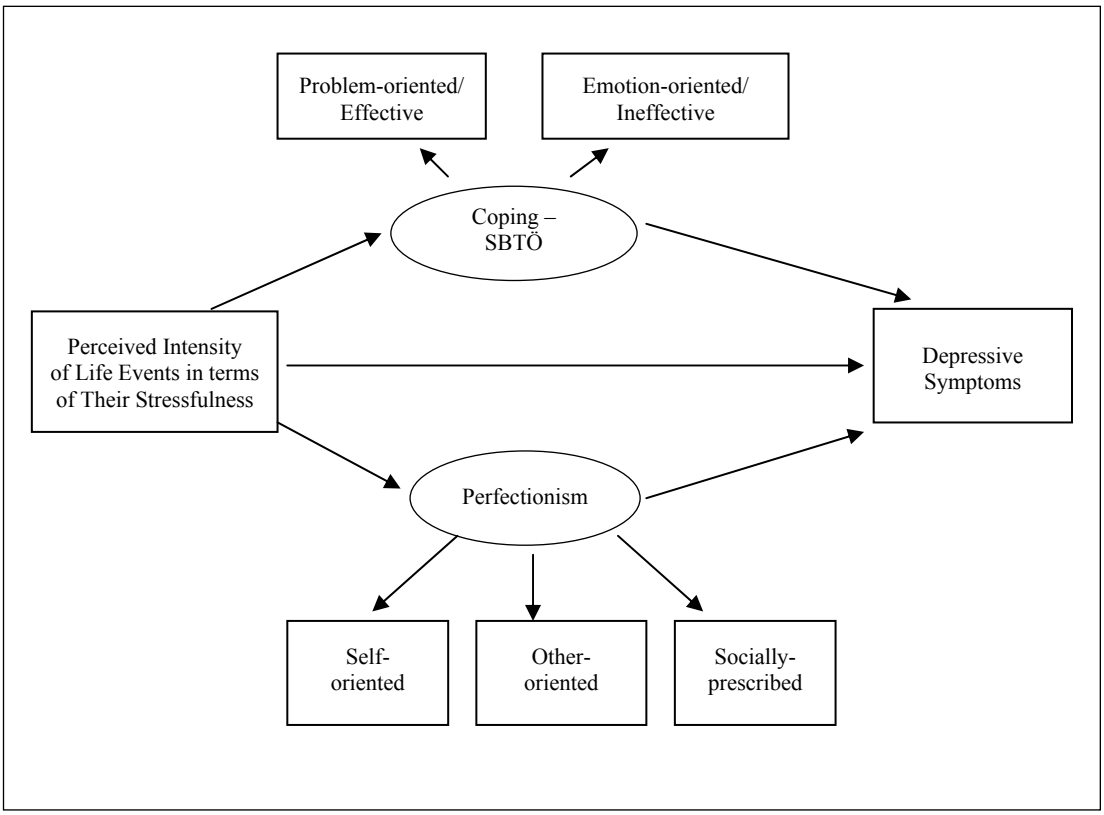
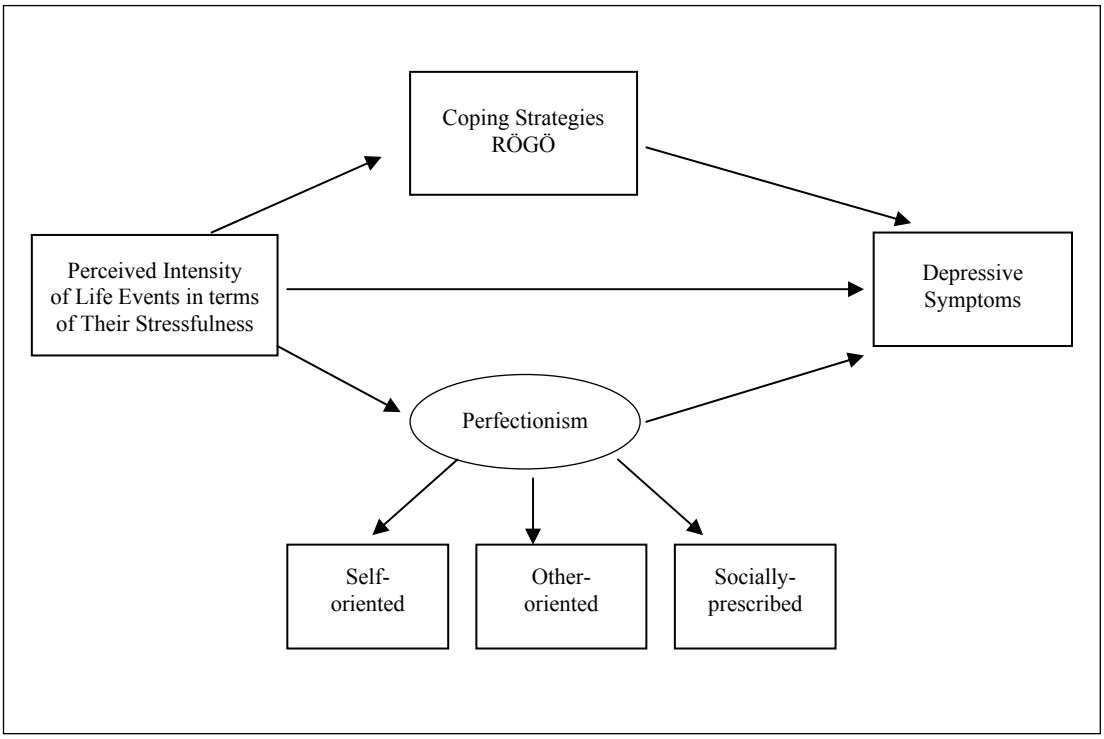


Fig. 3B shows the hypothesized general model including both measurement and structural components. In this model, depressive symptoms is the endogenous variable. The exogenous variables are coping strategies, as measured by RÖGÖ; perfectionism and its dimensions of "self-oriented", "other-oriented" and "socially-prescribed"; and perceived intensity of life events in terms of their stressfulness.

Fig. 3B: *Hypothesized General Model, according to Coping Strategies*



V -- RESULTS

In this chapter, the data analysis results related to variables and research questions of this study are given. First, the correlation matrix was formed. Then, results of descriptive statistics for variables are stated; the mean values and standard deviations of each variable were calculated for this. Results according to research questions are presented next. In the last part, regression analysis is stated. Data analysis of this study was done with SPSS 13.0 and AMOS 4.0.

A- Correlation Matrix

Correlation Matrix was calculated to see the relations between the scores of the perceived frequency of life events (ÜÖYO-S), the perceived intensity of life events in terms of their stressfulness (ÜÖYO-Y), two dimensions of SBTÖ ("Problem-oriented/effective": SBTÖ-PO; "Emotion-oriented/ ineffective": SBTÖ-EO), RÖGÖ, dimensions of ÇBMÖ ("self-oriented": ÇBMÖ-SO, "other-oriented": ÇBMÖ-OO; "socially-prescribed": ÇBMÖ-SP) and BDE. Table 13 shows the correlation values.

Table 13: *Correlation Matrix*

	ÜÖYÖ-Y	ÜÖYO-S	BDE-T	RöGö-T	SBTÖ-Conf	SBTÖ-Optim	SBTÖ-Sumiss.	SBTÖ-Helpless	SBTÖ-Soc.Sup.	SBTÖ-PO	SBTÖ-EO	ÇBMÖ-SO	ÇBMÖ-OO	ÇBMÖ-SP
ÜÖYÖ-Y	1	.894**	,555**	-.189*	-.175**	- .218**	.206**	.445**	-.016	-.219**	.385**	.075*	,089**	.294**
ÜÖYO-S	.894**	1	.560**	-.230**	-.199**	-.241**	.176**	.432**	-.025	-.245**	.361**	.049	.056	.292**
BDEt-T	.555**	.562**	1	-.323**	-.325**	-.320**	.245**	.473**	-.116**	-.358**	.424**	.031	.018	.232**
RÖGÖ-T	-.189**	-.230**	-.323**	1	.587**	.512**	-.166**	-.322**	.0500	.608**	-.288**	.233**	.104**	-.117**
SBTÖ- Conf.	-.175**	-.199**	-.325**	.587**	1	.627**	-.206**	-.327**	.100**	.896**	-.313**	.241**	.104**	-.087**
SBTÖ- Optim	-.218**	-.241**	-.320**	.512**	.627**	1	.014	-.304**	.034	.908**	-.180**	.009	-.026	-.091**
SBTÖ- Subm.	.206**	.176**	.245**	-.166**	-.206**	.014	1	.489**	-.067*	-.103**	.844**	-.086**	-.061*	.161**
SBTÖ- Helpls	.445**	.432**	.473**	-.322**	-.322**	-.304**	.489**	1	.002	-.349**	.881**	.061**	.041	.238**
SBTÖ- Soc S.	-.016	-.025	-.116**	.050	.100**	.034	-.067*	.002	1	.073*	-.036	-.026	.014	-.110**
SBTÖ-PO	-.219**	-.245**	-.358**	.608**	.896**	.908**	-.103**	-.349**	.073*	1	-.271**	.135**	.041	-.099**
SBTÖ-EO	.385**	.361**	.424**	-.288**	-.313**	-.180**	.844**	.891**	-.036	-.271**	1	-.010	-.008	.234**
ÇBMÖ-SO	.075*	.049	.031	.233**	.241**	.009	-.086**	.061*	-.026	.135**	-.010	1	.575**	.324**
ÇBMÖ-OO	.089**	.056	.018	.104**	.104**	-.026	-.061*	.041	.014	.041	-.008	.575**	1	.354**
ÇBMÖ-SP	.294**	.292**	..232**	-.117**	-.087**	-0.91**	.161**	.238**	-.110**	-.099**	.234**	.324**	.354**	1

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

As can be seen from Table 13, the correlation between perceived intensity of life events and frequency of life events, depressive symptoms, coping strategies, all factors of coping styles ("self-confidence", "optimistic", "submissive", "helpless", "seeking social support"), all dimensions coping styles ("problem-oriented" and "emotion-oriented"), and perfectionism: "self-oriented" and "other-oriented" dimensions; between frequency of life events and depressive symptoms, coping strategies, coping styles: "self-confidence", "optimistic", "submissive" and "helpless" factors, all dimensions of coping styles, and perfectionism: "socially-prescribed" perfectionism dimension; between depressive symptoms and coping strategies, all factors of coping styles, all dimensions of coping styles, and perfectionism: "socially-prescribed perfectionism" dimension; between coping strategies and coping styles: "self-confidence", "helpless", "optimistic", "submissive" and "helpless" factors, all dimensions of coping styles, and all dimensions of perfectionism ("self-oriented", "other-oriented", "socially-prescribed perfectionism" dimensions); between coping styles: "self-confidence" factor and all other factors of coping styles, all dimensions of coping styles, and all dimensions of perfectionism; between coping styles: "optimistic" factor and coping styles: "helpless" factor, all dimensions of coping styles, and perfectionism: "socially-prescribed perfectionism" dimension; between coping styles: "submissive factor" and coping styles: "helpless", "submissive" and "seeking social support" factors, between coping styles: "submissive" factor and all dimensions of coping styles, and all dimensions of perfectionism; between coping styles: "helpless" factor and all dimensions of coping styles, and perfectionism: "self-oriented" and "socially-prescribed perfectionism" dimensions; between coping styles: "seeking social support" factor and coping styles: "problem-oriented" dimension, and perfectionism:

“socially-prescribed perfectionism” dimension; between coping styles: “problem-oriented” dimension and coping styles: “emotion-oriented” dimension, and perfectionism: “self-oriented” and “socially-prescribed perfectionism” dimensions; between coping styles: “emotion-oriented” dimension and perfectionism: “socially-prescribed” dimension of perfectionism; between perfectionism: “self-oriented” dimension and all other dimensions of perfectionism, perfectionism: “socially-prescribed” perfectionism dimension; and between perfectionism: “other-oriented perfectionism” dimension and perfectionism: “socially-prescribed perfectionism” dimension were significant ($005<p<.01$).

However, the relationship between perceived intensity of life events and coping styles: “helpless” factor; between frequency of life events and coping styles: “seeking social support” factor, and perfectionism: “self-oriented” and “other-oriented perfectionism” dimensions; between depressive symptoms and perfectionism: “self-oriented” and “other-oriented perfectionism” dimensions; between coping strategies and coping styles: “seeking social support” factor; between coping styles: “optimistic” and coping styles: “submissive” and “seeking social support” factors, and perfectionism: “self-oriented” and “other-oriented perfectionism” dimensions; between coping styles: “helpless” factor and coping styles: “seeking social support” factor and perfectionism: “other-oriented perfectionism” dimension; between coping styles: “seeking social support” factor and coping styles: “emotion-oriented” dimension, and perfectionism: “self-oriented” and “other-oriented perfectionism” dimensions; between coping styles: “problem-oriented” dimension and perfectionism: “other-oriented perfectionism” dimension; and between coping styles: “emotion-oriented” dimension and perfectionism: “self-oriented” and “other-oriented perfectionism” dimensions were not significant.

ÜÖYO yields two scores: first is the score of perception of the intensity of the life events in terms of their stressfulness and the second is the score of the perception of the frequency of the life events. As can be seen from the table, the correlation between ÜÖYO-S and ÜÖYO-Y was .89 (p=.001). As a result, it was decided that they could be used interchangeably, and based on literature, the perceived frequency of life events (ÜÖYO-S) was taken out for this study. The perceived intensity of life events in terms of their stressfulness was kept as it was suggested by previous studies (Oral, 1999; Dinç, 2001).

After ÜÖYO-S was taken out, the new correlation matrix was calculated. Table 14 shows the values of the new correlation matrix.

Table 14: *Modified Correlation Matrix, without ÜÖYO-S*

	ÜÖYÖ-Y	BDEt-T	RÖGÖ-T	SBTÖ-Conf.	SBTÖ-Opt.	SBTÖ-Submis.	SBTÖ-Helpless	SBTÖ-Soc.Sup.	SBTÖ-PO	SBTÖ-EO	ÇBMÖ-SO	ÇBMÖ-OO	ÇBMÖ-SP
ÜÖYÖ-Y	1	.555**	-.189**	-.175**	-.218**	.206**	.445**	-.016	-.219**	.385**	.075*	.089**	.294**
BDEt-T	.555**	1	-.323**	-.325**	-.320**	.245**	.473**	-.116**	-.358**	.424**	.031	.018	.232**
RÖGÖ-T	-.189**	-.323**	1	.587**	.512**	-.166**	-.322**	.050	.608**	-.288**	.233**	.104**	-.117**
SBTÖ- Conf.	-.175**	-.325**	.587**	1	.627**	-.206**	-.327**	.100**	.896**	-.313**	.241**	.104**	-.087**
SBTÖ-Opt.	-.218**	-.320**	.512**	.627**	1	.014	-.304**	.034	.908**	-.180**	.009	-.026	-.091**
SBTÖ-Subm.	.206**	.245**	-.166**	-.206**	.014	1	.489**	-.067*	-.103**	.844**	-.086**	-.061*	.161**
SBTÖ- Helpless	.445**	.473**	-.322**	-.327**	-.304**	.489**	1	.002	-.349**	.881**	.061*	.041	.238**
SBTÖ- Soc. Sup	-.016	-.116**	.050	.100**	.034	-.067*	.002	1	.073*	-.036	-.026	.014	-.110**
SBTÖ-PO	-.219**	-.358**	.608**	.896**	.908**	-.103**	-.349**	.073*	1	-.271**	-.135**	.041	-.099**
SBTÖ-EO	.385**	.424**	-.288**	-.313**	-.180**	.844**	.881**	-.036	-.271**	1	-.010	-.008	.234**
ÇBMÖ-SO	.075*	.031	.233**	.241**	.009	-.086**	.061*	-.026	.135**	-.010	1	.575**	.324**
ÇBMÖ-OO	.089**	.018	.104**	.104**	-.026	-.061*	.041	.014	.041	-.008	.575**	1	.354**
ÇBMÖ-SP	.294**	.232**	-.117**	-.087**	-.091**	.161**	.238**	-.110**	-.099**	.234**	.324**	.354**	1

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

As can be seen from table 14, the correlation between perceived intensity of life events and depressive symptoms, coping strategies, coping styles: “self-confidence”, “optimistic”, “submissive” and “helpless” factors, all dimensions of coping styles (“problem-oriented”, and “emotion–oriented”), and all dimensions of perfectionism (“self-oriented”, “other-oriented” and “socially-prescribed” dimensions); between depressive symptoms and coping strategies, all factors of coping styles (“self-confidence”, “optimistic”, “submissive”, “helpless” and “seeking social support”), all dimensions of coping styles, and perfectionism: “socially-prescribed perfectionism” dimension; between coping strategies and coping styles: “self-confidence”, “optimistic”, “submissive”, “helpless”, all dimensions of coping styles and all dimensions of perfectionism; between coping styles: “self-confidence” and all other factors of coping styles, all dimensions of coping styles, and all dimensions of perfectionism; between coping styles: “optimistic” factor and coping styles: “helpless” factor, all dimensions of coping styles, and perfectionism: “socially-prescribed perfectionism” dimension; between coping styles: “submissive” factor and coping styles: “helpless”, and “seeking social support” factors, all dimensions of coping styles, and all dimensions of perfectionism; between coping styles: “helpless” factor and all dimensions of coping styles, and perfectionism: “self-oriented” and “socially-prescribed” perfectionism dimensions; between coping styles: “seeking social support” factor and coping styles: “problem–oriented” dimension, and perfectionism: “socially-prescribed” perfectionism dimension; between coping styles: “problem-oriented” dimension and coping styles: “emotion – oriented” dimension, and perfectionism: “self-oriented” and “socially-prescribed perfectionism” dimensions; between coping styles: “emotion-oriented” and perfectionism: “socially-prescribed” perfectionism dimension; between

perfectionism: “self-oriented perfectionism” dimension and all other dimensions of perfectionism; between perfectionism: “other–oriented perfectionism” dimension and perfectionism: “socially –prescribed perfectionism dimension” were significant.

However, the relationship between perceived intensity of life events and coping styles: “seeking social support” factor; between depressive symptoms and perfectionism: “self-oriented” and “other-oriented perfectionism” dimensions; between coping strategies and coping styles: “seeking social support” factor; between coping styles: “optimistic” factor and coping styles: “submissive” and “seeking social support” factors, and perfectionism: “self-oriented” and “other-oriented” perfectionism dimensions; between coping styles: “helpless” factor and coping styles: “seeking social support” factor, and perfectionism: “other-oriented perfectionism” dimension; between coping styles: “seeking social support” factor and coping styles: “emotion-oriented” dimension, and perfectionism: “self-oriented” and “other-oriented perfectionism” dimensions; between coping styles: “problem-oriented” dimension and perfectionism: “other-oriented perfectionism” dimension; and between coping styles: “emotion-oriented” dimension and perfectionism: “self-oriented” and “other-oriented perfectionism” dimensions were not significant.

B- Descriptive Analysis of Variables

1) Descriptive Analysis of Depressive Symptoms (BDE)

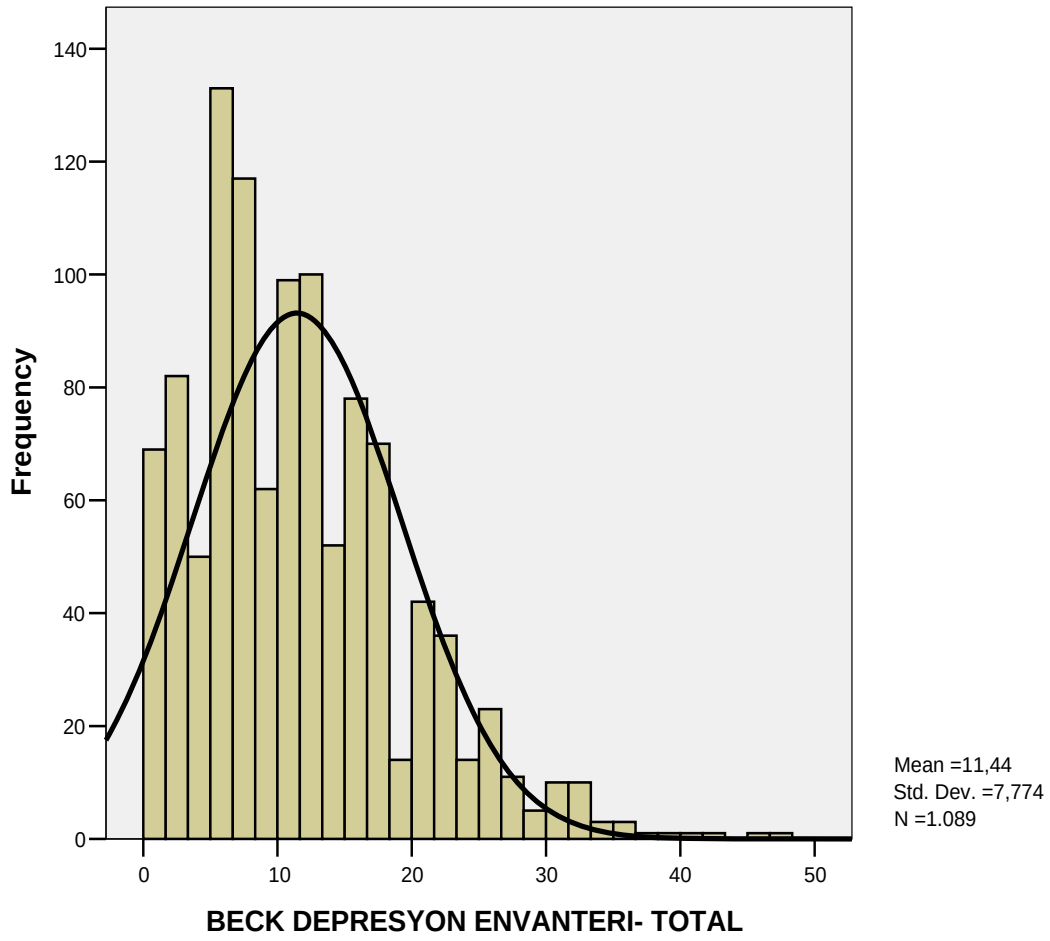
Depressive symptoms were measured by Beck Depression Inventory (BDE). The mean score for total sample was found to be 11.44, which is in the "mildly depressed" category according to Bryson's (1984) categorization, with a standard deviation value of 7.774 (n=1089). The range of the scores was 47, with a minimum score of 0, and a maximum score of 47. Table 15 shows the mean and standard deviation scores of BDE, in terms of gender. The mean score for females is 11.42, while for males it is 11.46.

Table 15: *Means and Standards Deviations of BDE by Gender*

BDE	*n*	$\bar{x}$	*sd*	*Min.*	*Max.*
Female	568	11.42	7.59	0	39
Male	521	11.46	7.98	0	47
Total	1089	11.44	7.77	0	47

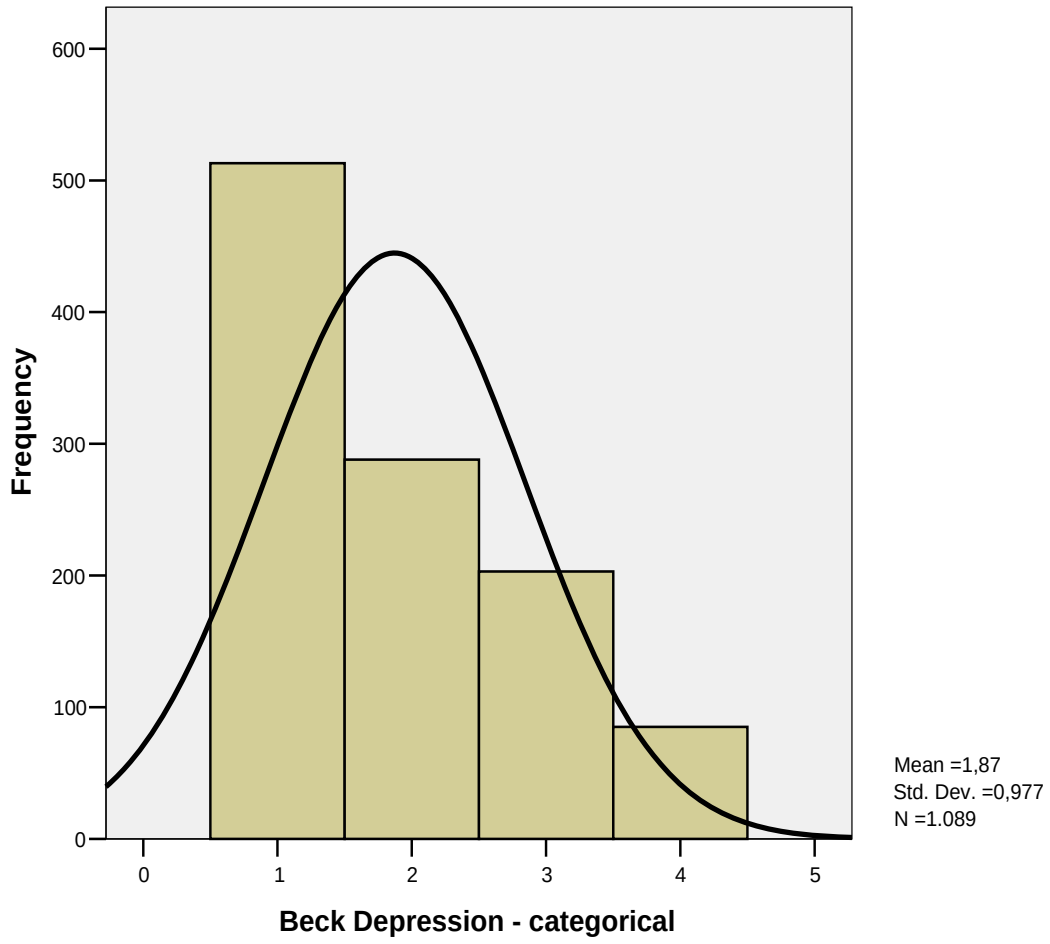
The frequency distribution of BDE scores can be seen in Figure 4.

Fig. 4: *Distribution of Participants according to BDE Scores*



For cut-off points, Bryson's (1984) classification was used which is determined as; 0-9: "not depressed"; 10-15: "mildly depressed"; 16-23: "moderately depressed"; 24-63: "severely depressed". As a result, it can be said that 47.10% of the target population is "not depressed", whereas 26.40% is "mildly depressed", 18.60% is "moderately depressed" and 7.80% of the population is "severely depressed" with a maximum score of 47. The frequency distribution of BDE scores according to categories can be seen in Figure 5.

Fig. 5: *Frequency Distribution of Participants according to BDE Categories*



2) Descriptive Analysis of Perceived Intensity of Life Events in terms of Their Stressfulness (ÜÖYO-Y)

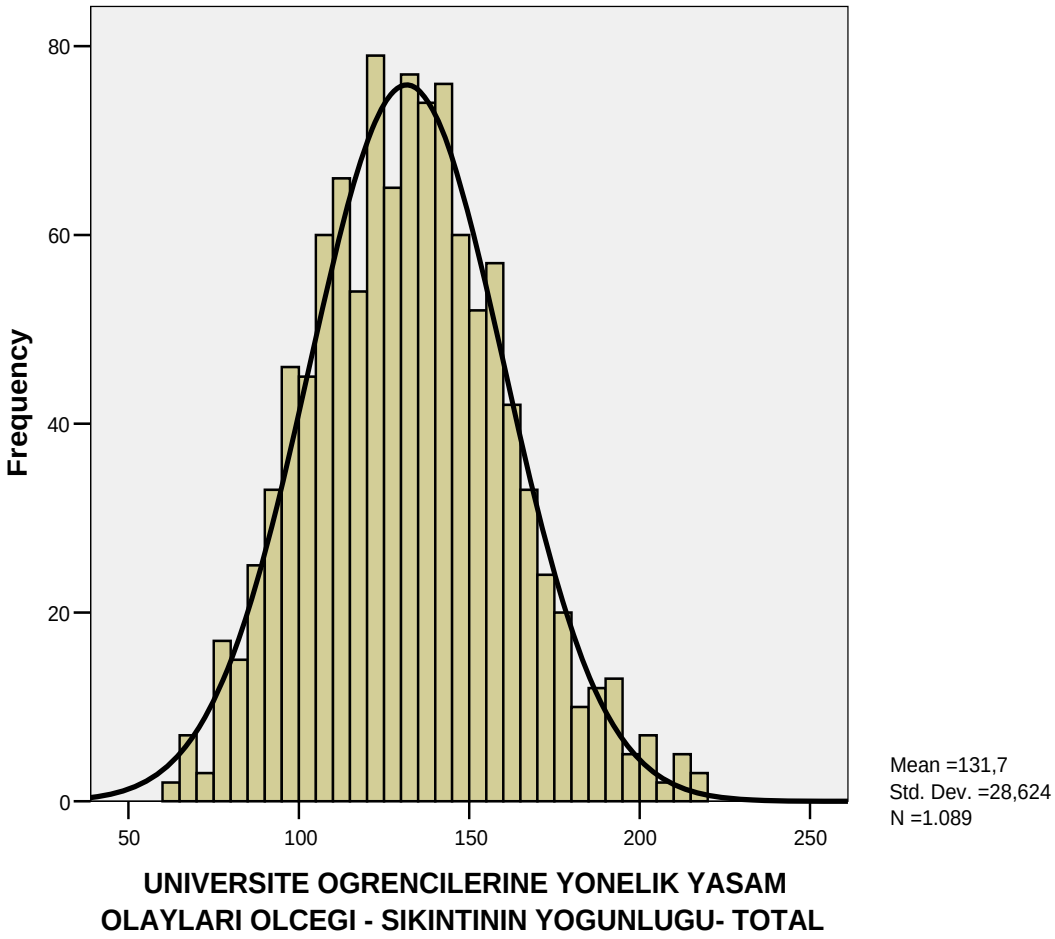
The perceived intensity of life events in terms of their stressfulness was measured by ÜÖYO-Y. The mean score for total sample was found to be 131.71, with a standard deviation value of 28.64 (n=1089). The range of the scores was 158, with a minimum score of 62, and a maximum score of 220. Table 16 shows the mean and standard deviation scores of ÜÖYO-Y, in terms of gender. The mean score for females is 134.33, while for males it is 128.84 (See Table 16).

Table 16: *Means and Standard Deviations of ÜÖYO-Y by Gender*

ÜÖYO-Y	*n*	$\bar{x}$	*sd*	*Min.*	*Max.*
Female	568	134.33	28.15	66	220
Male	521	128.84	28.92	62	216
Total	1089	131.71	28.64	62	220

The frequency distribution of ÜÖYO-Y scores can be seen in Figure 6.

Fig. 6. *Distribution of participants according to ÜÖYO-Y scores*



3) Descriptive Analysis of Coping Styles (SBTÖ)

The coping styles were measured by SBTÖ. SBTÖ has five factors which are: "self-confidence", "optimistic", "submissive", "helpless" and "seeking of social support". Four of these factors fall under two dimensions which are "Problem-oriented/effective style" ("self-confidence" and "optimistic") and "Emotion-oriented/ ineffective" style ("submissive" and "helpless"). First, the scores will be analyzed in terms of factors and secondly, in terms of dimensions.

In Terms of Factors

In terms of factors, the mean score for coping styles "self-confidence" factor was 2.92 with a standard deviation value of .537 (n=1089); "optimistic" was 2.70 with a standard deviation value of .55 (n=1089); "submissive" was 1.92 with a standard deviation value of .49 (n=1089); "helpless" was 2.26 with a standard deviation value of .56 (n=1089); and "seeking social support" was 2.87 with a standard deviation of .63 (n=1089). The range of the scores was 3, with a minimum score of 1, and a maximum score of 4 for all factors of SBTÖ. Table 17 shows the mean and standard deviation scores of factors of coping styles in terms of gender. The mean score of "self-confidence" factor for females is 2.90 and for males 2.94; "optimistic" factor for females is 2.57 and for males 2.70; "submissive" factor for females is 1.88 and for males 1.96; "helpless" factor for females is 2.28 and for males 2.23; and "seeking of social support" for females is 2.99 and for males 2.75.

Table 17: *Means and Standard Deviations of SBTÖ in terms of Factors by Gender*

	Gender	*n*	$\bar{x}$	sd	Min.	Max.
SBTO Self-Confidence	Female	568	2.90	.55	1	4
	Male	521	2.94	.52	1	4
	Total	1089	2.92	.54	1	4
SBTO Optimistic	Female	568	2.57	.58	1	4
	Male	521	2.70	.55	1	4
	Total	1089	2.63	.57	1	4
SBTO Submissive	Female	568	1.88	.50	1	4
	Male	521	1.96	.49	1	4
	Total	1089	1.92	.49	1	4
SBTO Helpless	Female	568	2.28	.57	1	4
	Male	521	2.23	.54	1	4
	Total	1089	2.26	.56	1	4
SBTO Seeking social support	Female	568	2.99	.62	1	4
	Male	521	2.75	.61	1	4
	Total	1089	2.87	.63	1	4

2-In Terms of Dimensions

The two dimensions of coping styles as measured by SBTÖ are "Problem-oriented/effective style" ("self-confidence" and "optimistic") and "Emotion-oriented/ ineffective style" ("submissive" and "helpless").

The mean score for "Problem-oriented/effective" style was 2.78 with a standard deviation value of .50. (*n*=1089); and "Emotion-oriented/ ineffective" style was 2.09 with a standard deviation value of .46 (*n*=1089). The range of the scores was 3, with a minimum score of 1, and a maximum score of 4 for both dimensions. Table 18 shows the mean and standard deviation scores of dimensions of coping

styles in terms of gender. The mean score of "Problem-oriented/effective coping" style dimension for females was 2.74 and for males 2.82; and "Emotion-oriented/ ineffective coping" style dimension for females was 2.08 and for males 2.10.

Table 18: *Means and Standard Deviations of SBTÖ in terms of Dimensions by Gender*

	Gender	*n*	$\bar{x}$	*sd*	*Min.*	*Max.*
SBTO Problem-Oriented/ Effective Style	Female	568	2.74	.51	1	4
	Male	521	2.82	.48	1	4
	Total	1089	2.78	.50	1	4
SBTO Emotion-Oriented/ Ineffective Style	Female	568	2.08	.46	1	4
	Male	521	2.10	.45	1	4
	Total	1089	2.09	.46	1	4

4) Descriptive Analysis of Coping Strategies (RÖGÖ)

RÖGÖ assesses how effective a person can cope with stress evoking life events; or in other words, the level of cognitive strategies used by a person to cope with stress and the skill to control oneself.

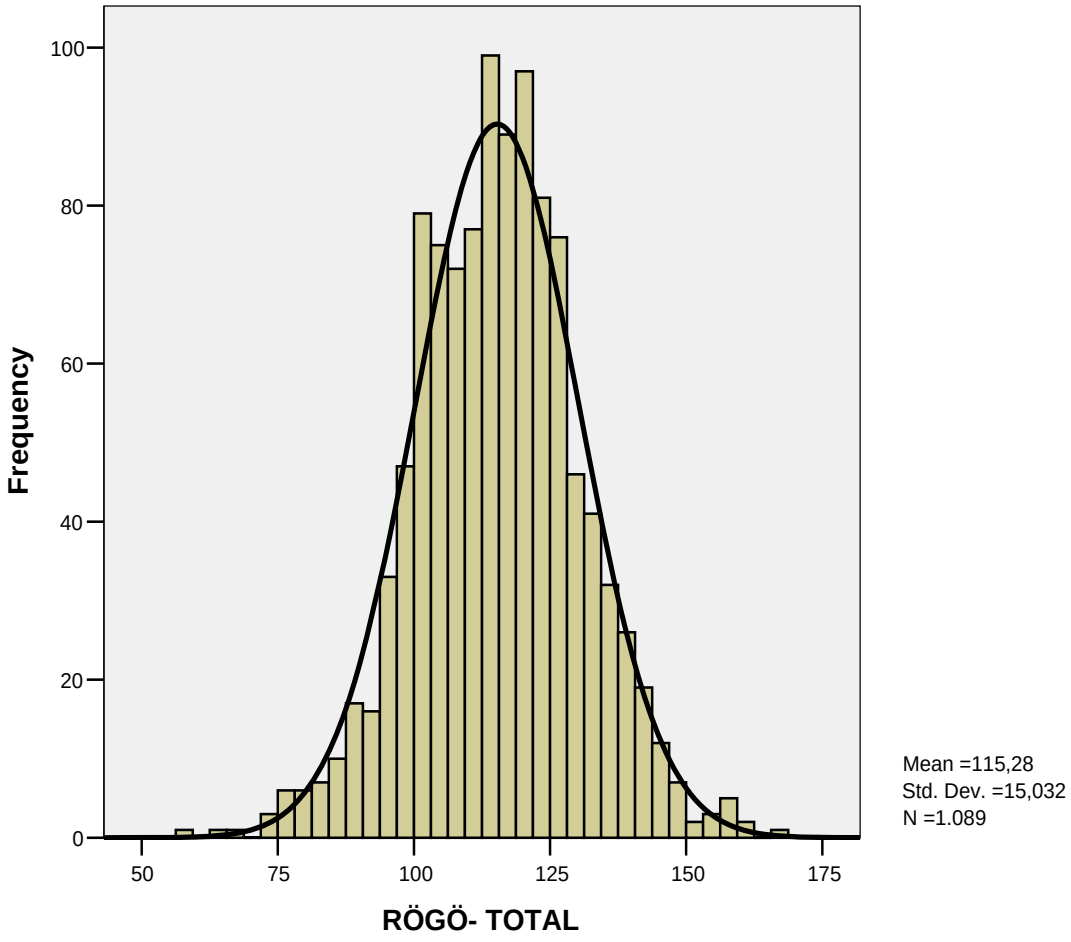
The mean score for coping strategies as measured by RÖGÖ was 115.28 with a standard deviation value of 15.75 (n=1089). The range of the scores was 110, with a minimum score of 57, and a maximum score of 167. Table 19 shows the mean and standard deviation scores of coping strategies as measured by RÖGÖ in terms of gender. The mean score for females is 116.69 and for males 113.76.

Table 19: *Means and Standard Deviations of RÖGÖ by Gender*

RÖGÖ	*n*	$\bar{x}$	*sd*	*Min.*	*Max.*
Female	568	116.69	15.75	57	167
Male	521	113.76	14.07	72	162
Total	1089	115.28	15.03	57	167

The frequency distribution of coping strategies (RÖGÖ) scores can be seen in Figure 7.

Fig. 7: *Distribution of Participants according to RÖGÖ Scores*



5) Descriptive Analysis of Perfectionism ÇBMÖ

ÇBMÖ measures three dimensions of perfectionism: “self-oriented perfectionism”, “other-oriented perfectionism” and “socially-prescribed perfectionism”.

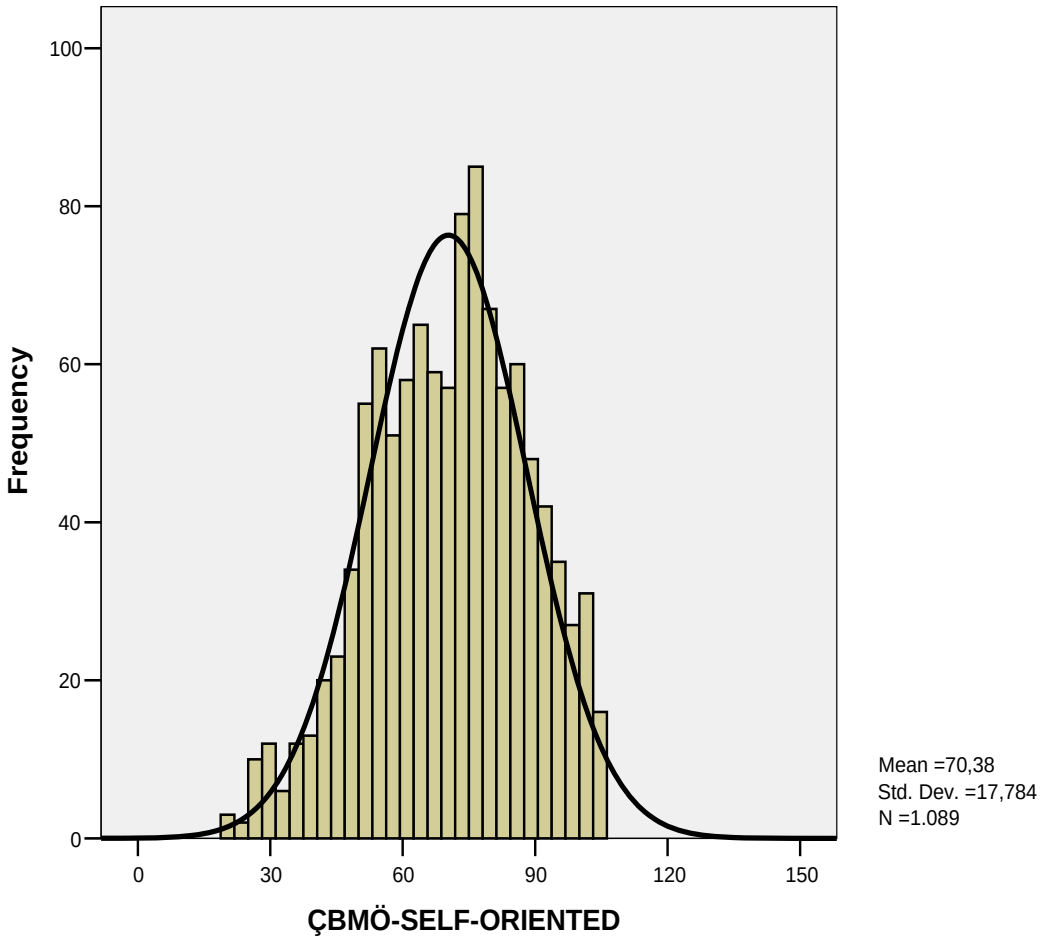
The mean score for “self-oriented” dimension of ÇBMÖ was 70.38 with a standard deviation value of 17.78 (n=1089); “other-oriented” dimension was 60.01 with a standard deviation value of 13.17 (n=1089); and “socially-prescribed” dimension was 55.67 with a standard deviation value of 13.12 (n=1089). The range of the scores for “self-oriented perfectionism” was 86, with a minimum score of 19, and a maximum score of 105; for “other-oriented perfectionism” the range was 90, with a minimum score of 15, and a maximum score of 105; and for “socially-prescribed perfectionism”, the range was 87, with a minimum score of 17 and a maximum score of 104. Table 20 shows the mean and standard deviation scores of ÇBMÖ dimensions in terms of gender.

Table 20: *Means and Standard Deviations of ÇBMÖ in terms of Dimensions by Gender*

	Gender	*n*	$\bar{x}$	*Sd*	*Min.*	*Max.*
ÇBMÖ Self-Oriented	Female	568	70.40	18.06	21	105
	Male	521	70.36	17.49	19	105
	Total	1089	70.38	17.78	19	105
ÇBMÖ Other-Oriented	Female	568	59.92	13.41	19	103
	Male	521	60.11	12.92	15	105
	Total	1089	60.01	13.17	15	105
ÇBMÖ Socially-Prescribed	Female	568	53.82	14.12	18	104
	Male	521	57.70	11.62	17	97
	Total	1089	55.67	13.12	17	104

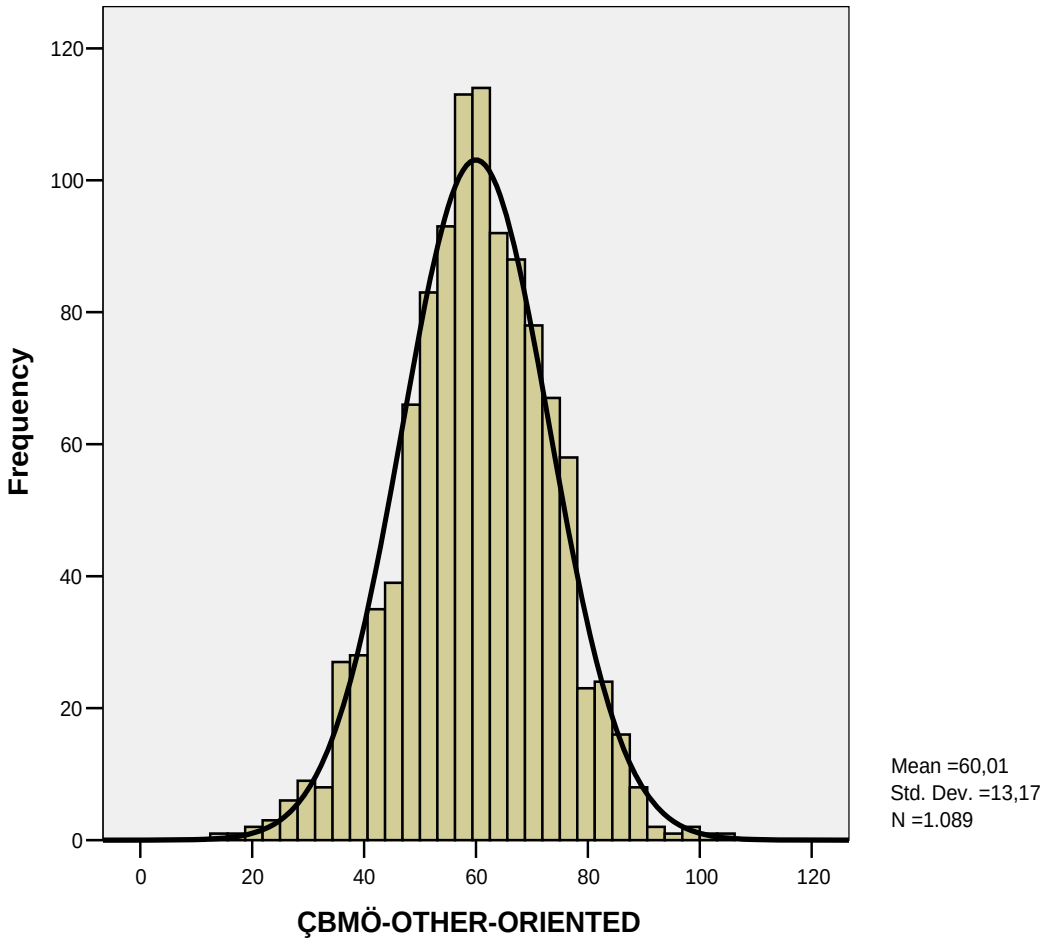
The frequency distribution of “self-oriented perfectionism” dimension of ÇBMÖ scores can be seen in Figure 8.

Fig. 8: *Distribution of Participants according to "Self-Oriented" Perfectionism Dimension Scores of ÇBMÖ*



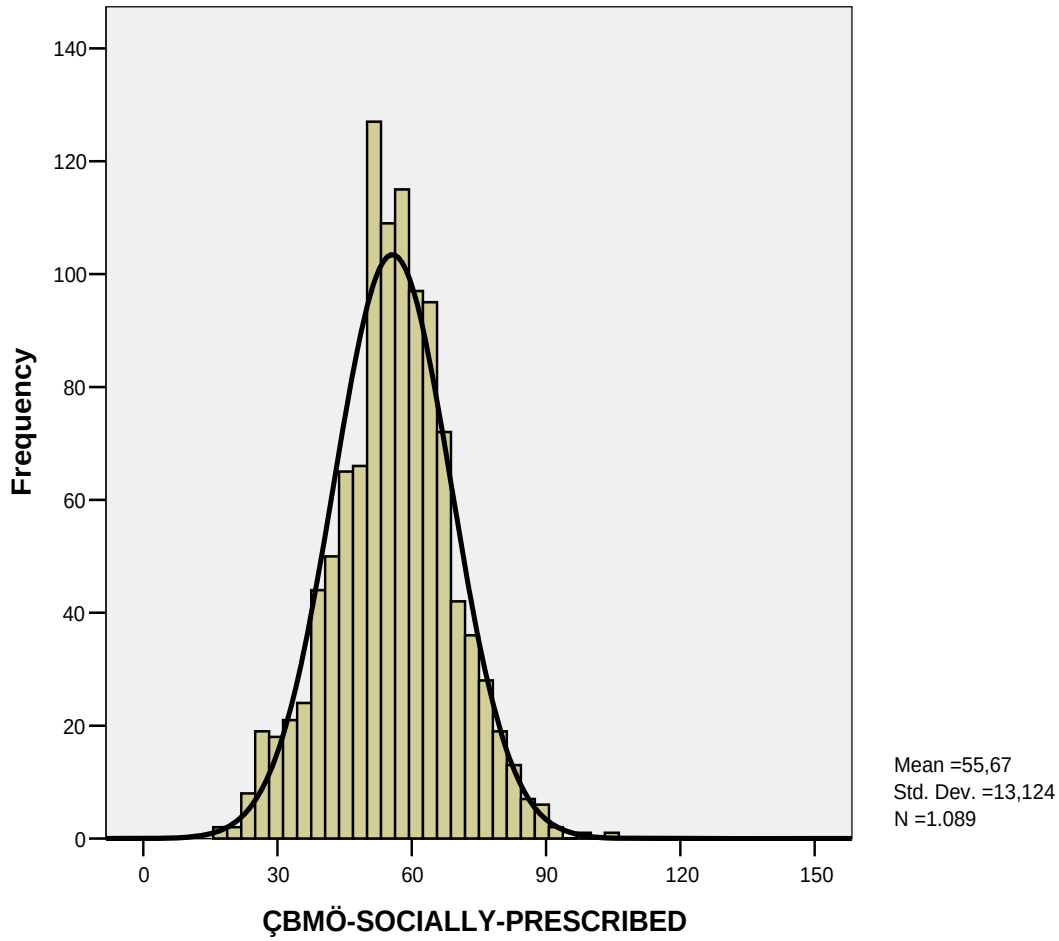
The frequency distribution of "other-oriented perfectionism" dimension of ÇBMÖ scores can be seen in Figure 9.

Fig. 9: *Distribution of Participants according to "Other-Oriented" Perfectionism Dimension scores of ÇBMÖ*



The frequency distribution of "socially-prescribed perfectionism" dimension of ÇBMÖ scores can be seen in Figure 10.

Fig. 10: *Distribution of Participants according to "Socially-Prescribed" Perfectionism Dimension Scores of ÇBMÖ*



C- Results According to Research Questions

There are three research questions in this study. Additionally, for the first and third research questions, there are two variations because two different measures for coping have been used. The questions, the definitions of variables in the specific question and the models designed for each question are all presented in this section.

For the research questions of the study, models for the specified relationships in research questions were investigated for analysis, and model – fitting processes was applied through AMOS. The model-fitting processes have the primary task of determining the goodness–of–fit between hypothesized model and the sample

data as stated by Byrne (2001). AMOS calculates, goodness-of-fit statistics, significance level of model, unstandardized (b values) and standardized (β values) values of covariance, and variance and regression weights of the parameters.

After model-fitting, if the model as a whole is identified and significant, then the next step is modification of the model. Model modification can be defined as carrying out pos hoc comparisons after ANOVA in SPSS (Hoyle, 1995). The insignificant relations in the model are skipped. The modification indices suggest expected relations which are not in the hypothesized model and based on these suggestions, modifications are done. At the end of the modification process, the significant model is the one that as a whole and in terms of parameters is significant (Eryiğit, 2004).

The values that were given for relationships in the models represent standardized β values for each relationship.

The hypothesized model for each research question was presented first. After the hypothesized model, the modified model was presented and the statistical results of the questions were presented in the form of tables after the modified models. The same pattern was used for each research question.

Research Question 1: Is there any difference between students in different categories of depressive symptoms as measured by BDE in terms of perceived intensity of life events (as measured by ÜÖYO-Y), coping styles (as measured by SBTÖ), coping strategies (as measured by SBTÖ), and perfectionism dimensions (as measured by ÇBMÖ)?

For this research question, investigation of differences of according to BDE was done.

Perceived Intensity of Life Events in terms of their Stressfulness (ÜÖYO-Y)

Mean scores of perceived intensity of life events in terms of their stressfulness according to depressive symptom categories of participants were calculated in order to see whether there was a specific relationship. A specific relationship was found: as ÜÖYÖ-Y scores increased, BDE scores increased also; meaning as participants experienced intensity of life events as more stressful, the more depressive symptoms they showed and vice versa. See Table 21 for means and standard deviations perceived intensity of life events in terms of their stressfulness scores according to depressive symptom categories.

Table 21: *Means and Standard Deviations of ÜÖYO-Y Scores according to BDE Categories*

BDE	*N*	$\bar{x}$	*Sd*	*Min.*	*Max.*
1	513	117.64	24.60	62	204
2	288	136.97	25.01	65	216
3	203	147.71	23.55	88	220
4	85	160.40	26.39	82	215
Total	1089	131.70	28.62	62	220

One-way analysis of variance was carried out to see whether mean differences of perceived intensity of life events in terms of their stressfulness according to depressive symptom category scores were statistically significant. The results showed there was a significant difference between mean differences of

perceived intensity of life events in terms of their stressfulness and depressive symptom category scores ($F(3,1085)=126.87$; $p<.00$) (See Table 22).

Table 22: *One-way Analysis of Variance for ÜÖYO-Y by BDE Categories*

ÜÖYÖ-Y	*SS*	*Df*	*MS*	*F*	*P*
Between Groups	231500.50	3	77166.83	126.87	.00
Within Groups	659945.89	1085	608.25		
Total	891446.39	1088			

Post-hoc analysis results showed that the mean differences of perceived intensity of life events in terms of their stressfulness and depressive symptom category scores were significant for all categories (See Appendix G).

Coping Styles (SBTÖ)

Mean scores coping styles' dimensions, as measured by SBTÖ, according to depressive symptom category scores, as measured by BDE, of participants were calculated in order to see whether there was a specific relationship. A specific relationship was found: the mean score for coping styles: "problem-oriented coping" dimension decreased as depressive symptom categories increased in terms of severity. In other words, as participants used less "problem-oriented/ effective" coping style, they displayed more depressive symptoms and vice versa. In addition, the mean score for coping styles: "emotion-oriented/ ineffective coping" dimension increased as depressive symptom categories increased in terms of severity. In other words, as participants used more "emotion- oriented / ineffective coping" style, they displayed more depressive symptoms and vice versa. See Table 23 for means and

standard deviations of dimensions of coping styles according to depressive symptom categories.

Table 23: *Means and Standard Deviations of Dimensions of SBTÖ Scores according to BDE Categories*

	BDE	*n*	$\bar{x}$	*sd*	*Min.*	*Max.*
SBTÖ Problem-Oriented	1	513	2.93	.46	2	4
	2	288	2.73	.46	2	4
	3	203	2.63	.48	1	4
	4	85	2.39	.54	1	4
	Total	1089	2.78	.50	1	4
SBTÖ Emotion-Oriented	1	513	1.92	.40	1	4
	2	288	2.14	.41	1	3
	3	203	2.27	.45	1	3
	4	85	2.49	.44	1	4
	Total	1089	2.09	.46	1	4

One-way analysis of variance was carried out to see whether mean differences of scores of coping dimensions according to depressive symptom category scores were statistically significant. The results showed there was a significant difference between mean differences of "problem-oriented / effective coping style" dimension scores according to depressive symptom categories ($F(3,1085)=44.75$; $p<.00$) and also between mean differences of "emotion-oriented/ ineffective coping style" dimension scores according to depressive symptom categories ($F(3,1085)=67.37$; $p<.00$) (See Table 24).

Table 24: *One-way Analysis of Variance of SBTÖ Dimensions by BDE Categories*

		SS	*Df*	*MS*	*F*	*P*
SBTÖ Problem-Oriented	Between Groups	29.78	3	9.927	44.75	.00
	Within Groups	240.71	1085	.222		
	Total	270.50	1088			
SBTÖ Emotion-Oriented	Between Groups	35.32	3	11.77	67.37	.00
	Within Groups	189.62	1085	.18		
	Total	224.94	1088			

Post-hoc analysis results showed that the mean differences of coping styles as measured by coping styles: "problem-oriented/ effective coping" dimension according to BDE category scores was significant for all categories except for the mean difference among 2nd and 3rd categories of depressive symptoms. On the other hand, the mean differences of coping styles: "emotion -oriented coping" dimension according to depressive symptom category scores was significant for all categories (See Appendix H).

Coping Strategies (RÖGÖ)

When coping strategies mean scores, as measured by RÖGÖ, according to depressive symptom category scores, as measured by BDE, of participants were calculated in order to see whether there was a specific relationship, and a specific relationship was found. As coping strategies' mean scores decreased, depressive symptom scores increased also; meaning as participants used more cognitive strategies for coping, they showed less depressive symptoms and vice versa. For means and standard deviations of coping strategies scores according to depressive symptom categories, please see Table 25.

Table 25: *Means and Standard Deviations of RÖGÖ Scores according to BDE Categories*

BDE	*n*	$\bar{x}$	*sd*	*Min.*	*Max.*
1	513	119.49	13.95	80	167
2	288	113.43	13.51	77	148
3	203	112.25	15.47	57	154
4	85	103.42	16.06	64	138
Total	1089	115.28	15.032	57	167

One-way analysis of variance was carried out to see whether mean differences of coping strategies according to depressive symptom category scores were statistically significant. The results showed there was a significant difference between mean scores of coping strategies, as measured by RÖGÖ, according to depressive symptom categories ($F(3,1085)=39.94$; $p<.00$) (See Table 26).

Table 26: *One-way Analysis of Variance of RÖGÖ by BDE Categories*

RÖGÖ	*SS*	*Df*	*MS*	*F*	*P*
Between Groups	23896.36	3	7965.45	38.94	.00
Within Groups	221961.39	1085	204.57		
Total	245857.75	1088			

Post-hoc analysis results showed that the mean differences of coping strategies, as measured by RÖGÖ, according to depressive symptom categories, as

measured by BDE, was significant for all categories except between 2nd and 3rd categories (p=.8). In other words, coping strategies' mean scores according to depressive symptom categories were not significantly different between 2nd and 3rd categories (See Appendix I).

Perfectionism (ÇBMÖ)

Mean scores of perfectionism dimensions, as measured by ÇBMÖ, according to BDE category scores of participants were calculated in order to see whether there was a relationship. A relationship was found for "socially-prescribed perfectionism": as "socially-prescribed perfectionism" scores increased, BDE scores also increased and vice versa. In other words, participants who were more "socially-prescribed perfectionists" showed more depressive symptoms. Yet, there was no trend for "self-oriented" and "other-oriented perfectionism" (See Table 27).

Table 27: *Means and Standard Deviations of ÇBMÖ Dimensions according to BDE Categories*

		n	$\bar{x}$	*sd*	*Min.*	*Max.*
ÇBMÖ Self-Oriented	1	513	69. 88	17.78	21	105
	2	288	71.00	16.86	24	105
	3	203	70.26	18.29	19	105
	4	85	71.53	19.75	30	105
	Total	1089	70.38	17.78	19	105
ÇBMÖ Other-Oriented	1	513	59.88	13.42	17	105
	2	288	59.83	12.40	19	89
	3	203	60.79	13.83	15	103
	4	85	59.52	12.72	22	88
	Total	1089	60.01	13.71	15	105
ÇBMÖ Socially-Prescribed	1	513	53.36	12.70	19	88
	2	288	56.27	12.98	17	88
	3	203	57.86	12.43	25	92
	4	85	62.39	14.50	24	104
	Total	1089	55.67	13.12	17	104

One-way analysis of variance (ANOVA) was carried out to see whether mean differences of perfectionism dimensions according to depressive symptom categories of Bryson (1984) were statistically significant. The results showed there was no significant difference between "self-oriented perfectionism" scores and depressive symptom categories; and between "other-oriented perfectionism" scores and depressive symptom categories; whereas a significant difference was found between mean differences of "socially- prescribed perfectionism" and depressive symptom categories ($F(3,1085)=15.41$; $p<.00$) (See Table 28).

Table 28: *One-way Analysis of Variance of ÇBMÖ- Socially-Prescribed Perfectionism Dimension by BDE Categories*

ÇBMÖ: Socially-Prescribed	*SS*	*Df*	*MS*	*F*	*p*
Between Groups	7656.42	3	2552.14	15.41	.000
Within Groups	179733.21	1085	165.65		
Total	187389.62	1088			

Post-hoc analysis results showed that the mean differences of "socially-prescribed perfectionism" according to depressive symptom category scores, as measured by BDE, was significant between all categories except between 2nd and 3rd categories (p=.5). In other words, the mean scores of perfectionism as measure by ÇBMÖ: "socially-prescribed dimension" were not significantly different between 2nd and 3rd categories of BDE (See Appendix J).

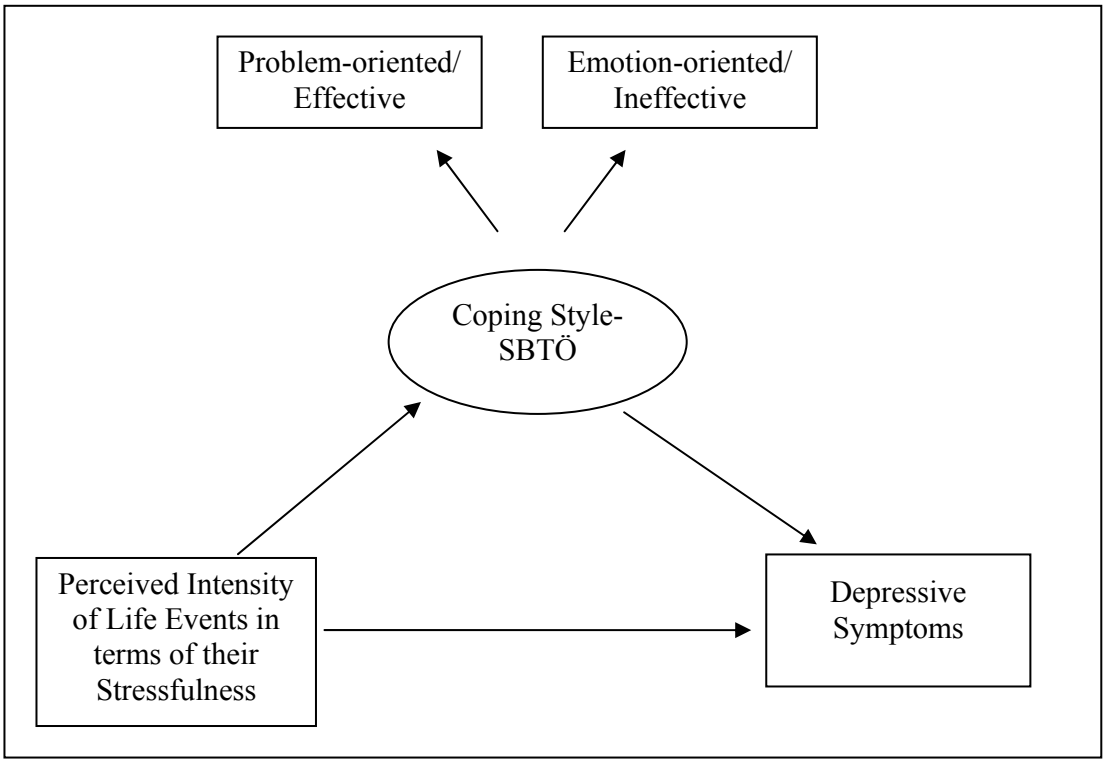
As a summary, when mean scores of perceived intensity of life events in terms of their stressfulness, as measured by ÜÖYO-Y; coping styles, as measured by SBTÖ; coping strategies as measured by RÖGÖ; and dimensions of perfectionism, as measured by ÇBMÖ, according to BDE categories were calculated; and a specific relationship was found for perceived intensity of life events in terms of their stressfulness, coping strategies, coping style dimensions and "socially- prescribed perfectionism" dimension of perfectionism. As ÜÖYÖ-Y scores increased, BDE scores increased also; meaning as participants experienced intensity of life events as more stressful, the more depressive symptoms they showed; as the mean score for SBTÖ: "problem-oriented/ effective coping" dimension decreased, BDE categories increased in terms of severity, in other words, as participants used less "problem-oriented/ effective coping style", they displayed more depressive symptoms and as

the mean score for SBTÖ: "emotion-oriented coping" dimension increased as BDE categories increased in terms of severity, in other words, as participants used more "emotion- oriented coping" style, they displayed more depressive symptoms; as RÖGÖ mean scores decreased, BDE scores increased also; meaning as participants used more cognitive strategies for coping, they showed less depressive symptoms; and as "socially-prescribed perfectionism" scores increased, BDE scores also increased, meaning as participants experienced more "socially-prescribed perfectionism", the more depressive symptoms they showed.. However, according to one-way analysis of variance results, for coping strategies, dimensions of coping styles, and "socially- prescribed perfectionism" dimension of ÇBMÖ, the mean differences for 2nd and 3rd categories of depressive symptoms, as measured by BDE, were not significantly different.

Research Question 2A: Does the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms change according to coping styles as measured by SBTÖ?

There is one latent variable in this research question: coping style, which is one of the exogenous variables in this question. It is measured by two dimensions, which are "problem-oriented / effective coping" dimension ("self-confidence", and "optimistic" factors) and "emotion-oriented/ ineffective coping" dimension ("submissive" and "helpless" factors). The second exogenous variable of this question is the perceived intensity of life events in terms of their stressfulness. The endogenous variable of this question is depressive symptoms. The hypothesized model of this research question can be seen in Fig. 11.

Fig. 11: *Hypothesized Model for the Relationship among the Perceived Intensity of Life Events in terms of Their Stressfulness, Depressive Symptoms, and Coping Styles as Measured by SBTÖ*

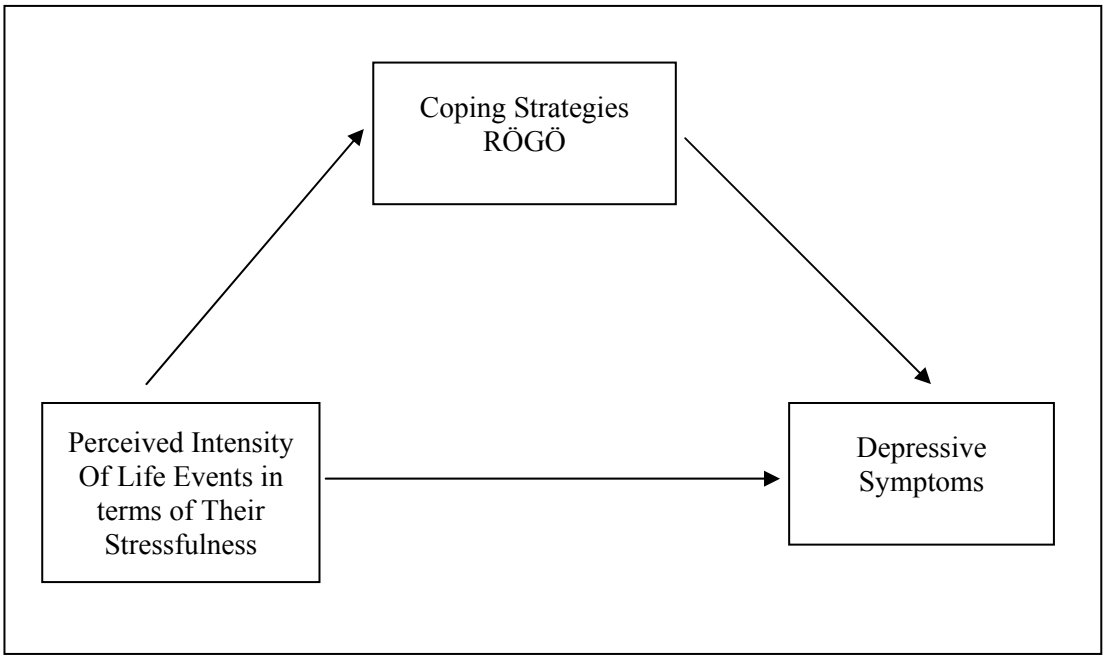


The results of analysis for this model showed that, the goodness of fit statistics did not fit significantly for the present sample, even after the modification procedure (χ^2=0.00, *df*=0, *p*=probability level cannot be computed). The χ^2 test shows difference which means that the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms does not significantly change according to coping styles as measured by SBTÖ in the present sample.

Research Question 2B: Does the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms change according to coping strategies as measured by RÖGÖ?

The exogenous variables in this question are coping styles as measured by RÖGÖ and perceived intensity of life events in terms of their stressfulness. The endogenous variable is depressive symptoms. The hypothesized model of this research question can be seen in Fig. 12.

Fig. 12: *Hypothesized Model for the Relationship among Coping Strategies as Measured by RÖGÖ, the Perceived Intensity of Life Events in terms of Their Stressfulness and Depressive Symptoms*

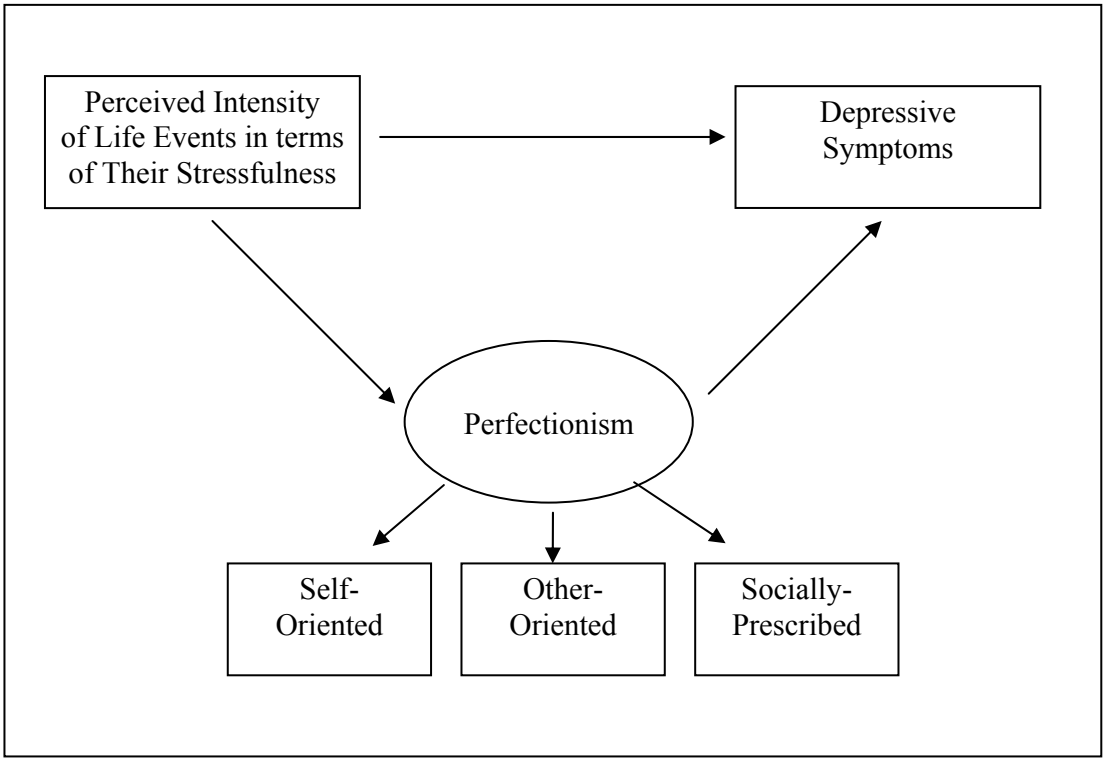


The goodness of fit statistics for this model did not fit significantly for the present sample, even after modifications were done (χ^2=361.65, *df*=1, *p*=.00). This means that the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms did not significantly change according to coping strategies as measured by RÖGÖ.

Research Question 3: Does the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms change according to dimensions of perfectionism as measured by ÇBMÖ?

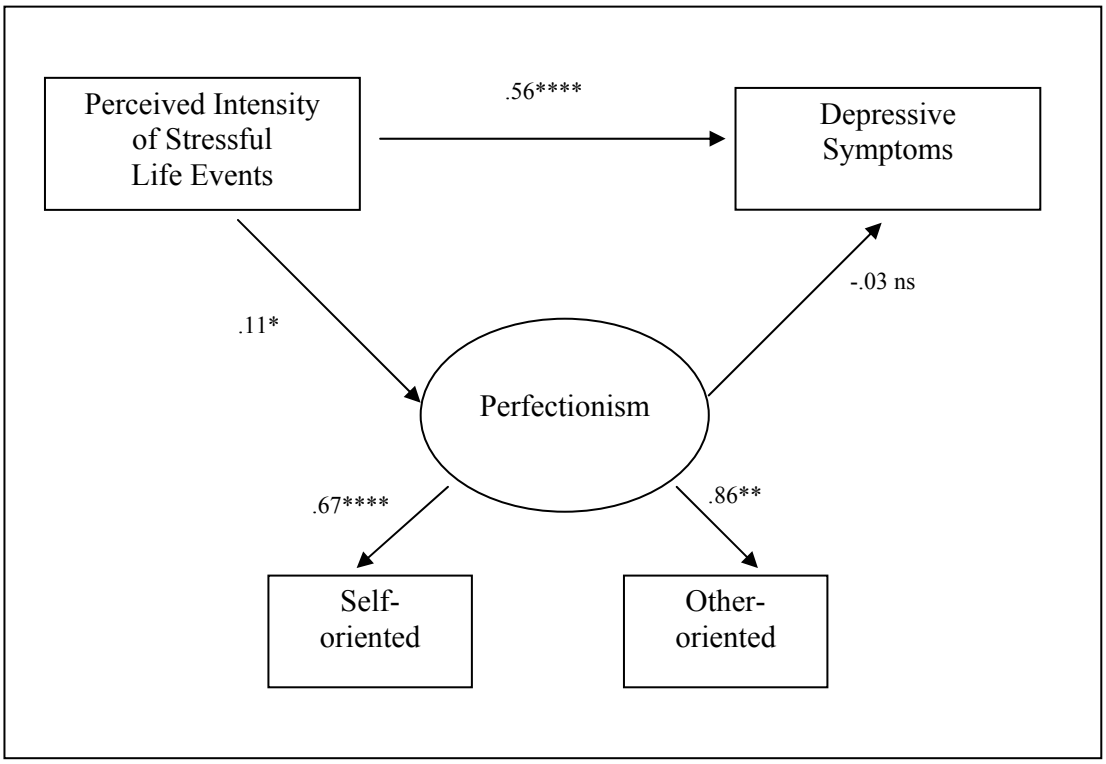
There is one latent variable in this research question: perfectionism, which is one of the exogenous variables in this research question. It is measured by three dimensions, which are "self-oriented", "other-oriented" and "socially-prescribed". The second exogenous variable of this question is the perceived intensity life events in terms of their stressfulness. The endogenous variable of this question is depressive symptoms. The hypothesized model of this research question can be seen in Fig. 13.

Fig. 13: *Hypothesized Model for the Relationship among the Perceived Intensity of Life Events in terms of Their Stressfulness, Depressive Symptoms and Dimensions of Perfectionism*



The goodness of fit statistics for this showed significant fitness, after modifications for the present sample (χ^2=.45, *df*=1, *p*=.50). This means that the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms significantly changed according to dimensions of perfectionism. However, modifications carried out showed significant difference after ruling out the "socially-prescribed dimension" of perfectionism. The goodness of fit indices showed a well-fit between sample data and the model (CFI=1.00) (See Figure 14).

Fig 14: *Estimated Model for the Relationship among the Perceived Intensity of Life Events in terms of Their Stressfulness, Depressive Symptoms and Dimensions of Perfectionism*



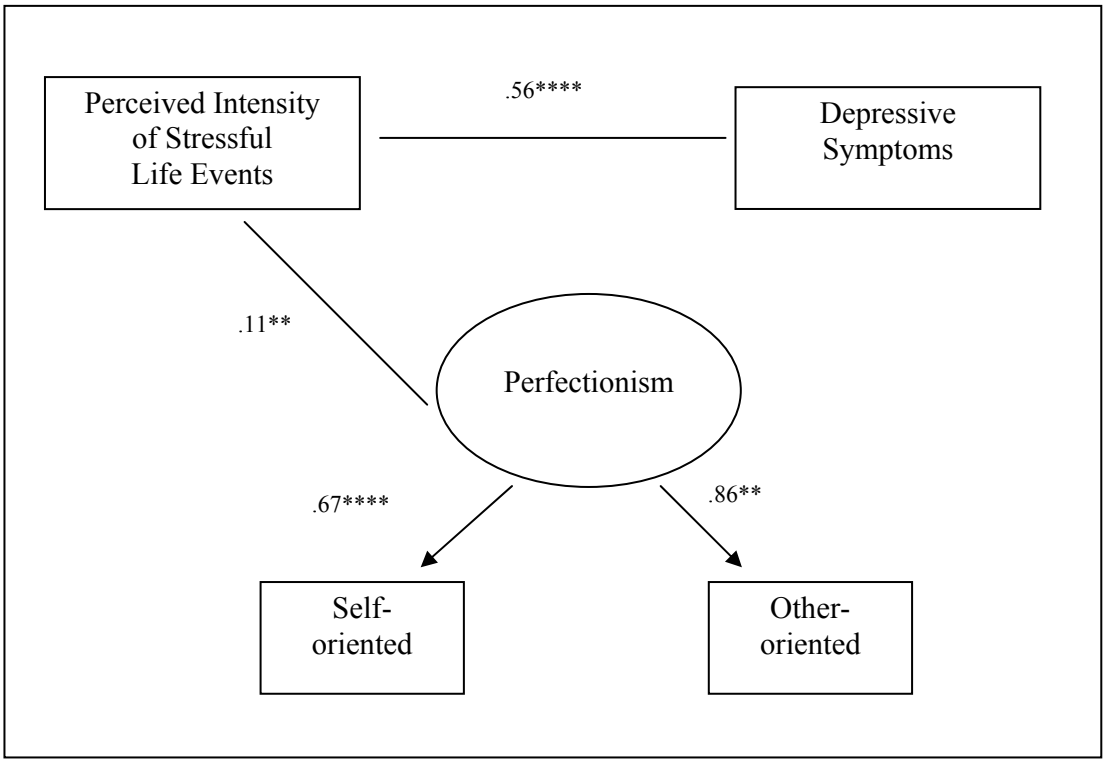
n=1089

*p<.05, **p<.01, ***p<.005; ****p< .001

All the relationships within this model were not significant (See Figure 14). The relationship between perfectionism and depressive symptoms was found insignificant (p=.27). This means that perfectionism was not able to significantly explain BDE Total scores, or in other words perfectionism by itself could not have a significant effect on the relationship between the perceived intensity of life events in terms of their stressfulness and depressive symptoms.

Figure 15 represents only the statistical results of the relationships within the model. The χ^2 showed no difference (χ^2=1.70, df=2, p=.43), and the goodness of fit indices show a well-fit between sample data and the model (CFI=1.00). In addition, each relationship in the model is significant.

Fig. 15: *Modified Model for the Relationship among Dimensions of Perfectionism, the Perceived Intensity of Stressful Life Events and Depressive Symptoms*



n=1089

*p<.05, **p<.01, ***p<.005; ****p< .001

Table 29 presents the β values and accounted amount of variances both for the hypothesized and the modified model. The relationship between perceived intensity of life events in terms of their stressfulness and depressive symptoms is significant with a β value of .56 (p=.00), and perceived intensity of life events in terms of their stressfulness and perfectionism is significant with a β value of .11 (p=.01). As can be seen from Table 29, perceived intensity of life events in terms of their stressfulness accounts for 31% of depressive symptoms. In addition, perceived intensity of life events in terms of their stressfulness accounts for 12% of perfectionism.

Table 29: *The Relationship Values for the Model for the Relationship among the Effect of Perceived Intensity of Life Events in terms of Their Stressfulness on Depressive Symptoms according to Dimensions of Perfectionism*

Relationship between the Perceived Intensity of Life Events in terms of Their Stressfulness and Depressive Symptoms

	b value	*β value*	*Standard error*	*Z value*	*Amount of variance accounted*	*Alpha*
Hypothesized model	.15	.56	.01	22.02	.31	.00
Modified model	.15	.56	.01	22.02	.31	.00

Relationship between the Perceived Intensity of Life Events in terms of Their Stressfulness and Perfectionism

	b value	*β value*	*Standard error*	*Z value*	*Amount of variance accounted*	*Alpha*
Hypothesized model	.04	.11	.02	2.3	.12	.10
Modified model	.04	.11	.02	2.5	.12	.01

Relationship between Perfectionism and Depressive Symptoms

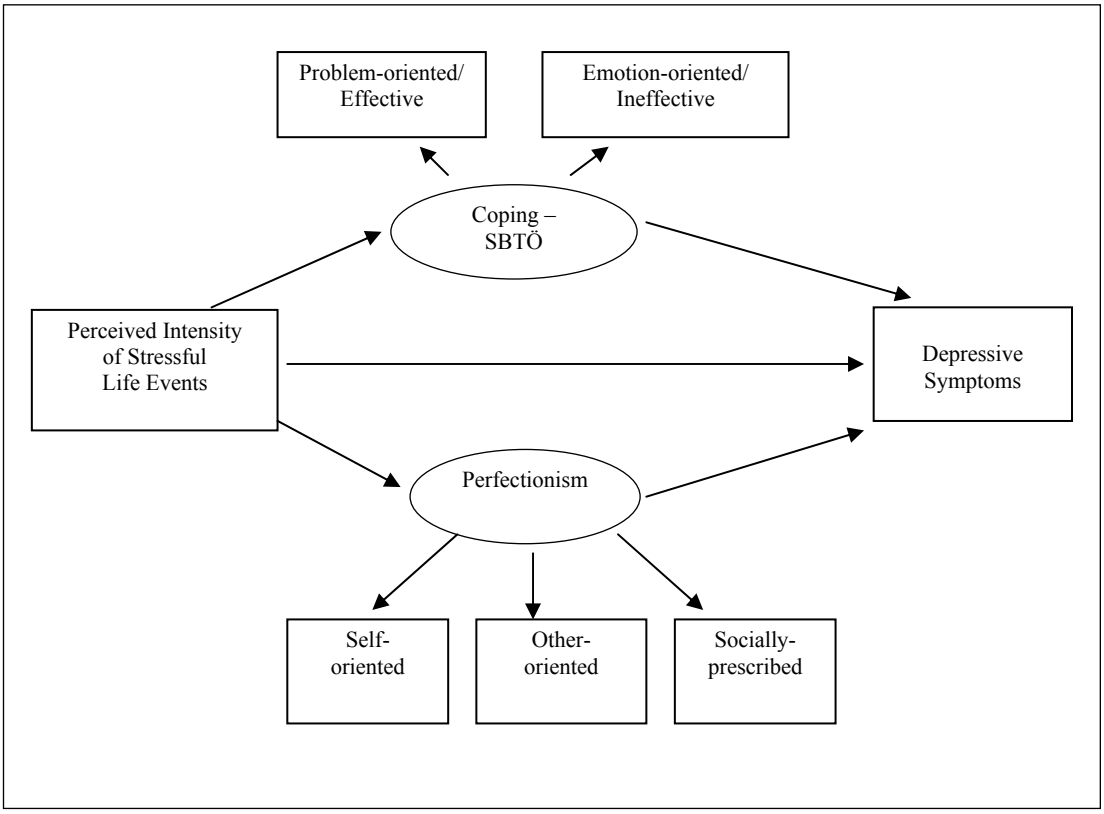
	b value	*β value*	*Standard error*	*Z value*	*Amount of variance accounted*	*Alpha*
Hypothesized model	-.02	-.03	.02	-1.1	-	Ns
Modified model	-	-	-	-	-	-

As a result, it can be said that although the model is significant, and the answer to this research question is that the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms did not significantly change according perfectionism as measured by ÇBMÖ in this sample.

Research Question 4A: Does the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms change according to coping styles as measured by SBTÖ and dimensions of perfectionism as measured by ÇBMÖ?

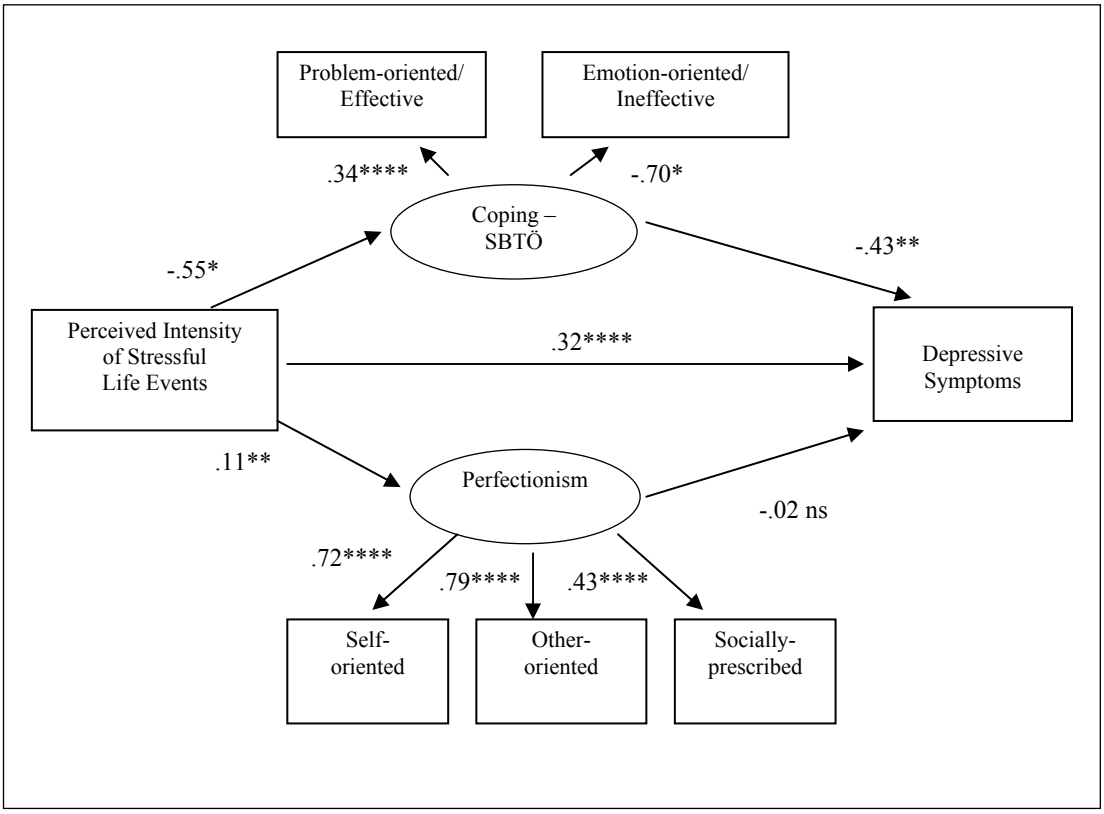
There are two latent variables in this research question. First latent variable is the coping styles as measured by SBTÖ, which is an exogenous variable of this question. It is measured by two dimensions: “problem-oriented / effective coping style” and “emotion-oriented / ineffective coping style”. The second latent variable of this research question is perfectionism, which is one of the other exogenous variables of this question. It is measured by three dimensions, namely “self-oriented”, “other-oriented” and “socially-prescribed”. The last exogenous variable of this question is perceived intensity of life events in terms of their stressfulness and the endogenous variable is depressive symptoms. The hypothesized model of this research question is shown in Fig 16.

Fig. 16: *Hypothesized Model for the Relationship among the Perceived Intensity of Life Events in terms of Their Stressfulness, Depressive Symptoms, Coping Styles as Measured by SBTÖ and Dimensions of Perfectionism*



The goodness of fit statistics for this model fit significantly, for the present sample (χ^2=5.90, *df* =6, *p*=.40), and the goodness of indices showed a well-fit between sample data and the model (CFI=1.00). However, not all relationships in the model were significant. The relationship between perfectionism and BDE was not significant (*p*=.40) (See Figure 17).

Fig.17: *Estimated Model for the Relationship among the Perceived Intensity of Life Events in terms of Their Stressfulness, Depressive Symptoms, Coping Styles as Measured by SBTÖ and Dimensions of Perfectionism*

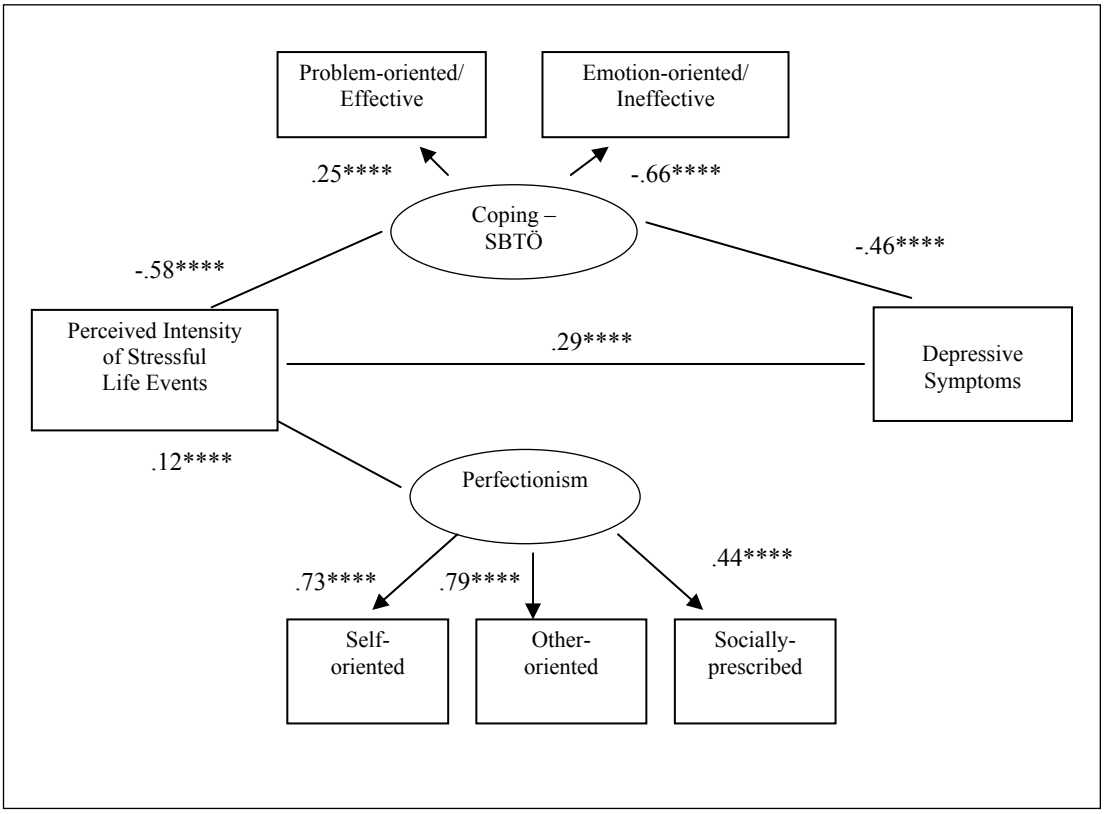


n=1089

*p<.05, **p<.01, ***p<.005; ****p< .001

Figure 18 represents only the statistical results of the relationships within the model. The χ^2 showed no difference (χ^2=13.60, *df* =9, p=.20), and the goodness of fit indices show a well-fit between sample data and the model (CFI=1.00). The model is shown in Figure 18.

Fig. 18: *Modified Model for the Relationship among the Perceived Intensity of Life Events in terms of Their Stressfulness, Depressive Symptoms, Coping Styles as Measured by SBTÖ and Dimensions of Perfectionism*



n=1089

*p<.05, **p<.01, ***p<.005; ****p< .001

Table 30 presents the β values and accounted amount of variances both for the hypothesized and the modified model. As can be seen from the table, all relationships in the modified model were significant (p= .001).

Table 30: *The Relationship Values of the Model for the Relationship among the Perceived Intensity of Life Events in terms of Their Stressfulness, Depressive Symptoms, Coping Styles as measured by SBTÖ and Dimensions of Perfectionism as Measured by ÇBMÖ*

Relationship between the Perceived Intensity of Life Events as Stressful and Coping Styles

	b value	*β value*	*Standard error*	*Z value*	*Amount of variance accounted*	*Alpha*
Hypothesized model	-.01	-.55	.01	-1.90	.30	.05
Modified model	-137.25	-.59	31.80	-4.30	.35	.00

Relationship between Coping Styles and Depressive Symptoms

	b value	*β value*	*Standard error*	*Z value*	*Amount of variance accounted*	*Alpha*
Hypothesized model	-.19.38	-.43	6.40	-3.10	.18	.01
Modified model	-29.16	-.46	6.80	-4.30	.21	.00

Relationship between the Perceived Intensity of Life Events as Stressful and Depressive Symptoms

	b value	*β value*	*Standard error*	*Z value*	*Amount of variance accounted*	*Alpha*
Hypothesized model	.08	.32	.02	4.89	.10	.00
Modified model	.08	.29	.01	5.52	.08	.00

Relationship between the Perceived Intensity of Life Events as Stressful and Perfectionism

	b value	*B value*	*Standard error*	*Z value*	*Amount of variance accounted*	*Alpha*
Hypothesized model	.02	.11	.01	3.1	.12	.01
Modified model	.03	.12	.01	3.2	.14	.00

Relationship between Perfectionism and Depressive Symptoms

	b value	*β value*	*Standard error*	*Z value*	*Amount of variance accounted*	*Alpha*
Hypothesized model	-.03	-.02	.04	-.80	.00	.50
Modified model	-	-	-	-	-	-

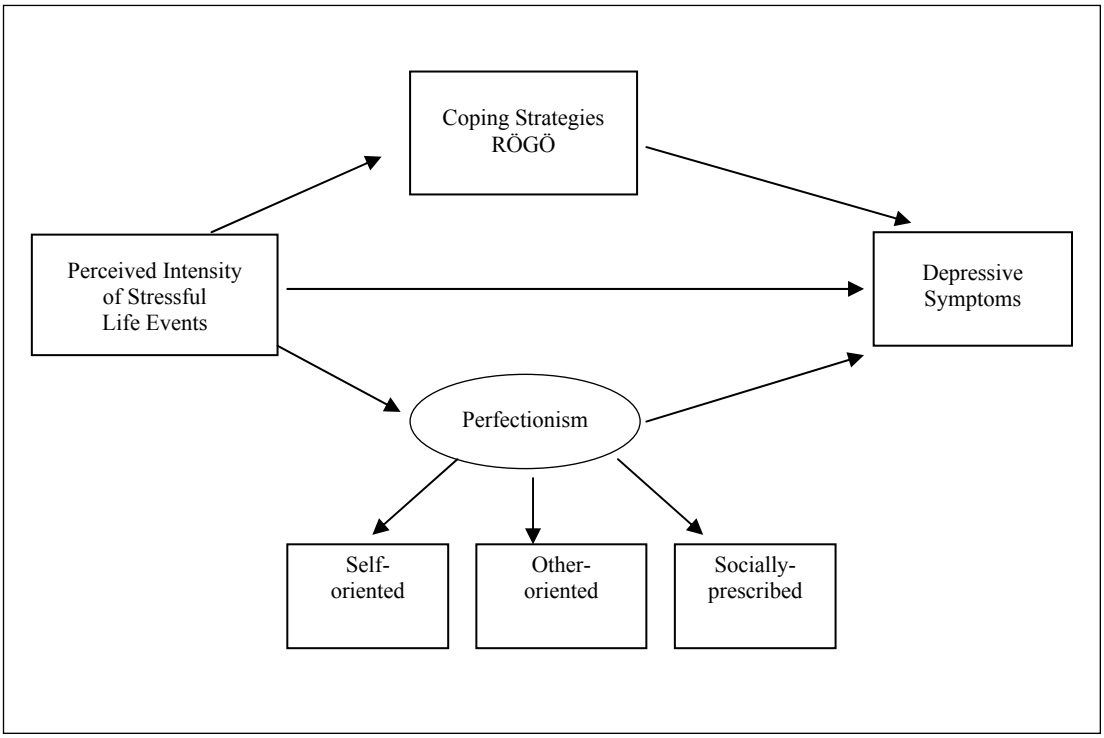
As seen in Table 30, the relationship between perceived intensity of life events and coping styles is significant with a standardized β value of -.59 (p=.00); between coping styles and depressive symptoms with a standardized β value of -.46 (p=.00) between perceived intensity of life events and depressive symptoms with a standardized β value of .29 (p=.00); and between perceived intensity of life events and perfectionism with a standardized β value of .12 (p=.00). Moreover, perceived intensity of life events accounts for 8% of depressive symptoms. In addition, coping styles account for 21% depressive symptoms. Overall, perceived intensity of life events and coping styles account for 29% of depressive symptoms.

The results pointed out that Coping styles had a significant effect on the effect of the perceived intensity of life events in terms of their stressfulness on depressive symptoms. However, the same effect was untrue for perfectionism. In other words, as an answer to the research question, it can be said that the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms changed according to coping styles as measured by SBTÖ, but not according to perfectionism as measured by ÇBMÖ.

Research Question 4B: Does the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms change according to coping styles as measured by RÖGÖ and dimensions of perfectionism as measured by ÇBMÖ?

There is one latent variable in this research question. It is perfectionism, which is an exogenous variable of this research question. It is measured by three dimensions, namely “self-oriented”, “other-oriented” and “socially-prescribed”. Another exogenous variable of this research question is coping strategies as measured by RÖGÖ. The last exogenous variable of this question is perceived intensity of life events in terms of their stressfulness and the endogenous variable is depressive symptoms. The hypothesized model of this research question is shown in Fig 19.

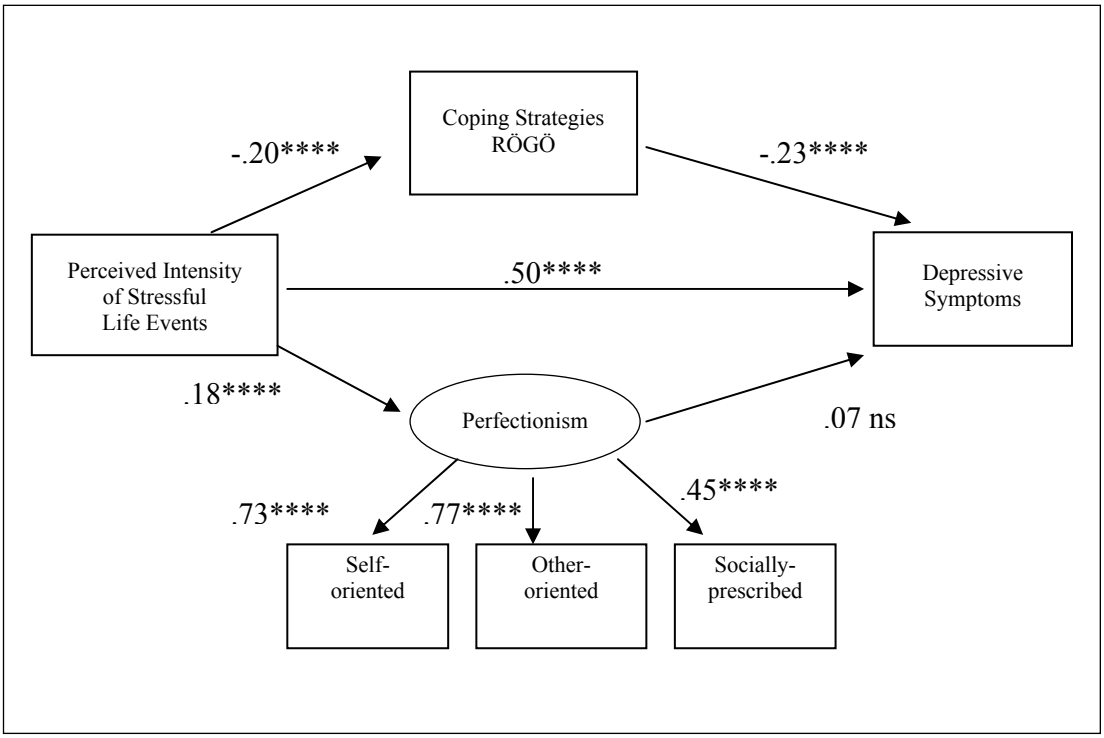
Fig. 19: *Hypothesized Model for the Relationship among Coping Strategies as Measured by RÖGÖ, Dimensions of Perfectionism, the Perceived Intensity of Life Events in terms of Their Stressfulness and Depressive Symptoms*



The goodness of fit statistics for this model fit significantly, for the present sample (χ^2=1.52, *df*=2, *p*=.50), and the goodness of indices show a well-fit between

sample data and the model (CFI=1.00). However, not all relationships in the model are significant. The relationship between perfectionism and BDE is not significant (p=.02) (See Figure 20).

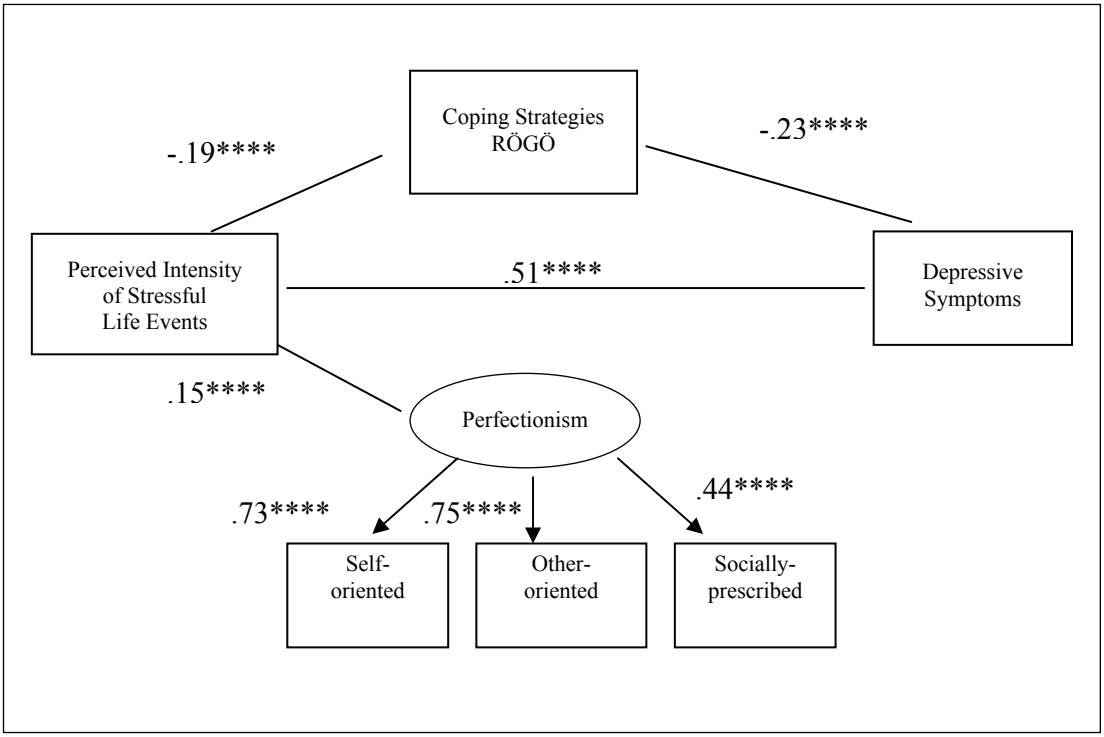
Fig. 20: *Estimated Model for the Relationship among Coping Strategies as Measured by RÖGÖ, Dimensions of Perfectionism, the Perceived Intensity of Life Events in terms of Their Stressfulness and Depressive Symptoms*



n=1089
*p<.05, **p<.01, ***p<.005; ****p< .001

The modified model, which represents only the statistical results of the relationships within the model, again fit significantly for the present sample (χ^2=1.90, df=2, p=.40), the χ^2 showing no difference. The goodness of indices show a well-fit between sample data and the model (CFI=.1.00). The modified model is shown in Figure 21.

Fig. 21: *Modified Model for the Relationship among Coping Strategies as Measured by RÖGÖ, Dimensions of Perfectionism, the Perceived Intensity of Life Events in terms of Stressfulness and Depressive Symptoms*



n=1089

*p<.05, **p<.01, ***p<.005; ****p< .001

Table 31 presents the β values and accounted amount of variances both for the hypothesized and the modified model. As can be seen from the table, all relationships in the modified model are significant (p=.00).

Table 31*: The Relationship Values for the Model for the Relationship among the Perceived Intensity of Life Events in terms of Their Stressfulness, Depressive Symptoms, Coping Strategies as Measured by RÖGÖ and Dimensions of Perfectionism as Measured by ÇBMÖ*

Relationship between the Perceived Intensity of Life Events in terms of Their Stressfulness and Coping Strategies

-	*b value*	*β value*	*Standard error*	*Z value*	*Amount of variance accounted*	*Alpha*
Hypothesized model	-.01	-.02	.02	4.50	.00	.00
Modified model	-.09	-.18	.02	-6.30	.03	.00

Relationship between Coping Strategies and Depressive Symptoms

	b value	*β value*	*Standard error*	*Z value*	*Amount of variance accounted*	*Alpha*
Hypothesized model	-.12	-.23	.02	-9.10	.05	.00
Modified model	-.12	-.23	.01	-9.10	.05	.00

Relationship between the Perceived Intensity of Life Events in terms of Their Stressfulness and Depressive Symptoms

	b value	*β value*	*Standard error*	*Z value*	*Amount of variance accounted*	*Alpha*
Hypothesized model	.14	.5	.01	19.69	.25	.00
Modified model	.14	.5	.01	20.70	.25	.00

Relationship between the Perceived Intensity of Life Events in terms of Their Stressfulness and Perfectionism

	b value	*β value*	*Standard error*	*Z value*	*Amount of variance accounted*	*Alpha*
Hypothesized model	.04	.18	.00	4.50	.03	.00
Modified model	.03	.14	.01	3.80	.01	.00

Relationship between Perfectionism and Depressive Symptoms

	b value	*β value*	*Standard error*	*Z value*	*Amount of variance accounted*	*Alpha*
Hypothesized model	.09	.07	.04	2.30	.00	.02
Modified model	-	-	-	-	-	-

As seen in Table 31, the relationship between perceived intensity of life events and coping strategies is significant with a standardized β value of -.18 (p=.00); between coping strategies and depressive symptoms with a standardized β value of -.23 (p=.00); between perceived intensity of life events and depressive symptoms with a standardized β value of .50 (p=.00); and between perceived intensity of life events and perfectionism with a standardized β value of .14 (p=.00). Perceived intensity of life events accounts for 25.00% of depressive symptoms, whereas coping strategies account for 5% of depressive symptoms. Together, perceived intensity of life events and coping strategies account for 33% of depressive symptoms.

As a result, it can be said that the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms changed according to coping strategies as measured by RÖGÖ. However, the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms did not change according to perfectionism as measured by ÇBMÖ.

D- Additional Analysis

Regression Analysis

After ÜÖYO-S was taken out, stepwise regression analysis was carried out to test the validity of the relationship between the independent variables and the dependent variable, which is depressive symptoms, as measured by BDE, in this

study (Tsuang *et al*., 1995). The independent variables entered for regression analysis were: perceived intensity of life events in terms of their stressfulness (ÜÖYO-Y), dimensions of coping styles (SBTÖ): "problem-oriented/ effective" and "emotion-oriented/ in effective", coping styles (SBTÖ): "seeking social support" factor, coping strategies (RÖGÖ), dimensions of perfectionism (ÇBMÖ): "self-oriented" (ÇBMÖ-SO), "other-oriented" (ÇBMÖ-OO) and "socially-prescribed" (ÇBMÖ-SP). All the dimensions of perfectionism, as measured by ÇBMÖ, were excluded. The results show that depressive symptom scores, as measured by BDE, are 30.8% explained by perceived intensity of life events in terms of their stressfulness alone; 36.60% by perceived intensity of life events in terms of their stressfulness and coping styles: "problem-oriented/ effective coping style"; 39.80% by perceived intensity of life events in terms of their stressfulness, coping styles: "problem-oriented/ effective coping" , coping styles: "emotion-oriented/ ineffective coping"; and 40.50% by perceived intensity of life events in terms of their stressfulness, coping styles: "problem-oriented/ effective coping" , coping styles: "emotion-oriented/ ineffective coping", and coping styles: "seeking social support" factor; and 41% explained by perceived intensity of life events in terms of their stressfulness, coping styles: "problem-oriented/ effective coping" , coping styles: "emotion-oriented/ ineffective coping", and coping styles: "seeking social support" factor and coping strategies, as measured by RÖGÖ (p= .00) (See Table 33).

Table 32: *Model Summary of Regression Analysis- Stepwise*

Model	*R*	*R²*	*Adj. R Square*	*Std. Error of the Estimate*	*Change Statistics*				
					R Square Change	*F Change*	*Df1*	*df2*	*Sig. F Change*
1 ÜÖYO-Y	.56[a]	.31	.31	6.47	.31	484.68	1	1087	.00
2 ÜÖYO-Y, SBTÖ-PO	.61[b]	.37	.37	6.19	.06	100.48	1	1086	.00
3 ÜÖYO-Y, SBTÖ-PO, SBTÖ-EO	.63[c]	.40	.40	6.03	.03	59.52	1	1085	.00
4 ÜÖYO-Y, SBTÖ-PO, SBTÖ-EO, SBTÖ-Sos	.64[d]	.41	.41	6.00	.01	13.70	1	1084	.00
5 ÜÖYO-Y, SBTÖ-PO, SBTÖ-EO, SBTÖ-Sos, RÖGÖ	.642[e]	.41	.41	5.97	.01	9.34	1	1083	. 00

Table 33: *One-way Analysis of Variance of Regression*

Model		*Sum of Squares*	*Df*	*Mean Square*	*F*	*Sig.*
1	Regression	20277.61	1	20277.61	484.68	.00
	Residual	45477.06	1087	41.84		
	Total	65754.66	1088			
2	Regression	24128.92	2	12064.46	314.76	.00
	Residual	41625.74	1086	38.33		
	Total	65754.66	1088			
3	Regression	26293.55	3	8764.52	240.98	.00
	Residual	39461.11	1085	36.37		
	Total	65754.66	1088			
4	Regression	26759.00	4	6696.50	186.28	.00
	Residual	38968.66	1084	35.949		
	Total	65754.66	1088			
5	Regression	27119.19	5	5423.84	152.04	.00
	Residual	38635.47	1083	35.67		
	Total	65754.66	1088			

The coefficients of stepwise regression are shown in Table 34. As can be seen from the table, perceived intensity of life events in terms of their stressfulness (ÜÖYO-Y), coping styles (SBTÖ): “problem-oriented/ effective coping” and “emotion-oriented/ ineffective coping”, coping styles (SBTÖ): “seeking social support”, and coping strategies (RÖGÖ), were all found to be significant.

Table 34: *Coefficients of Stepwise Regression*

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	*Std. Error*	*Beta*	*T*	*Sig.*
1	Constant	-8.42	.92		-9.12	.00
	UOYO-Y	.15	.01	.56	22.02	.00
2	Constant	4.26	1.54		2.76	.01
	ÜÖYO-Y	.14	.01	.50	20.25	.00
	SBTÖ-PO	-3.87	.39	-.25	-10.02	.00
3	Constant	-2.17	1.72		-1.26	.21
	ÜÖYO-Y	.12	.01	.43	16.82	.00
	SBTÖ-PO	-3.25	.38	-.21	-8.47	.00
	SBTÖ-EO	3.44	.45	.20	7.72	.00
4	Constant	.70	1.88		.37	.71
	ÜÖYO-Y	.12	.01	.43	16.94	.00
	SBTÖ-PO	-3.16	.38	-.20	-8.25	.00
	SBTÖ-EO	3.41	.44	.20	7.69	.00
	SBTÖ-Sos	-1.08	.29	-.09	-3.70	.00
5	Constant	4.33	2.21		1.95	.05
	ÜÖYO-Y	.12	.01	.43	16.95	.00
	SBTÖ-PO	-2.35	.46	-.15	-5.07	.00
	SBTÖ-EO	3.21	.45	.19	7.20	.00
	SBTÖ-Sos	-1.07	.29	-.09	-3.70	.00
	RÖGÖ	-.05	.02	-.09	-3.06	.00

Additional analyses to investigate the possible differences on depressive symptoms (measured by BDE), perceived intensity of life events (measured by ÜÖYO-Y), coping styles (as measured by SBTÖ), coping strategies (as measured by RÖGÖ) and dimensions of perfectionism (as measured by ÇBMÖ) according to gender, grade level and faculty have been done. See Appendix K for one-way analysis of variance results.

VI – DISCUSSION

In this part, initially, the descriptive results of the study variables, namely depressive symptoms, perceived intensity of life events in terms of their stressfulness, coping styles and strategies, and perfectionism, will be discussed followed by the discussion of results according to the research questions. Although the main aim of this study was to analyze the interaction of coping styles and strategies and depressive symptoms, all study variables have been analyzed and discussed. In the last part of discussion section, implications as well as the limitations of the study and recommendations for further work are given.

A- General Discussion

1) Discussion According to Descriptive Results

Depressive Symptoms (BDE)

As the dependent variable of this study, BDE scores are an important source of information. For this study, the mean score of BDE was found as 11.44 (n=1089) (Table 15). In terms of frequency and percentage distribution, in this study, 47.10% of the sample was “not depressed”, whereas 26.40% was “mildly depressed”, 18.60% was “moderately depressed” and 7.80% of the sample was “severely depressed” with a maximum score of 47 out of 63, according to the classification of Bryson (1984). According to Bryson, scores between 0-9 refers to “not depressed” category; between 10-15 refers to “mildly depressed” category; between 16-23 refers to “moderately depressed” category, and between 24-63 refers to “severely depressed” category. It can be stated that only less than half of the sample is not depressed, or in other words, more than half of the sample is depressed at some level. Since, according to Bryson (1984), scores between 10 and 15 indicate “mildly depressed”

state, it can also be stated that, generally the sample in this study is in "mildly depressed" state.

Other studies done with university students in Turkey have found very similar results (Yorulmaz, 2002; Kaymakçıoğlu, 2001; Oral, 1999). In Turkey, Yorulmaz (2002), in his study with 388 students from Uludağ University, found a mean BDI score of 10.27 for the total sample. Kaymakçıoğlu (2001), in her study with 220 Boğaziçi University students, found an average mean score of 11.34. In 1999, Oral, in her study with 333 students from Middle East Technical University, found a BDE mean of 10.50 for the total sample (Oral, 1999, p.46). As can be seen in cited literature, the data after 1999 shows that university students' mean for depressive tendency is in the "mildly depressed" level, according to Bryson's classification (1984). However, Aytar (1985), in her study with 306 Medical Faculty students of Istanbul University, found a mean score of 9.1 for the total sample. Also, Yeniçeri (1984), in her study with 124 lycee-two students with a mean age of 17, found a BDI score of 8.12 for the total sample. This shows that during 1980's, studies show young people to be in the "not depressed" state, according to Bryson's classification (1984). This change in depressive symptom levels might be due to the fact that, modern life brings with itself more responsibilities and time constraints, also more stress which is likely to result in experiencing more depressive symptoms.

Studies done with university students in United States of America (U.S.A.) also have found similar results (Hewitt, 2003). In the U.S.A, in a study carried out with 280 university students by Hewitt et al. (2003), the mean score of Beck Depression Inventory for total sample has been found to be 10.26.

In terms of gender difference according to BDI scores, the mean score for females was 11.42, while for males it was 11.46 (See Table 15) and no difference

was found for gender in this study. Other studies in Turkey have found similar results (Kaymakçıoğlu, 2001; Oral, 1999; Yeniçeri, 1984). Kaymakçıoğlu (2001), in her study with 220 Boğaziçi University students, found an average mean score of 10.29 for males and 12.28 for females. In 1999, Oral found a mean of 10.57 for males and 10.52 for females. In addition, Yeniçeri (1984), in her study with 124 lycee-two students with a mean age of 17, found a BDI score of 7.80 for males and 8.48 for females. All of these studies found no significant difference between males and females in terms of BDI scores (Kaymakçıoğlu, 2001; Oral, 1999; Yeniçeri, 1984). On the other hand, Tokay-Özdamar et. al. (1997), in a study with 1883 Boğaziçi University undergraduate students, determined "low depression group" and high "depression group" according to classifying the students falling in the first 25 percentage and the fourth 25 percentage of depression scores; found females to be more depressed than males. She has found that the scores of females in the high depression group are higher than that of males, suggesting females being more depressed than males.

Some studies done in the U.S.A. with university students have not found significant gender differences (Hewitt et al., 2003; Vredenburg et al., 1988). On the other hand, some studies found significant gender differences (Nolen-Hoeksema, 2001 & Kessler et al., 1994 cited in Clark et al., 1999). Nolen-Hoeksema (2001) has stated that females are twice as likely as males to experience depression, from early adolescence through early adulthood, based on results of research they have carried out. Other researchers have stated similar findings. Lifetime risk for depression is stated to be approximately 21% for females, and 12% for males by Kessler et al. (1994) (cited in Clark et al., 1999, p.260), suggesting a difference for gender, just like Nolen-Hoeksema did. According to recent studies that have focused on gender

differences in literature, both in Turkey and in the U.S.A., findings are not conclusive, some studies finding significant gender differences while others do not. It is interesting that for university populations in Turkey, in general, significant gender differences are not found. This might mean that the environment and stressors of university students in Turkey are such that, it minimizes gender differences.

Perceived Intensity of Life events in terms of Their Stressfulness (ÜÖYO-Y)

The perceived intensity of life events in terms of their stressfulness was measured by ÜÖYO-Y for this study. The minimum score a person can get is 54, and the maximum score is 270. Since this measure has been developed in 1999, not many studies have been done using this measure. As a result, it is not possible to make comparisons among a wide range of different samples.

In the present study, the mean score for the total sample was found to be 131.71 (See Table 16). Another study in Turkey has found similar results (Oral, 1999). Oral used ÜÖYO as a measure of frequency of life events, not perception of life events in terms of their stressfulness and found a mean of 113.72 for females, and 109.70 for males (1999).

In this study, in terms of gender, the mean score for females was 134.33, while for males it was 128.84 (See Table 16), and there was a significant difference between females and males: scores of females being significantly higher ($p<.001$) (See Table 40). In terms of gender differences, some studies in Turkey have found contradictory results (Dinç, 2001; Kaymakçıoğlu, 2001; Oral, 1999). Dinç (2001) found that there was no significant difference between the ÜÖYO-Y scores of females and males. In Oral's (1999) study, a significant difference in terms of gender according to ÜÖYO scores was not found, either. On the other hand, Kaymakçıoğlu (2001) reported that females reported significantly higher levels of perceived stress.

Coping Styles (Stresle Başa Çıkma Tarzları Ölçeği- SBTÖ)

Coping styles was measured by SBTÖ in this study. In terms of factors, the mean score for SBTÖ "self-confident" factor was found to be 2.92; "optimistic" was 2.70; "submissive" was 1.92; "helpless" was 2.26; and "seeking social support" was 2.87 (See Table 17). The highest mean for total sample in this study belonged to "self-confidence" factor, followed by "seeking social support", "optimistic", "helpless" and "submissive" factors. Other studies done with Boğaziçi University undergraduate students have found both similar and contradictory results (Tokay-Özdamar, 1997). In a study by Tokay-Özdamar et. al.(1997) with 1883 Boğaziçi University undergraduate students, it was found that the highest mean belonged to "self-confidence" factor ($\bar{x}$=1.99), which is the same factor that has the highest mean in this study. The second factor that has the highest mean in Tokay-Özdamar et. al.'s study (1997) is "optimistic" factor ($\bar{x}$=1.63). However, "optimistic" factor is the third factor in this study that has the highest mean. In addition, the lowest mean belonged to "helplessness" factor ($\bar{x}$=.75) in Tokay-Özdamar et. al.'s study (1997); whereas in this study, the lowest mean belonged to "submissive factor".

The mean score of "self-confidence" factor for females was 2.90 and for males 2.94; "optimistic" factor for females was 2.57 and for males 2.70; "submissive" factor for females was 1.88 and for males 1.96; "helpless" factor for females was 2.28 and for males 2.23; and "seeking of social support" for females was 2.99 and for males 2.75 (See Table 17). Results of ANOVA showed that the mean differences for "Optimistic" (F(1, 1087)=15.67, p<.00), "submissive" (F(1,1087)=7.18, p<.01) and "seeking social support" (F(1, 1087)=42.39, p<.00) factors were significantly different for gender (See Table 45). Males used "optimistic" and "submissive" factors significantly more than females did, whereas

females used “seeking social support” style of coping more than males did. But, no significant gender differences were found for “self-confidence” and “helpless” factors. In Turkey in studies similar results were found (Şahin & Durak, 1995). Şahin & Durak found that for “submissive” and “helpless” factors, no gender difference was found, which partly supports the findings of this study in terms of “helpless” factor results. In addition, Şahin & Durak (1995, p.69) found that for seeking social support factor, there was a significant gender difference according to ANOVA results: females used this coping factor more than males did, which was also found in this study.

In terms of dimensions, the coping styles scale (SBTÖ) has two dimensions, which are “problem-oriented/effective style” (self-confident and optimistic) and “emotion-oriented/ ineffective style” (submissive and helpless).The mean score for “problem-oriented/effective style” was 2.78; and “emotion-oriented/ ineffective style” was 2.09 (See Table 18).

The mean score of “problem-oriented/effective style” dimension for females was 2.74 and for males 2.82; and “emotion-oriented/ ineffective style” dimension for females was 2.08 and for males 2.10 (See Table 18). ANOVA results showed that gender differences were statistically significant for “Problem-oriented/effective style” dimension ($F(1, 1087)=8.31$, $p<.00$); males using this style significantly more than females (See Table 47); whereas for “emotion-oriented / ineffective style” there was no gender difference. In Turkey, supporting the outcome of this study, Şahin & Durak (1995) have not found any gender difference for “emotion-oriented” coping style too.

Literature, however, states that females use more emotion-oriented coping. Şahin & Durak state that this difference in results might be due to the fact that the females in their study were mainly university students or university graduates.

Coping Strategies (Rosenbaum's Learned Resourcefulness Schedule- RÖGÖ)

Coping strategies as measured by RÖGÖ, in terms of mean differences will be discussed, including gender. In this study, the mean score for RÖGÖ was 115.28 with a standard deviation value of 15.749. The mean score for females was 116.69 and for males 113.76 (See Table 19). In addition, there was a significant difference among females and males for RÖGÖ scores ($F(1, 1087)=10.42$, $p<.00$) (See Table 49). The mean scores of females were significantly higher than males, meaning than females used more cognitive strategies for coping.

Erseven Yılmaz, in her study with 222 Hacettepe University students in Ankara, found similar mean scores (1993). She found a mean score of 110.32 for total sample; for females the mean was 108.1, for males 112.54. However, contrary to the findings of this study, the significant difference between females and males that Erseven Yılmaz (1993) found showed that males used significantly more cognitive strategies than females. As a result, it can be stated that the results in literature are inconsistent for gender differences.

Perfectionism (ÇBMÖ)

Perfectionism dimensions as measured by ÇBMÖ, in terms of mean differences will be discussed, including gender as well. In the present study, the mean score for "self-oriented" dimension of ÇBMÖ was 70.38; "other-oriented" dimension was 60.01; and "socially-prescribed" dimension was 55.67 (See Table 20).

The mean and standard deviation scores of perfectionism dimensions in terms of gender is as the following: “self-oriented perfectionism” for females 70.40, and for males 70.36; “other-oriented perfectionism” for females 59.92, and for males 60.11; “socially-prescribed perfectionism” for females 53.82, and for males 57.70 (See Table 20). On the other hand, Oral (1999) found for “self-oriented perfectionism”, a mean score of 82.93 for females and 85.17 for males; for “other-oriented perfectionism”, a mean score of 37.50 for females and 39.76 for males, and for “socially-prescribed perfectionism”, a mean score of 52.09 for females and 52.96 for males. On other-oriented perfectionism dimension, the mean for females and males seem to be higher than the means found in Oral’s study.

In this study, there was a significant difference for “socially-prescribed perfectionism” dimension of perfectionism, as measured by ÇBMÖ, between females and males *(F*(1, 1087)=24.26, *p*=.00) (See Table 50); whereas there was no significant difference for “self-oriented perfectionism” and “other-oriented perfectionism” dimensions Males were found to experience significantly more “socially-prescribed perfectionism” than females. Other studies have found contradictory results (Oral, 1999). Oral (1999), in terms of gender, found that the means for “self-oriented perfectionism” and “socially-prescribed perfectionism” did not significantly differ; however, a significant difference was found for “other-oriented perfectionism” in terms of gender. Compared to females, males scored higher on “other-oriented perfectionism” according to the results of Oral’s study; whereas in this study the difference for males was found for “socially-prescribed perfectionism” dimension.

In addition, Dinç (2001) found that students tended to have higher “self-oriented perfectionism” scores compared to “socially-prescribed” and “other-oriented

perfectionism" scores. She also found a significant gender difference: both males ($\bar{x}$=4.58) and females ($\bar{x}$=4.58) received higher scores on "self-oriented perfectionism" dimension as compared to "socially- described perfectionism" ($\bar{x}$=3.98 for males; $\bar{x}$=3.62 for females) and "other-oriented perfectionism" ($\bar{x}$=3.82 for males; $\bar{x}$=3.84 for females). In addition males scored significantly higher on "socially-prescribed perfectionism" dimension ($\bar{x}$= 3.98) compared to females ($\bar{x}$=3.62), supporting this study's findings. However, there were no significant differences among females and males according to "self-oriented perfectionism" ($\bar{x}$=4.58 both for males and females) and "other-oriented perfectionism" ($\bar{x}$= 3.82 for females and $\bar{x}$=3.82 for males). It should be noted that females received higher scores on "other-oriented perfectionism" compared to "socially-prescribed perfectionism". However, scores of males on "other-oriented perfectionism dimension" and "socially-prescribed perfectionism" dimensions didn't significantly differ.

As can be seen in literature, there are studies that support gender as well as studies which support the view that there are no significant gender differences.

2) Discussion According to Research Questions

Research Question 1: Is there any difference between students who are not depressed and as well as those in different categories of depressive symptoms as measured by BDE in terms of perceived intensity of life events (as measured by ÜÖYO-Y), coping styles (as measured by SBTÖ), coping strategies (as measured by SBTÖ), and perfectionism dimensions (as measured by ÇBMÖ)?

To be able to answer this question, depressive symptom scores were categorized according to Bryson's (1984) classification as discussed earlier.

Perceived Intensity of Life events in terms of Their Stressfulness (ÜÖYO-Y) and Depressive Symptoms:

The correlation analysis results showed that there was a positive correlation between ÜÖYO-Y and BDE (r= .56; p<.01) (See Table 14). Literature supports this interaction. Aytar (1985) found a positive correlation between BDI scores and self-rating of negative perception of life events; in other words, the higher the negative perception scores on life events, the higher the depressive symptom scores on the BDI (r=.0.53; p<.001).

Mean scores of ÜÖYÖ-Y according to BDE categories of participants were calculated in order to see whether there was a specific relationship. A specific relationship was found between perceived intensity of life events and depressive symptoms: as participants experienced intensity of life events as more stressful, the more depressive symptoms they showed and vice versa (See Table 21). Analysis showed that there was a significant difference between mean differences of perceived intensity of life events and depressive symptoms for all categories (F(3,1085)=126.87; p<.00) (Table 22). Multiple regression analysis results also supported these findings: that is perceived intensity of life events explain 30.8% of depressive symptoms (See Table 33).

As a result it can be said that as cognitive theory of depression states, there is a significant interaction between how people perceive life events and the level of depressive symptoms they show (Clark et. al., 1999).

Coping Styles (Stresle Başa Çıkma Tarzları Ölçeği- SBTÖ) and Depressive Symptoms:

The correlation analysis results showed that there was a negative correlation between "problem-oriented / effective coping" style and depressive symptoms (r =-.36; p<.01) (See Table 14). In other words, as people use more "problem-oriented coping" style, they show less depressive symptoms. Also, there was a positive correlation between "emotion-oriented / ineffective coping" style and depressive symptoms (r= .42; p<.01) (See Table 14) . In other words, as people used more "emotion-oriented coping" style, the more depressive symptoms they showed. Literature supports this interaction (Şahin& Durak, 1995). Results of studies indicated that "emotion-oriented coping" style was used by individuals who experienced more psychological symptoms, while "problem-oriented coping" style was used by individuals who experienced less psychological symptoms (Şahin & Durak, 1995).

Mean scores of dimensions of coping styles according to depressive symptom scores of participants were calculated in order to see whether there was a specific relationship. A specific relationship was established, such that as participants used less "problem-oriented/ effective coping" style, they displayed more depressive symptoms and vice versa (See Table 23). In addition, a specific relationship was found for "emotion-oriented / ineffective coping" style, that is as participants used more "emotion-oriented/ ineffective coping" style, they displayed more depressive symptoms and vice versa (See Table 23). ANOVA results showed that there was a significant difference between mean differences of "problem-oriented/ effective coping" style and depressive symptoms except for second and third categories, which are mildly and moderately depressed categories (See Table 24; Appendix H). In

terms of “emotion-oriented/ ineffective coping” style, there was a significant difference for all categories.

Multiple regression analysis results also supported these findings: “problem-oriented/ effective coping” style explained 6.6% of depressive symptoms; and “emotion-oriented / ineffective coping” explained 3.2% of depressive symptoms (See Table 33).

Şahin & Durak (1995) have found in the three studies carried out to test the validity and reliability of coping styles as measured by SBTÖ that, participants who show more depressive symptoms were found to use more “emotion-oriented/ effective coping” styles as compared to “problem-oriented/ effective coping” styles, which is also supportive of the findings of the present study. As a result, it can be said that “problem-oriented / effective coping” style may be an effective method of coping whereas “emotion-oriented/ ineffective coping” may not be as effective.

Coping Strategies (Rosenbaum’s Learned Resourcefulness Schedule-RÖGÖ) and Depressive Symptoms:

The correlation analysis results showed that there was a negative correlation between coping strategies and depressive symptoms: -.32 ($p<.01$) (See Table 14). In other words, as people use more coping strategies, they show less depressive symptoms. Literature supports this interaction (Siva, 1991; Dağ, 1991; Erseven Yılmaz, 1993).

Mean scores of coping strategies according to depressive symptom scores of participants were calculated and a specific relationship was found; that is as participants used more coping strategies, they displayed less depressive symptoms (See Table 25). Supporting this finding, Erseven Yılmaz (1993) found that

participants who showed different levels of stress had significantly different RÖGÖ scores; the more depressive symptoms the individuals experienced, the lower were the scores of RÖGÖ. Using Global Symptom Index to assess different levels of stress, Erseven Yılmaz (1993) found a negative correlation between Global Symptom Index and RÖGÖ scores (r= -.6740). People who displayed more symptoms used less cognitive strategies.

ANOVA results showed that scores of coping strategies according to depressive symptoms was significant for all categories except between 2nd and 3rd categories, which are the "mildly depressed" and the "moderately depressed" categories, according to Bryson's classification (1984) (See Table 26; Appendix I). As a result, it can be said that the "mildly depressed" and the "moderately depressed" groups are not significantly different from each other.

Multiple regression analysis results also supported these findings: "problem-oriented/ effective coping" style explains 5.8% of depressive symptoms (See Table 33).

Perfectionism (Çok Boyutlu Mükemmelliyetçilik Ölçeği-ÇBMÖ) and Depressive Symptoms:

The correlation analysis results showed that there was positive relationship among the dimensions of perfectionism and depressive symptoms: between "self-oriented perfectionism" dimension and depressive symptoms ($r=.08$; $p<.05$), "other-oriented perfectionism" dimension and depressive symptoms ($r=.09$; $p<.01$) and "socially-prescribed perfectionism" dimension and depressive symptoms ($r=.29$; $p<.01$) and depressive symptoms (See Table 14). This means that as people

experienced more “self-oriented perfectionism”, “other-oriented perfectionism” and “socially-prescribed perfectionism”, the more depressive symptoms they showed.

Mean scores of ÇBMÖ dimensions according to BDE category scores of participants were calculated and a specific relationship was found for “socially-prescribed perfectionism”: as participants experienced more “socially-prescribed perfectionism”, they displayed more depressive symptoms and vice versa (See Table 27). However, a relationship was not found for “self-oriented” and “other-oriented perfectionism” dimensions. Post hoc analysis results showed that the mean differences of perfectionism dimensions according to depressive symptom categories were statistically significant. There was no significant difference between “self-oriented perfectionism” and “other-oriented perfectionism” scores and depressive categories, whereas a significant difference was found between mean differences of “socially- prescribed perfectionism” and depressive symptom categories, that is the more “socially-prescribed” perfectionism an individual felt, the more depressive symptoms s/he experienced ($F(3,1085)=15.41$; $p<.00$) (See Table 28). The scores of “socially-prescribed perfectionism” according to depressive symptom categories was significant for all categories, except for the 2nd and 3rd categories (See Appendix J), which are the “mildly” and the “moderately depressed” categories according to Bryson’s classification (1984). As a result, it can be said that the mildly and the moderately depressed groups are not significantly different from each other for “socially-prescribed perfectionism” dimension.

In regression analysis, all the dimensions of perfectionism were excluded, which actually supports the fact that no pattern was found between “self-oriented” and “other-oriented perfectionism” scores and depressive symptom categories. The reason for this may be that in general most of the students have scored highly on the

self-oriented and other-oriented perfectionism and because most of the students experience high levels of perfectionism, it may not have a differentiating effect.

As a summary, a specific relationship was found for perceived intensity of life events in terms of "their stressfulness", coping strategies, dimensions of coping and "socially- prescribed perfectionism" dimension and depressive symptom categories. In other words, as participants experienced intensity of life events as more stressful; used less "problem-oriented coping" style and used more "emotion-oriented coping style; used less coping strategies and experienced "more social-prescribed perfectionism, they displayed more depressive symptoms. All of these findings are supported by literature. However, in this study, the mean differences for "mildly depressed" and "moderately depressed" students were not significantly different according to coping strategies, "problem-focused" and "emotion-focused coping" styles and "socially- prescribed perfectionism" dimensions.

Research Question 2A: Does the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms change according to coping styles as measured by SBTÖ?

When this research question was tested as a model in this study, it was found that the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms did not significantly change according to coping styles as measured by SBTÖ in the present sample.

Although correlation analysis showed that problem-oriented / effective and emotion-oriented coping styles were correlated with depressive symptom scores (See Table 14), the effect of coping styles on the relationship between perceived intensity of life events in terms of their stressfulness and depressive symptoms may not be

enough to explain this interaction. This result is consistent with cognitive theory of depression, which states that people have certain diathesis, or in other words vulnerabilities, that when in interaction with events that are congruent to those diathesis, may cause people to show depressive symptoms, based on how the event is perceived and how the person copes. As a result, coping styles by themselves may not be enough to explain the interaction between perceived intensity of life events and depressive symptoms is not surprising.

Research Question 2B: Does the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms change according to coping strategies as measured by RÖGÖ?

The result of the hypothesized model was that the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms did not significantly change according to coping strategies as measured by RÖGÖ.

Just like the result of the previous research question, the result of this research question is again consistent with cognitive theory of depression. Cognitive model of depression states that many factors are effective in the formation of depression, such as perception, personality variables, coping, etc.

As a result, the coping strategies, by themselves, may not be enough to explain the interaction between perceived intensity of life events and depressive symptoms.

Research Question 3: Does the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms change according to dimensions of perfectionism?

The results showed that the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms did not significantly change according to perfectionism as measured by ÇBMÖ in this sample. The relationship between perfectionism and depressive symptoms was found insignificant, which means that perfectionism was not able to significantly explain BDI Total scores, or in other words, perfectionism by itself could not have a significant effect on the relationship between the perceived intensity of life events in terms of their stressfulness and depressive symptoms.

The results imply that perfectionism may not have a moderating effect on the relationship between perceived intensity of life events in terms of their stressfulness and depressive symptoms (See Figure 15).

In a study, Oral (1999) found similar results. Oral measured the role of other-oriented perfectionism, life events and their interaction to predict depression. It was observed that all subscales of perfectionism contributed significantly to the BDI scores. However, the direction of the relationships according to ÇBMÖ subscales were different; there was a negative relationship between self-oriented perfectionism and BDI scores as well as other-oriented perfectionism and BDI scores; whereas there was a positive correlation between socially-prescribed perfectionism and BDI. Life events were found to be the most significant variable that contributed to the BDI scores. In addition, she also found that all of the perfectionism subscales were related to depression scores in both correlation and regression analyses. However, these relationships were in a negative direction for self and other-oriented perfectionism. There was a positive relation between socially prescribed perfectionism and depression. Also, there was a positive relationship between life events and depression scores in all of the regression and correlational analyses. She also tested whether the

interaction of life events with perfectionism subscales would be related to depression scores. The result was that none of the perfectionism dimensions interacted with life events to predict depression scores (Oral, 1999).

Research Question 4A: Does the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms change according to coping styles as measured by SBTÖ and dimensions of perfectionism?

According to the results of this model, coping styles had a significant effect on the relationship between the perceived intensity of life events in terms of their stressfulness and depressive symptoms. However, the same effect was untrue for perfectionism. In other words, as an answer to the research question, it can be said that the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms changed according to coping styles as measured by SBTÖ, but not according to perfectionism as measured by ÇBMÖ (See Figure 17).

The results imply that when both coping styles and perfectionism enter the model, perfectionism may act as a mediating variable, causing coping styles to have a significant relationship with depressive symptoms (See Figure 18).

In addition, the interaction of perfectionism causes coping styles to have a moderating effect between perceived intensity of life events in terms of their stressfulness and depressive symptoms. Coping styles account for 21% depressive symptoms. Overall, perceived intensity of life events and coping styles account for 29% of depressive symptoms (See Table 30).

Research Question 4B: Does the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms change according to coping styles as measured by RÖGÖ and dimensions of perfectionism?

According to the results of this model, the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms changed according to coping strategies as measured by RÖGÖ. However, the effect of perceived intensity of life events in terms of their stressfulness on depressive symptoms didn't change according to perfectionism as measured by ÇBMÖ (See Figure 20).

Consistent with the results of the previous research question, the results imply that when both coping strategies and perfectionism enter the model, perfectionism may act as a mediating variable, causing coping strategies to have a significant relationship with depressive symptoms.

In addition, the interaction of perfectionism causes coping strategies to have a moderating effect between perceived intensity of life events in terms of their stressfulness and depressive symptoms (See Figure 21). Perceived intensity of life events accounts for 25% of depressive symptoms, whereas coping strategies account for 5% of depressive symptoms. Together, perceived intensity of life events and coping strategies account for 33% of depressive symptoms (See Table 31).

Although both perceived intensity of life events and coping styles; and perceived intensity of life events and coping strategies accounted for around 30% of depressive symptoms; coping styles accounted for 21% of depressive symptoms whereas on the other hand, coping strategies accounted for 5% of depressive symptoms. This implies that coping strategies can only explain 5% variance compared to coping styles which can explain 21% variance.

3) Conclusion

When categories of depressive symptoms and their relationship to study variables, which are perceived intensity of life events in terms of their stressfulness, coping styles, coping strategies and perfectionism dimensions, are analyzed, the results showed that there are significant differences. As a summary, a specific relationship was found for perceived intensity of life events in terms of "their stressfulness", coping strategies, dimensions of coping and "socially- prescribed perfectionism" dimension and depressive symptom categories. In other words, as participants experienced intensity of life events as more stressful; used less "problem-oriented coping" style and used more "emotion-oriented coping style; used less coping strategies and experienced "more social-prescribed perfectionism, they displayed more depressive symptoms. However, in this study, the mean differences for "mildly depressed" and "moderately depressed" students were not significantly different according to coping strategies, "problem-focused" and "emotion-focused coping" styles and "socially- prescribed perfectionism" dimensions.

In addition, through model testing with Structural Equation Modeling, it was found that coping styles, coping strategies and perfectionism by themselves did not have a significant effect on the relationship between perceived intensity of life events and depressive symptoms. However, when both coping styles and strategies and perfectionism entered the model designed by Structural Equation Modeling, perfectionism acted as a mediator and caused coping, in terms of styles ($\beta = -.46$, $p < .001$) and strategies ($\beta = -.23$, $p < .001$), to have a significant effect on the relationship. The results also showed that an implication of the findings is that coping strategies can only explain 5% variance compared to coping styles which can explain 21% variance.

B- Implications

The results of this study show that coping styles and strategies may have a significant moderating effect on depressive symptoms. However, coping styles seem to account for 21% of depressive symptoms whereas coping strategies account for 5% of depressive symptoms. As a result, through giving training about coping styles, depressive symptoms can be changed.

For prevention of depressive symptoms, we need to work on skills training on problem-oriented and emotion-oriented coping styles, as well as perception of life events, perfectionism dimensions and coping strategies, especially with university students.

Since this study was done with Boğaziçi University students, the results can provide the Boğaziçi University Guidance and Psychological Counseling Centre with important information to plan and apply preventive studies for depressive symptoms.

In addition the results of the study showed that although coping styles and strategies and perfectionism alone could not have a significant effect on the relationship between perceived intensity of life events and depressive symptoms; when both coping styles and strategies, and perfectionism interacted, then coping became significant. As a result it can be said that perception, perfectionism, coping styles and strategies are all important variables related to depressive symptoms.

As stated by Frederich F. Flach (1974), “treatment after the fact is never as effective as prevention” (p.257). What prevention refers to is developing educational programs that will help individuals to strengthen their abilities to cope more effectively with the demands of living in a rapidly-changing world (Flach, 1974).

C-Limitations of the Study

The first limitation of this study is the length of the questionnaire. There are a total number of 6 measures to respond to, which takes about 25 to 60 minutes. Participants are likely to loose concentration while they are answering the last questions which can result in low reliability. Although two test taking orders have been used to prevent this, using shorter forms can be better to prevent reliability problems.

Another limitation is caused by the characteristics of the sample. Data was collected from university students mainly during class hours to be able to carry out stratified sampling. This caused data collection to take place during class hours in class environment. As a consequence, a limitation occurred which was other students being able to see the answers of students who are sitting next to them. --There are questions about the private life of participants which they may not desire to be learned by others, such as whether they are experiencing sexual problems. As a result, the presence of others is likely to cause social desirability bias. In addition, one of the aims of this study is finding out the severity of depressive symptoms students show. However, it is most likely that depressed students may not be attending classes which results in not being able to reach a part of the target population resulting in less generalizable and reliable results.

The Life Events Inventory for university students (ÜÖYO-Y) has been developed in 1999 and not many studies have been done using this measure. As a result, it was not possible to make comparisons among a wide range of different samples for this measure.

The generalizability of the results to whole student population could have been achieved if the questionnaire was applied in other public universities in addition

to private universities. Increasing the number of universities might have increased the generalizibility of the result.

D-Recommendations and Suggestions for Further Research

First of all, further research is recommended to investigate the role and effects of physiological factors in the diathesis-stress model of Cognitive Theory of Depression. This is an area which should be given priority. Moreover, further research is recommended to investigate the role and effects of psychological factors in the diathesis-stress model of Cognitive Theory of Depression. Although research is done with certain psychological factor such as perfectionism and locus of control, research with new variables should be also carried out, as well as research carried out with a combination of physiological and psychological factors together to give a better picture of Diathesis Stress Model.

In addition, further research is recommended in order to investigate the role and effect of psychological factors in the diathesis- stress model of depression. Parallel to the area of interest for this study, further research with different samples in terms of private/ public, more successful / less successful universities with an increased number of universities is recommended. In addition, studies with different age groups can also be very beneficial for comparison among age levels. Wide-scale studies would also serve the generalizability of the results.

A balanced representation of the faculties is recommended for further studies since unproportional representations of faculties are likely to cause problems about the reliability of post hoc analysis. It would be better if the faculties could have been represented proportionally in the sense that the results would be more generalizable for the target populations in the future.

The use of different sources for measurement is also recommended to measure variables more accurately. Different measures should be used to assess strategies and styles of coping, dimensions of perfectionism, as well as depression. More studies with ÜÖYO, which assesses the frequency and perceived stressfulness of life events, should be carried out to develop the measure to assess perception of life events or to use different measures for comparison. In this way, with the use of a wider range of measures, results of further research can be more reliable and can contribute to present research results.

More studies to test the diathesis-stress model of depression should be carried out. The role of personality variables and their interaction with other variables play an important moderating or mediating role in predicting depressive symptoms, which has been given importance lately. Studies with different approaches and different populations can provide a lot of information that can contribute to the cognitive theory of depression.

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Appendix – A

Demographic Information Form (DIF)

(Demografik Bilgi Formu)

BİLGİ FORMU

Boğaziçi Üniversitesi lisans öğrencilerinde yaşamda karşılaşılan durumlarla başetme ve değişik durumlar karşısındaki duygu ve tutumlar ile ilgili bir yüksek lisans tezi araştırması yürütmekteyiz. Çalışmanın sonuçlarını üniversitede öğrencilere verilen hizmetlerin etkinliğini arttırmak üzere kullanmak istiyoruz.

Bu anketi açıklıkla, içtenlikle ve soru atlamadan yanıtlayarak bu konuda yaptığımız araştırmaya yardımcı olacağınıza inanıyoruz.
Lütfen her soruyu dikkatlice okuyun ve sizin için en uygun olan seçeneği işaretleyin ya da bırakılan boşluğa yanıtınızı yazın. Lütfen emin olmasanız da her soruyu yanıtlamaya çalışın.

Verilen tüm yanıtlar sadece araştırmacılar tarafından, bireysel olarak değil toplu olarak değerlendirilecektir. Formda kimliğinizi belirtecek hiçbir bilgi bulunmamaktadır ve yanıtlarınız tamamen gizli tutulacaktır.

Katılımınız için teşekkür ediyoruz.

Eğitim Bilimleri Bölümü

1) Cinsiyetiniz: ( ) K ( ) E

2) Uyruğunuz: ( ) T.C.
( ) Diğer : Belirtiniz _____

3) Medeni durumunuz ( ) Bekar ( ) Evli

4) Doğduğunuz yıl: _____

5) Mezun olduğunuz lise:
( ) Anadolu Lisesi ( ) Teknik Lise
( ) Özel yabancı lise ( ) Özel Türk lisesi
( ) Düz Lise (Genel Lise) ( ) Fen Lisesi
( ) Meslek Lisesi ( ) Süper Lise
( ) Anadolu Öğretmen Lisesi ( ) Açık Öğretim
( ) İmam Hatip Lisesi
( ) Diğer: Belirtiniz _____

6) Fakülteniz:
( ) Fen Edebiyat Fakültesi
( ) İktisadi İdari Bilimler Fakültesi
( ) Eğitim Fakültesi
( ) Mühendislik Fakültesi
( ) Yabancı Diller Yüksekokulu
( ) Uygulamalı Bilimler Yüksekokulu
( ) Meslek Yüksekokulu

7) Bölümünüzün adı:
_____

8) Sınıfınız:
Hazırlık : ( ) Beginner ( ) Intermediate ( ) Advanced

( ) 1. Sınıf ( ) 2. Sınıf ( ) 3. Sınıf ( ) 4. sınıf ( ) 5. Sınıf

( ) Master ( ) Doktora

9) Lütfen doğru olan kutuya çarpı işareti koyun (**X**).

	Babanızın eğitim düzeyi
Okur-yazar değil	( )
Okur-yazar (ilkokul mezunu değil)	( )
İlkokul mezunu	( )
Ortaokul mezunu	( )
Lise mezunu	( )
Yüksekokul mezunu	( )
Üniversite mezunu	( )
Yüksek lisans mezunu	( )
Doktora mezunu	( )
Bilmiyorum	( )
	Annenizin eğitim düzeyi
Okur-yazar değil	( )
Okur-yazar (ilkokul mezunu değil)	( )
İlkokul mezunu	( )
Ortaokul mezunu	( )
Lise mezunu	( )
Yüksekokul mezunu	( )
Üniversite mezunu	( )
Yüksek lisans mezunu	( )
Doktora mezunu	( )
Bilmiyorum	( )

10) Okul masraflarınızı nasıl karşılıyorsunuz? (Birden fazla işaret / şık olabilir)
( ) Ailemden destek alıyorum.
( ) Burs alıyorum.
( ) Akrabalarımdan destek alıyorum.
( ) Çalışıyorum.
( ) Diğer (belirtiniz) _____

11) Hangisi sizin için doğru?
( ) Ailemle birlikte yaşıyorum.
( ) Bir aile üyesi veya akraba ile kalıyorum.
( ) Yalnız yaşıyorum.
( ) Evde arkadaşlarımla kalıyorum.
(Arkadaşlarımla bir evi paylaşıyorum.)
( ) Özel bir yurtta kalıyorum:
Belirtiniz_____
( ) B.Ü. yurdunda kalıyorum:
Belirtiniz_____
( ) Diğer (Belirtiniz) _____

12) Psikolojik problemlerden dolayı hiç yardım aldınız mı?

( ) Evet ( ) Hayır

Evet ise: Ne kadar süreyle? Belirtiniz:

_____

13) Çekirdek ailenizde psikolojik sorunlardan dolayı yardım almış / almakta olan kimse var mı?

( ) Evet ( ) Hayır

Evet ise: Kim (ler) Belirtiniz: _____

Ne kadar süreyle: Belirtiniz _____

Appendix – B

Life Events Inventory for University Students (LEIU)

(Üniversite Öğrencilerine Yönelik Yaşam Olayları Ölçeği -ÜÖYO)

SORU FORMU 1

Aşağıda günlük yaşantınızda size sıkıntı verebilecek bazı olaylar ve sorunlardan bahsedilmektedir. Her maddeyi dikkatli bir şekilde okuyarak, son bir ay içerisinde bu olay ya da sorunun size ne yoğunlukta bir sıkıntı yaşattığını ve ne kadar sıklıkla böyle bir olay ya da sorunla karşılaştığınızı maddelerin karşılarında bulunan seçeneklerden uygun rakamları işaretleyerek belirtiniz.

	Bu sorun size ne yoğunlukta bir sıkıntı yaşattı veya yaşatmakta?					Bu sorunu ne sıklıkta yaşadınız?				
	Hiç	Az	Orta	Fazla	Çok Fazla	Hiç	Az	Orta	Fazla	Çok Fazla
1. Derslerin ağırlığı ve yoğunluğu	1	2	3	4	5	1	2	3	4	5
2. Genel sağlık problemleri	1	2	3	4	5	1	2	3	4	5
3. Kız / Erkek arkadaşımla olan problemler	1	2	3	4	5	1	2	3	4	5
4. Barınma ile ilgili sorunlar	1	2	3	4	5	1	2	3	4	5
5. Ulaşım sorunu	1	2	3	4	5	1	2	3	4	5
6. Zaman sıkışıklığı	1	2	3	4	5	1	2	3	4	5
7. Anne babamla aramızdaki çatışmalar	1	2	3	4	5	1	2	3	4	5
8. Gelecekle ilgili kaygılar	1	2	3	4	5	1	2	3	4	5
9. Arkadaş ilişkilerinde yaşanan sorunlar	1	2	3	4	5	1	2	3	4	5
10. Ülkedeki olumsuz siyasi gelişmeler	1	2	3	4	5	1	2	3	4	5
11. Sevdiğim insanlardan ayrı olmak (Aile, arkadaşlar, vs.)	1	2	3	4	5	1	2	3	4	5
12. Çevresel koşullardan (gürültü, havalar, kirlilik, vs.) dolayı yaşanan sorunlar	1	2	3	4	5	1	2	3	4	5
13. Okula uyum sağlayamamak	1	2	3	4	5	1	2	3	4	5
14. Maddi problemler	1	2	3	4	5	1	2	3	4	5
15. Sosyal faaliyetlere katılamamak (spor, sinemaya, tiyatroya gitmek, vs.)	1	2	3	4	5	1	2	3	4	5
16. Öğretim görevlileri ile ilgili sorunlar	1	2	3	4	5	1	2	3	4	5
17. İnsanların birbirine karşı duyarsız olmaları	1	2	3	4	5	1	2	3	4	5
18. Yalnızlık kaygıları	1	2	3	4	5	1	2	3	4	5
19. Kişiliğimle ilgili kendimi sorgulamak	1	2	3	4	5	1	2	3	4	5
20. Yorgunluk	1	2	3	4	5	1	2	3	4	5
21. İçki, sigara ve benzeri alışkanlıkların verdiği rahatsızlıklar	1	2	3	4	5	1	2	3	4	5
22. Karar vermekte güçlük çekmek	1	2	3	4	5	1	2	3	4	5
23. Uykusuzluk	1	2	3	4	5	1	2	3	4	5
24. Beslenme problemi	1	2	3	4	5	1	2	3	4	5

25. Sorumluluklarımı yerine getirememek	1	2	3	4	5	1	2	3	4	5
26. Reddedilme korkusu	1	2	3	4	5	1	2	3	4	5
27. Fiziksel görünüşümle ilgili endişeler	1	2	3	4	5	1	2	3	4	5
28. Okulda başarısız olmak	1	2	3	4	5	1	2	3	4	5
29. Aileden birinin rahatsızlığı	1	2	3	4	5	1	2	3	4	5
30. Ödevler ya da projelerin verdiği rahatsızlıklar	1	2	3	4	5	1	2	3	4	5
31. Okuduğum bölümden memnun olmamak	1	2	3	4	5	1	2	3	4	5
32. Tüm ya da bazı konularda emeğimin karşılığını alamamak	1	2	3	4	5	1	2	3	4	5
33. Yeterince ders çalışamamak	1	2	3	4	5	1	2	3	4	5
34. Sınavların sıkışıklığı, sınav kaygısı	1	2	3	4	5	1	2	3	4	5
35. Okula devamsızlık problemleri	1	2	3	4	5	1	2	3	4	5
36. Yurt ya da ev arkadaşlarımla aramızdaki sorunlar	1	2	3	4	5	1	2	3	4	5
37. Kardeşim/lerimle ilgili sorunlar	1	2	3	4	5	1	2	3	4	5
38. Zamanımı yeterince iyi değerlendirememek	1	2	3	4	5	1	2	3	4	5
39. Kendimi insanlara yeterince ifade edememek	1	2	3	4	5	1	2	3	4	5
40. Ailevi problemler	1	2	3	4	5	1	2	3	4	5
41. Çalıştığım işle ilgili sorunlar	1	2	3	4	5	1	2	3	4	5
42. İş görüşmeleri ile ilgili kaygılar	1	2	3	4	5	1	2	3	4	5
43. Yayın organlarındaki kötü haberlerle ilişkili kaygılar	1	2	3	4	5	1	2	3	4	5
44. Derslerin İngilizce olmasından dolayı zorluk çekmek	1	2	3	4	5	1	2	3	4	5
45. Cinsel sorunlar	1	2	3	4	5	1	2	3	4	5
46. Kilomla ilgili kaygılar	1	2	3	4	5	1	2	3	4	5
47. Mezun olamama kaygısı	1	2	3	4	5	1	2	3	4	5
48. Hata yapma kaygısı	1	2	3	4	5	1	2	3	4	5
49. Eleştirilmekten duyduğum rahatsızlık	1	2	3	4	5	1	2	3	4	5
50. Tatmin edici ilişkiler kuramama / bulamama	1	2	3	4	5	1	2	3	4	5
51. Kız / erkek arkadaştan ayrılma	1	2	3	4	5	1	2	3	4	5
52. Ailemin beklentilerini yerine getirememe kaygısı	1	2	3	4	5	1	2	3	4	5
53. Tüm ya da bazı derslerde başarısız olma endişesi	1	2	3	4	5	1	2	3	4	5
54. Yaşadığım yere uyum sağlayamamak	1	2	3	4	5	1	2	3	4	5

Appendix – C

Beck Depression Inventory (BDI)

(Beck Depresyon Envanteri- BDE)

SORU FORMU 2

YÖNERGE: Aşağıda, kişilerin ruh durumlarını ifade ederken kullandıkları bazı cümleler verilmiştir. Her madde, bir çeşit ruh durumunu anlatmaktadır. Her maddede o ruh durumunun derecesini belirleyen 4 seçenek vardır. Lütfen bu seçenekleri dikkatle okuyunuz. Son bir hafta içindeki (şu an dahil) kendi ruh durumunuzu göz önünde bulundurarak, size en uygun olan ifadeyi bulunuz. Daha sonra, o maddenin yanındaki harfin üzerine (**X**) işareti koyunuz.

1- (a) Kendimi üzgün hissetmiyorum.
(b) Kendimi üzgün hissediyorum.
(c) Her zaman için üzgünüm ve kendimi bu duygudan kurtaramıyorum.
(d) Öylesine üzgün ve mutsuzum ki dayanamıyorum.

2- (a) Gelecekten umutsuz değilim.
(b) Geleceğe biraz umutsuz bakıyorum.
(c) Gelecekten beklediğim hiçbir şey yok.
(d) Benim için bir gelecek yok ve bu durum düzelmeyecek.

3- (a) Kendimi başarısız görmüyorum.
(b) Çevremdeki birçok kişiden daha fazla başarısızlıklarım oldu sayılır.
(c) Geriye dönüp baktığımda, çok fazla başarısızlığımın olduğunu görüyorum.
(d) Kendimi tümüyle başarısız bir insan olarak görüyorum.

4- (a) Herşeyden eskisi kadar zevk alabiliyorum.
(b) Herşeyden eskisi kadar zevk alamıyorum.
(c) Artık hiçbir şeyden gerçek bir zevk alamıyorum.
(d) Bana zevk veren hiçbir şey yok. Her şey çok sıkıcı.

5- (a) Kendimi suçlu hissetmiyorum.
(b) Arada bir kendimi suçlu hissettiğim oluyor.
(c) Kendimi çoğunlukla suçlu hissediyorum.
(d) Kendimi her an için suçlu hissediyorum.

6- (a) Cezalandırıldığımı düşünmüyorum.
(b) Bazı şeyler için cezalandırılabileceğimi hissediyorum.
(c) Cezalandırılmayı bekliyorum.
(d) Cezalandırıldığımı hissediyorum.

7- (a) Kendimden hoşnutum.
(b) Kendimden pek hoşnut değilim.
(c) Kendimden hiç hoşlanmıyorum.
(d) Kendimden nefret ediyorum.

8- (a) Kendimi diğer insanlardan daha kötü görmüyorum.
(b) Kendimi zayıflıklarım ve hatalarım için eleştiriyorum.
(c) Kendimi hatalarım için çoğu zaman suçluyorum.
(d) Her kötü olayda kendimi suçluyorum.

9- (a) Kendimi öldürmek gibi düşüncelerim yok.
(b) Bazen kendimi öldürmeyi düşünüyorum, fakat bunu yapmam.
(c) Kendimi öldürebilmeyi isterdim.
(d) Bir fırsatını bulsam kendimi öldürürüm.

10- (a) Her zamankinden daha fazla ağladığımı sanmıyorum.
(b) Eskisine göre şu sıralarda daha fazla ağlıyorum.
(c) Şu sıralarda her an ağlıyorum.
(d) Eskiden ağlayabilirdim, ama şu sıralarda istesem de ağlayamıyorum.

11- (a) Her zamankinden daha sinirli değilim.
(b) Her zamankinden daha kolayca sinirleniyor ve kızıyorum.
(c) Çoğu zaman sinirliyim.
(d) Eskiden sinirlendiğim şeylere bile artık sinirlenemiyorum.

12- (a) Diğer insanlara karşı ilgimi kaybetmedim.
(b) Eskisine göre insanlarla daha az ilgiliyim.
(c) Diğer insanlara karşı ilgimin çoğunu kaybettim.
(d) Diğer insanlara karşı hiç ilgim kalmadı.

13- (a) Kararlarımı eskisi kadar kolay ve rahat verebiliyorum.
(b) Şu sıralarda kararlarımı vermeyi erteliyorum.
(c) Kararlarımı vermekte oldukça güçlük çekiyorum.
(d) Artık hiç karar veremiyorum.

14- (a) Dış görünüşümün eskisinden daha kötü olduğunu sanmıyorum.
(b) Yaşlandığımı ve çekiciliğimi kaybettiğimi düşünüyor ve üzülüyorum.
(c) Dış görünüşümde artık değiştirilmesi mümkün olmayan olumsuz değişiklikler olduğunu hissediyorum.
(d) Çok çirkin olduğumu düşünüyorum.

15- (a) Eskisi kadar iyi çalışabiliyorum.
(b) Bir işe başlayabilmek için eskisine göre kendimi daha fazla zorlamam gerekiyor.
(c) Hangi iş olursa olsun, yapabilmek için kendimi çok zorluyorum.
(d) Hiçbir iş yapamıyorum.

16- (a) Eskisi kadar rahat uyuyabiliyorum.
(b) Şu sıralarda eskisi kadar rahat uyuyamıyorum.
(c) Eskisine göre 1 veya 2 saat erken uyanıyor ve tekrar uyumakta zorluk çekiyorum.
(d) Eskisine göre çok erken uyanıyor ve tekrar uyuyamıyorum.

17- (a) Eskisine kıyasla daha çabuk yorulduğumu sanmıyorum.
(b) Eskisinden daha çabuk yoruluyorum.
(c) Şu sıralarda neredeyse her şey beni yoruyor.
(d) Öyle yorgunum ki hiçbir şey yapamıyorum.

18- (a) İştahım eskisinden pek farklı değil.
(b) İştahım eskisi kadar iyi değil.
(c) Şu sıralarda iştahım epey kötü.
(d) Artık hiç iştahım yok.

19- (a) Son zamanlarda pek fazla kilo kaybettiğimi sanmıyorum.
(b) Son zamanlarda istemediğim halde üç kilodan fazla kaybettim.
(c) Son zamanlarda istemediğim halde beş kilodan fazla kaybettim.
(d) Son zamanlarda istemediğim halde yedi kilodan fazla kaybettim.

Daha az yemek yemeye çalışarak kilo kaybetmeye çalışıyorum.
Evet ( ) Hayır ( )

20- (a) Sağlığım beni pek endişelendirmiyor.
(b) Son zamanlarda ağrı, sızı, mide bozukluğu, kabızlık gibi sorunlarım var.
(c) Ağrı, sızı gibi sıkıntılarım beni epey endişelendirdiği için başka şeyleri düşünmek zor geliyor.
(d) Bu tür sıkıntılar beni öyle endişelendiriyor ki, artık başka hiçbir şey düşünemiyorum.

21- (a) Son zamanlarda cinsel yaşamımda dikkatimi çeken bir şey yok.
(b) Eskisine oranla cinsel konularla daha az ilgileniyorum.
(c) Şu sıralarda cinsellikle pek ilgili değilim.
(d) Artık cinsellikle hiç bir ilgim kalmadı.

Appendix – D

Coping Styles Scale (CSI)

(Stresle Başa Çıkma Tarzlar Envanteri -SBTÖ)

SORU FORMU 3

Aşağıda kötü bir durum veya olayla karşılaşıldığında kişilerin neler yapabileceğini anlatan 36 ifade vardır. Lütfen her maddeyi dikkatle okuyarak o maddede yer alan ifadenin size ne derece uygun olduğuna karar veriniz. Verdiğiniz karara göre aşağıdaki ölçeği dikkate alarak yandaki sayılardan uygun olanın üzerine (**X**) işareti koyunuz.

1. Hiç tanımlamıyor.
2. Biraz tanımlıyor.
3. Oldukça iyi tanımlıyor.
4. İyi tanımlıyor.
5. Çok iyi tanımlıyor.

	Sizi ne kadar tanımlıyor?				
	Hiç	Biraz	Oldukça iyi	İyi	Çok iyi
1. Sıkıcı bir iş yaparken, işin en az sıkıcı olan yanını ve bitirdiğimde elde edeceğim kazancı düşünürüm.	1	2	3	4	5
2. Beni bunaltan bir iş yapmak zorunda olduğumda, bunaltımı nasıl yenebileceğimi hayal eder, düşünürüm.	1	2	3	4	5
3. Duygularımı düşüncelerime göre değiştirebilirim.	1	2	3	4	5
4. Sinirlilik ve gerginliğimi yardım almadan yenmek bana güç gelir.	1	2	3	4	5
5. Kendimi bedbin (üzüntülü) hissettiğimde hoş olayları düşünmeye çalışırım.	1	2	3	4	5
6. Geçmişte yaptığım hataları düşünmekten kendimi alamam.	1	2	3	4	5
7. Güç bir sorunla karşılaştığımda düzenli bir biçimde çözüm yolları ararım.	1	2	3	4	5
8. Birisi beni zorlarsa işimi daha çabuk yaparım.	1	2	3	4	5
9. Zor bir karar vereceksem bütün bilgiler elimde olsa bile bu kararı ertelerim.	1	2	3	4	5
10. Okuduğum şeye kendimi veremediğimi farkettiğim zaman, dikkatimi toplamak için yollar ararım.	1	2	3	4	5
11. Çalışmayı planladığımda, işimle ilgili olmayan herşeyi ortadan kaldırırım.	1	2	3	4	5
12. Kötü bir huyumdan vazgeçmek istediğimde, bu huyumu devam ettiren nedir diye araştırırım.	1	2	3	4	5
13. Beni sıkan bir düşünce karşısında güzel şeyler düşünmeye çalışırım.	1	2	3	4	5
14. Günde iki paket sigara içiyor olsam, sigarayı bırakmak için muhtemelen başkasının yardımına ihtiyaç duyarım.	1	2	3	4	5
15. Kendimi kötü hissettiğimde neşeli görünmeye çalışarak ruh halimi değiştiririm.	1	2	3	4	5
16. Kendimi sinirli ve gergin hissettiğimde, sakinleştirici ilacım varsa, bir tane alırım.	1	2	3	4	5
17. Bedbin (üzüntülü) olduğumda kendimi hoşlandığım şeylerle uğraşmaya zorlarım.	1	2	3	4	5
18. Hemen yapabilecek durumda olsam bile hoşlanmadığım işleri geciktiririm.	1	2	3	4	5
19. Bazı kötü huylarımdan vazgeçebilmem için başkasının yardımına ihtiyaç duyarım.	1	2	3	4	5
20. Oturup belli bir iş yapmam güç geldiğinde, başlayabilmek için değişik yollar ararım.	1	2	3	4	5
21. Beni kötümser yapsa da, gelecekte olabilecek bütün felaketleri düşünmekten kendimi alamam.	1	2	3	4	5

22. Önce yapmam gereken işi bitirip, daha sonra gerçekten hoşlandığım işlere başlamayı tercih ederim.	1	2	3	4	5
23. Bedenimin herhangi bir yerinde ağrı hissettiğimde, bunu dert etmemeye çalışırım.	1	2	3	4	5
24. Kötü bir huyumu yendiğimde kendime olan güvenim artar.	1	2	3	4	5
25. Başarısızlıkla birlikte gelen kötü duyguları yenmek için, sık sık kendime bunun bir felaket olmadığını ve bir şeyler yapabileceğimi telkin ederim.	1	2	3	4	5
26.Kendimi patlayacakmış gibi hissettiğimde, "Dur, bir şey yapmadan önce düşün" derim.	1	2	3	4	5
27. Birine çok öfkelensem bile davranışlarımı kontrol ederim.	1	2	3	4	5
28. Genellikle bir karar vereceğim zaman, ani kararlar yerine bütün ihtimalleri gözönüne alarak sonuca varmaya çalışırım.	1	2	3	4	5
29. Acilen yapılması gereken şeyler olsa bile, önce yapmaktan hoşlandığım şeyleri yaparım.	1	2	3	4	5
30. Önemli bir işi elimde olmayan nedenlerle geciktirdiğimde kendi kendime sakin olmayı telkin ederim.	1	2	3	4	5
31. Bedenimde bir ağrı hissettiğim zaman, ağrıdan başka şeyler düşünmeye çalışırım.	1	2	3	4	5
32. Yapılacak çok şey olduğunda genellikle bir plan yaparım.	1	2	3	4	5
33. Kısıtlı param olduğunda, kendime bir bütçe yaparım.	1	2	3	4	5
34. Bir iş yaparken dikkatim dağılırsa, işi küçük bölümlere ayırırım.	1	2	3	4	5
35. Sık sık beni rahatsız eden nahoş düşünceleri yenemediğim olur.	1	2	3	4	5
36. Aç olduğum halde yemek yeme imkanım yoksa, ya açlığımı unutmaya ya da tok olduğumu düşünmeye çalışırım.	1	2	3	4	5

Appendix – E

Rosenbaum's Learned Resourcefulness Schedule (RLRS)

(Rosenbaum'un Öğrenilmiş Güçlülük Ölçeği- RÖGÖ)

SORU FORMU 4

Aşağıda kişilik özellik ve davranışlarına ilişkin bir dizi ifade bulunmaktadır. Her ifadeyi okuduktan sonra o görüşe ne kadar katıldığınızı belirtiniz. Tamamen katılıyorsanız 7 rakamını, hiç katılmıyorsanız 1 rakamını işaretleyiniz. Bu iki görüş arasındaki düşüncelerinizi rakamlardan sizce en uygun olanını yuvarlak içine alarak ifade edebilirsiniz. Eğer bir ifade ile ilgili fikriniz yoksa ya da kararsızsanız, 4 rakamını işaretleyiniz.

	Hiç Katılmıyorum						Tamamen Katılıyorum
1. Bir iş üzerinde çalıştığımda iş kusursuz olana kadar rahatlayamam.	1	2	3	4	5	6	7
2. Başkalarını, kolay pes ettikleri için eleştirmem.	1	2	3	4	5	6	7
3. Yakınlarımın başarılı olmaları gerekmez.	1	2	3	4	5	6	7
4. Arkadaşlarımı, en iyisinden azına razı oldukları için pek eleştirmem.	1	2	3	4	5	6	7
5. Başkalarının benden beklentilerini karşılamakta zorlanırım.	1	2	3	4	5	6	7
6. Amaçlarımdan bir tanesi yaptığım herşeyde mükemmel olmaktır.	1	2	3	4	5	6	7
7. Başkaları, yaptıkları herşeyin en iyisini yapmalıdırlar.	1	2	3	4	5	6	7
8. İşlerimde asla mükemmelliği hedeflemem.	1	2	3	4	5	6	7
9. Çevremdekiler benim de hata yapabileceğimi kolayca kabullenirler.	1	2	3	4	5	6	7
10. Bir yakınımın, yapabileceğinin en iyisini yapmamış olması benim için önemli değildir.	1	2	3	4	5	6	7
11. Bir işi ne kadar iyi yaparsam çevremdekiler daha da iyisini yapmamı beklerler.	1	2	3	4	5	6	7
12. Mükemmel olma ihtiyacını çok az hissederim.	1	2	3	4	5	6	7
13. Yaptığım birşey kusursuz değilse, çevremdekiler tarafından yetersiz bulunur.	1	2	3	4	5	6	7
14. Olabildiğim kadar mükemmel olmaya çalışırım.	1	2	3	4	5	6	7
15. Giriştiğim her işte mükemmel olmam çok önemlidir.	1	2	3	4	5	6	7
16. Benim için önemli olan insanlardan beklentilerim yüksektir.	1	2	3	4	5	6	7
17. Yaptığım her şeyde en iyi olmaya çalışırım.	1	2	3	4	5	6	7
18. Çevremdekiler, yaptığım her şeyde başarılı olmamı beklerler.	1	2	3	4	5	6	7
19. Çevremdeki insanlar için çok yüksek standartlarım yoktur.	1	2	3	4	5	6	7
20. Kendim için mükemmelden daha azını kabul edemem.	1	2	3	4	5	6	7
21. Başkalarının benden hoşlanması için her konuda üstün başarı göstermem gerekmez.	1	2	3	4	5	6	7
22. Kendilerini geliştirmek için uğraşmayan kişilere değer vermem.	1	2	3	4	5	6	7

23. Yaptığım işte hata bulmak beni rahatsız eder.	1	2	3	4	5	6	7
24. Arkadaşlarımdan çok şey beklemem.	1	2	3	4	5	6	7
25. Benim için başarı, başkalarını memnun etmek için daha çok çalışmak anlamına gelir.	1	2	3	4	5	6	7
26. Birisinden bir iş yapmasını istersem, o işi mükemmel yapmasını beklerim.	1	2	3	4	5	6	7
27. Yakınlarımın hata yapmasına tahammül edemem.	1	2	3	4	5	6	7
28. Hedeflerimi belirlemede mükemmelliyetçiyimdir.	1	2	3	4	5	6	7
29. Değer verdiğim kişiler beni hiç bir zaman hayal kırıklığına uğratmamalıdırlar.	1	2	3	4	5	6	7
30. Başarısız olduğum zamanlar bile, başkaları yetersiz olduğumu düşünmezler.	1	2	3	4	5	6	7
31. Başkalarının, benden çok şey beklediklerini düşünüyorum.	1	2	3	4	5	6	7
32. Her zaman, yapabileceğimin en iyisini yapmaya çalışmalıyım.	1	2	3	4	5	6	7
33. Bana göstermeseler bile, hata yaptığım zaman diğer insanlar bana çok bozulurlar.	1	2	3	4	5	6	7
34. Yaptığım her şeyde mükemmel olmak zorunda değilim.	1	2	3	4	5	6	7
35. Ailem benden mükemmel olmamı bekler.	1	2	3	4	5	6	7
36. Kendime yüksek hedefler koymam.	1	2	3	4	5	6	7
37. Annem ve babam hayatımın her alanında en başarılı olmamı pek beklemezler.	1	2	3	4	5	6	7
38. Sıradan insanlara değer veririm.	1	2	3	4	5	6	7
39. İnsanlar benden, mükemmelden aşağısını kabul etmezler.	1	2	3	4	5	6	7
40. Kendim için çok yüksek standartlar koyarım.	1	2	3	4	5	6	7
41. İnsanlar benden, verebileceğimden fazlasını beklerler.	1	2	3	4	5	6	7
42. Okulda veya işte her zaman başarılı olmalıyım.	1	2	3	4	5	6	7
43. Bir arkadaşımın, elinden gelenin en iyisini yapmaya çalışmaması benim için önemli değildir.	1	2	3	4	5	6	7
44. Hata yapsam bile, etrafımdaki insanlar yetersiz ve beceriksiz olduğumu düşünmezler.	1	2	3	4	5	6	7
45. Çevremdekilerin, yaptıkları her şeyde üstün başarı göstermelerini pek beklemem.	1	2	3	4	5	6	7

Appendix – F

Multidimensional Perfectionism Scale (MPS)

(Çok Boyutlu Mükemmelliyetçilik Ölçeği- ÇBMÖ)

SORU FORMU 5

YÖNERGE: Bu ölçek, kişilerin yaşamlarındaki sıkıntılar ve stresle başa çıkmak için neler yaptıklarını belirlemek amacıyla geliştirilmiştir. Lütfen sizin için sıkıntı ya da stres oluşturan olayları düşünerek bu sıkıntılarınızla başa
çıkmak için genellikle neler yaptığınızı hatırlayın ve aşağıdaki davranışların sizi tanımlama ya da size uygunluk derecesini gösteren şıkkı işaretleyin. Herhangi bir davranış size hiç uygun değilse, % 0'ın altındaki parantezin içine
(**X**) işareti koyun. Çok uygun ise % 100'ün altındaki parantezin içine (**X**) işareti koyun.

Sizi ne kadar tanımlıyor / Size ne kadar uygun

Bir sıkıntım olduğunda	%0	%30	%70	%100
1. Kimsenin bilmesini istemem.	( )	( )	( )	( )
2. İyimser olmaya çalışırım.	( )	( )	( )	( )
3. Bir mucize olmasını beklerim.	( )	( )	( )	( )
4. Olayı / olayları büyütmeyip, üzerinde durmamaya çalışırım.	( )	( )	( )	( )
5. Başa gelen çekilir diye düşünürüm.	( )	( )	( )	( )
6. Sakin kafayla düşünmeye, öfkelenmemeye çalışırım.	( )	( )	( )	( )
7. Kendimi kapana sıkışmış gibi hissederim.	( )	( )	( )	( )
8. Olayın / olayların değerlendirmesini yaparak en iyi kararı vermeye çalışırım.	( )	( )	( )	( )
9. İçinde bulunduğum kötü durumu, kimsenin bilmesini istemem.	( )	( )	( )	( )
10. Ne olsursa olsun direnme ve mücadele etme gücünü kendimde bulurum.	( )	( )	( )	( )
11. Olanları kafama takıp, sürekli düşünmekten kendimi alamam.	( )	( )	( )	( )
12. Kendime karşı hoşgörülü olmaya çalışırım.	( )	( )	( )	( )
13. İş olacağına varır diye düşünürüm.	( )	( )	( )	( )
14. Mutlaka bir yol bulacağıma inanır, bunun için uğraşırım.	( )	( )	( )	( )
15. Problemin çözümü için adak adarım.	( )	( )	( )	( )
16. Herşeye yeniden başlayacak gücü kendimde bulurum.	( )	( )	( )	( )
17. Elimden hiçbirşey gelmeyeceğine inanırım.	( )	( )	( )	( )
18. Olaydan / olaylardan olumlu birşey çıkarmaya çalışırım.	( )	( )	( )	( )
19. Herşeyin istediğim gibi olamayacağına inanırım.	( )	( )	( )	( )
20. Problemi / problemleri adım adım çözmeye çalışırım.	( )	( )	( )	( )
21. Mücadeleden vazgeçerim.	( )	( )	( )	( )
22. Sorunun benden kaynaklandığını düşünürüm.	( )	( )	( )	( )
23. Hakkımı savunabileceğime inanırım.	( )	( )	( )	( )

24. Olanlar karşısında "kaderim buymuş" derim.	( )	( )	( )	( )
25. "Keşke daha güçlü bir insan olabilseydim diye düşünürüm.	( )	( )	( )	( )
26. Bir kişi olarak iyi yönde değiştiğimi ve olgunlaştığımı hissederim.	( )	( )	( )	( )
27. "Benim suçum ne?" diye düşünürüm.	( )	( )	( )	( )
28. "Hep benim yüzümden oldu" diye düşünürüm.	( )	( )	( )	( )
29. Sorunun gerçek nedenini anlayabilmek için başkalarına danışırım.	( )	( )	( )	( )
30. Bana destek olabilecek kişilerin varlığını bilmek beni rahatlatır.	( )	( )	( )	( )

Appendix – G

Post-Hoc Analysis Results for ÜÖYO-Y according to BDE Categories

BDE Categories (I)	*Beck Categories (J)*	*Mean Diff. (I-J)*	*Std. Error*
1	2	-19.33****	1.82
	3	-30.08****	2.05
	4	-42.76****	2.89
2	1	19.33****	1.82
	3	-10.74****	2.26
	4	-23.43****	3.04
3	1	30.08****	2.05
	2	10.74****	2.26
	4	-12.69****	3.19
4	1	42.76****	2.89
	2	23.43****	3.04
	3	12.69****	3.19

****$p<.001$

Appendix – H

Post-Hoc Analysis Results for SBTÖ Dimensions according to BDE Categories

	BDE Categories (I)	*Beck Categories (J)*	*Mean Diff. (I-J)*	*Std. Error*	*Sig.*
SBTÖ Problem-Oriented	1	2	.12*	.04	.00
		3	.30*	.04	.00
		4	.54*	.06	.00
	2	1	-.20*	.04	.00
		3	.11*	.04	.07
		4	.35*	.06	.00
	3	1	-.30*	.04	.00
		2	-.11*	.04	.07
		4	.24*	.06	.00
	4	1	-.54*	.06	.00
		2	-.35*	.06	.00
		3	-.24*	.06	.00
SBTÖ Emotion-Oriented	1	2	-.22*	.03	.00
		3	-.35*	.04	.00
		4	-.57*	.05	.00
	2	1	.22*	.03	.00
		3	-.13*	.04	.00
		4	-.35*	.05	.00
	3	1	.35*	.04	.00
		2	.13*	.04	.00
		4	-.22*	.05	.00
	4	1	.57*	.05	.00
		2	.35*	.05	.00
		3	.22*	.05	.00

*$p<.05$

Appendix – I

Post-Hoc Analysis Results for RÖGÖ according to BDE Categories

BDE Categories (I)	*Beck Categories (J)*	*Mean Diff. (I-J)*	*Std. Error*	*Sig.*
1	2	6.06*	1.05	.00
	3	7.25*	1.19	.00
	4	16.07*	1.68	.00
2	1	-6.06*	1.05	.00
	3	1.19	1.31	.80
	4	10.01*	1.77	.00
3	1	-7.25*	1.19	.00
	2	-1.19	1.31	.80
	4	8.82*	1.85	.00
4	1	-16.07*	1.68	.00
	2	-10.01*	1.77	.00
	3	-8.83*	1.85	.00

*$p<.05$

Appendix – J

Post-Hoc Analysis Results for ÇBMÖ: "Socially- Prescribed" Dimension according to BDE Categories

BDE Categories (I)	*Beck Categories (J)*	*Mean Diff. (I-J)*	*Std. Error*	*Sig.*
1	2	-2.91*	.95	.01
	3	-4.50*	1.07	.00
	4	-9.03*	1.51	.00
2	1	2.91*	.95	.01
	3	-1.59	1.18	.53
	4	-6.12*	1.59	.00
3	1	4.50*	1.07	.00
	2	1.59	1.18	.53
	4	-4.53*	1.66	.03
4	1	9.03*	1.51	.00
	2	6.12*	1.59	.00
	3	4.53*	1.66	.03

*$p<.05$

Appendix – K

Analysis of Variance for

BDE, ÜÖYO-Y, SBTÖ, RÖGÖ and ÇBMÖ

by Gender, Grade Level, and Faculty

Analysis of Variance for Variables

Depressive Symptoms (BDE)

One-way analysis of variance (ANOVA) was carried out to see whether significant differences existed between the depressive symptom scores of females and males. The results showed that there was no significant difference between males and females for the BDE. Also, one way ANOVA results showed that there were no significant differences for grade levels, either.

In terms of faculty, there was a significant difference according to ANOVA results ($F(5,1083)=4.55$, $p=.00$) (See Table 36).

Table 36: *One-Way Analysis of Variance for BDE by Faculty*

	SS	*Df*	*MS*	*F*	*P*
Between Groups	1353.58	5	270.72	4.55	.00
Within Groups	64401.08	1083	59.47		
Total	65754.66	1089			

The students of Faculty of Education ($\bar{x}=12.63$) scored significantly higher than the students of School of Foreign Languages ($\bar{x}=10.52$) according to the results of post hoc analysis. The other Faculties; which are Faculty of Economics and Administrative Sciences, Faculty of Arts and Sciences, Faculty of Engineering, Faculty of Applied Disciplines; were neither significantly different from each other, nor from Faculty of Education or School of Foreign Languages (See Table 37).

Table 37: *Post-Hoc Analysis Results for BDE according to Faculty*

(I) FACULTY	(J) FACULTY	*Mean Difference (I-J)*	*Std. Error*	*Sig.*	*95% Confidence Interval*	
					Lower Bound	*Upper Bound*
Arts & Sciences	Economics & Administrative Sciences	1.17	1.42	.98	-3.56	5.90
	Education	-2.53	.90	.16	-5.51	.45
	Engineering	-1.78	1.05	.72	-5.26	1.71
	School of Foreign Languages	-.42	.93	1.00	-3.52	2.69
	Applied Sciences	-.70	1.10	1.00	-4.38	2.97
Economics & Administrative Sciences	Arts & Sciences	-.1.17	1.42	.98	-5.90	3.56
	Education	-3.70	1.22	.10	-7.77	.37
	Engineering	-2.94	1.34	.43	-7.40	1.51
	School of Foreign Languages	-1.59	1.25	.90	-5.75	2.58
	Applied Sciences	-1.87	1.39	.87	-6.48	2.73
Education	Arts & Sciences	2.53	.90	.16	-.45	5.51
	Economics & Administrative Sciences	3.70	1.22	.10	-.37	7.77
	Engineering	.75	.76	.96	-1.77	3.28
	School of Foreign Languages	2.11*	.60	.03	.15	4.08
	Applied Sciences	1.83	.83	.44	-.95	4.61
Engineering	Arts & Sciences	1.78	1.05	.72	-1.71	5.26
	Economics & Administrative Sciences	2.94	1.34	.43	-1.51	7.40
	Education	-.75	.76	.96	-3.28	1.77
	School of Foreign Languages	1.36	.80	.72	-1.31	4.03
	Applied Sciences	1.07	1.00	.95	-2.24	4.39
School of Foreign Languages	Arts & Sciences	.42	.93	1.00	-2.69	3.52
	Economics & Administrative Sciences	1.59	1.25	.90	-2.58	5.75
	Education	-2.11*	.60	.03	-4.08	-.15
	Engineering	-1.36	.80	.72	-4.03	1.31
	Applied Sciences	-.29	.87	1.00	-3.20	2.63
Applied Sciences	Arts & Sciences	.70	.1.10	1.00	-2.97	4.38
	Economics & Administrative Sciences	1.87	1.38	.87	-2.73	6.48
	Education	-1.83	.83	.44	-4.61	.95
	Engineering	-1.07	1.00	.95	-4.39	2.24
	School of Foreign Languages	.29	.87	1.00	-2.63	3.20

*p<.05

The faculties were not equally represented in this study. In harmonic mean analysis, the harmonic mean of the group sizes is used and as a result, there is an uncontrolled, increased risk for Type 1 error. For example, the harmonic mean results for faculty point out that there is a significant difference between Faculty of Education (*n*=425) and Faculty of Economics & Administrative Sciences (*n*=44), which is contrary to the post hoc results. In this case, it can be said that ANOVA results showed an overall significant result; yet post hoc analysis result have not been able to define or pinpoint this difference, due to unequal group sizes. As a result, the harmonic mean results were not considered in this study.

In addition, the relation between BDE scores and getting psychological help was analyzed for this sample. The mean BDE score of participants who got psychological help was 14.52, with a standard deviation value of 8.958 (*n*=144). The range of the scores was 47, with a minimum score of 0, and a maximum score of 47. The scores of participants who did not get psychological help was 10.98, with a standard deviation value of 10.98 (*n*=932). The range of the scores was 46, with a minimum score of 0, and a maximum score of 46 (See Table 38).

Table 38: *Means and Standard Deviations of BDE Scores by Getting Psychological Help for Self*

Getting Psychological Help for Self	*N*	$\bar{x}$	*Sd*	*Min.*	*Max.*
Yes	144	14.52	8.96	0	47
No	932	10.98	7.47	0	46
Total	1076	11.46	7.77	0	47

There was a significant difference between participants who got psychological help for themselves and participants who did not according to ANOVA results ($F(1, 1074)=26.44$, $p=.00$), which means that the participants who got psychological help for themselves experienced significantly more depressive symptoms, or in other words had significantly higher scores from BDE (See Table 39).

Table 39: *One-way Analysis of Variance for BDE by getting Psychological Help for Self*

	SS	*df*	*MS*	*F*	*P*
Between Groups	1559.39	1	1559.39	26.44	.00
Within Groups	63349.73	1074	58.99		
Total	64909.12	1075			

Perceived Intensity of Life Events in terms of their Stressfulness (ÜÖYO-Y)

In terms of gender, there was a significant difference between the ÜÖYO-Y scores of females and males according to ANOVA results ($F(1, 1087)=10.15$, $p=.00$) (See Table 40). The mean score of females was significantly higher than the mean score of males.

Table 40: *One-way Analysis of Variance for ÜÖYO-Y by Gender*

ÜÖYO-Y- Total	*SS*	*df*	*MS*	*F*	*P*
Between Groups	8242.86	1	8242.86	10.15	.00
Within Groups	883203.50	1087	812.52		
Total	891446.40	1088			

In terms of grade level, again there was a significant difference according to ANOVA results ($F(7,1081)=7.19$, $p=.00$) (See Table 41).

Table 41: *One-way Analysis of Variance for ÜÖYO-Y by Grade Level*

UOYOY- Total	*SS*	*df*	*MS*	*F*	*P*
Between Groups	39677.58	7	5668.23	7.19	.00
Within Groups	851768.80	1081	787.95		
Total	891446.40	1088			

Significant differences ($p=.018$) in terms of grade level existed between English Preparatory Class (EPC)-Intermediate ($\bar{x}=120.66$) and first grade ($\bar{x}=134.41$); EPC-Intermediate ($\bar{x}=120.66$) and second grade ($\bar{x}=134.72$); EPC-Intermediate ($\bar{x}=120.66$) and third grade ($\bar{x}=134.08$); EPC-Intermediate ($\bar{x}=120.66$) and fourth grade ($\bar{x}=136.22$); EPC-Advanced ($\bar{x}=115.43$) and first grade ($\bar{x}=134.41$); EPC-Advanced ($\bar{x}=115.43$) and second grade ($\bar{x}=134.72$); EPC-Advanced ($\bar{x}=115.43$) and third grade ($\bar{x}=134.08$); EPC-Advanced ($\bar{x}=115.43$) and fourth grade ($\bar{x}=136.22$) according to post hoc analysis results. According to mean results, the highest mean belonged to students of fifth grade ($\bar{x}=137.75$), followed by

fourth grade ($\bar{x}$=136.22), second grade ($\bar{x}$=134.72), first grade ($\bar{x}$=134.41), third grade ($\bar{x}$=134.08), EPC-Beginner ($\bar{x}$=130.43), Intermediate EPC-Intermediate ($\bar{x}$=120.66), and EPC-Advanced ($\bar{x}$=115.43) (See Table 42).

Table 42: *Post-Hoc Analysis Results for ÜÖYO-Y according to Grade Level*

(I) GRADE LEVEL	(J) GRADE LEVEL	*Mean Difference (I-J)*	*Std. Error*	*Sig.*	*95% Confidence Interval*	
					Lower Bound	*Upper Bound*
EPC – beginner	EPC- intermediate	9.77	3.82	.48	-4.59	24.13
	EPC – advanced	15.00	4.33	.10	-1.29	31.28
	1.	-3.98	3.41	.99	-16.79	8.83
	2.	-4.29	3.22	.97	-16.39	7.80
	3.	-3.65	3.33	.99	-16.16	8.87
	4.	-5.80	3.60	.92	-19.34	7.76
	5.	-7.32	14.30	1.00	-61.05	46.41
EPC- intermediate	EPC – beginner	-9.77	3.82	.48	-24.13	4.59
	EPC – advanced	5.23	4.32	.98	-11.00	21.46
	1.	-13.75*	3.39	.02	-26.49	-1.01
	2.	-14.06*	3.20	.01	-26.08	-2.04
	3.	-13.42*	3.31	.02	-25.85	-.98
	4.	-15.56*	3.59	.01	-29.04	-2.08
	5.	-17.09	14.29	.99	-70.80	36.62
EPC – advanced	EPC – beginner	-15.00	4.33	.10	-31.28	1.29
	EPC- intermediate	-5.23	4.32	.98	-21.46	11.00
	1.	-18.98*	3.96	.00	-33.86	-4.09
	2.	-19.29*	3.80	.00	-33.56	-5.02
	3.	-18.64*	3.89	.00	-33.26	-4.02
	4.	-20.79*	4.13	.00	-36.31	-5.27
	5.	-22.32	14.44	.94	-76.57	31.94
1.	EPC – beginner	3.98	3.41	.99	-8.83	16.79
	EPC- intermediate	13.75*	3.39	.02	1.01	26.49
	EPC – advanced	18.98*	3.96	.00	4.09	33.86
	2.	-.31	2.69	1.00	-10.44	9.81
	3.	.34	2.82	1.00	-10.28	10.95
	4.	-1.81	3.14	1.00	-13.63	10.01
	5.	-3.34	14.19	1.00	-56.66	49.98
2.	EPC – beginner	4.30	3.22	.97	-7.80	16.39
	EPC- intermediate	14.06*	3.12	.01	2.04	26.08
	EPC – advanced	19.29*	3.80	.00	5.02	33.56
	1.	.312	2.69	1.00	-9.81	10.44
	3.	.647	2.59	1.00	-9.09	10.38
	4.	-1.50	2.94	1.00	-12.54	9.54
	5.	-3.03	14.14	1.00	-56.18	50.12

3.	EPC – beginner	3.65	3.33	.99	-8.87	16.16
	EPC- intermediate	13.42*	3.31	.02	.98	25.85
	EPC – advanced	18.64*	3.89	.00	4.02	33.26
	1.	-.34	2.82	1.00	-10.95	10.28
	2.	-.65	2.59	1.00	-10.38	9.09
	4.	-2.15	3.06	.1.00	-13.64	9.34
	5.	-3.68	14.17	1.00	-56.92	49.57
4.	EPC – beginner	5.79	3.60	.92	-7.76	19.34
	EPC- intermediate	15.56*	3.59	.01	2.08	29.04
	EPC – advanced	20.79*	4.13	.00	5.27	36.31
	1.	1.81	3.14	1.00	-10.01	13.63
	2.	1.50	2.94	1.00	-9.54	12.54
	3.	2.15	3.06	1.00	-9.34	13.64
	5.	-1.53	14.23	1.00	-55.03	51.97
5.	EPC – beginner	7.32	14.30	1.00	-46.41	61.05
	EPC- intermediate	17.09	14.29	.99	-36.62	70.80
	EPC – advanced	22.32	14.44	.94	-31.94	76.57
	1.	3.34	14.19	1.00	-49.98	56.66
	2.	3.03	14.14	1.00	-50.12	56.18
	3.	3.68	14.17	1.00	-49.57	56.92
	4.	1.53	14.23	1.00	-51.97	55.03

In terms of faculty, there was also a significant difference according to ANOVA results ($F(5, 1083)=10.02$, $p=.00$) (See Table 43).

Table 43: *One-way Analysis of Variance for ÜÖYO-Y by Faculty*

UOYOY- Total	*SS*	*Df*	*MS*	*F*	*p*
Between Groups	39406.25	5	7881.25	10.02	.00
Within Groups	852040.14	1083	786.74		
Total	891446.39	1088			

There was a significant difference between the mean scores of Faculty of Education ($\bar{x}$=137.76) and School of Foreign Languages ($\bar{x}$=123.01). The other Faculties; which are Faculty of Economics and Administrative Sciences, Faculty of Arts and Sciences, Faculty of Engineering, Faculty of Applied Disciplines; were neither significantly different from each other, nor from Faculty of Education or School of Foreign Languages (See Table 44).

Table 44: *Post-Hoc Analysis Results for ÜÖYO-Y according to Faculty*

(I) FACULTY	(J) FACULTY	*Mean Difference (I-J)*	*Std. Error*	*Sig.*	*95% Confidence Interval*	
					Lower Bound	*Upper Bound*
Arts & Sciences	Economics & Administrative Sciences	4.17	3.65	.93	-7.98	16.33
	Education	-9.20*	2.69	.04	-18.16	-.24
	Engineering	-1.20	3.06	1.00	-11.41	9.01
	School of Foreign Languages	2.89	14.35	1.00	-44.93	50.70
	Applied Sciences	-2.42	3.42	.99	-13.82	8.99
Economics & Administrative Sciences	Arts & Sciences	-4.17	3.65	.93	-16.33	7.98
	Education	-13.37*	3.05	.00	-23.55	-3.20
	Engineering	-5.37	3.39	.77	-16.67	5.92
	School of Foreign Languages	-1.29	14.42	1.00	-49.35	46.77
	Applied Sciences	-6.59	3.72	.68	-18.98	5.80
Education	Arts & Sciences	9.20*	2.69	.04	.24	18.16
	Economics & Administrative Sciences	13.37*	3.05	.00	3.20	23.55
	Engineering	8.00*	2.32	.04	.26	15.74
	School of Foreign Languages	12.09	14.21	.98	-35.27	59.44
	Applied Sciences	6.78	2.78	.31	-2.49	16.05
Engineering	Arts & Sciences	1.20	3.10	1.00	-9.01	11.41
	Economics & Administrative Sciences	5.37	3.39	.77	-5.92	16.67
	Education	-8.00*	2.32	.04	-15.74	-.26
	School of Foreign Languages	4.09	14.28	1.00	-43.52	51.69
	Applied Sciences	-1.22	3.15	1.00	-11.70	9.27
School of Foreign Languages	Arts & Sciences	-2.89	14.35	1.00	-50.70	44.93
	Economics & Administrative Sciences	1.29	14.42	1.00	-46.77	49.35
	Education	-12.09	14.21	.98	-59.44	35.27
	Engineering	-4.09	14.28	1.00	-51.69	43.52
	Applied Sciences	-5.30	14.36	1.00	-53.18	42.58
Applied Sciences	Arts & Sciences	2.42	3.42	.99	-8.99	13.82
	Economics & Administrative Sciences	6.59	3.72	.68	-5.80	18.98
	Education	-6.78	2.78	.31	-16.05	2.49
	Engineering	1.22	3.14	1.00	-9.27	11.70
	School of Foreign Languages	5.30	14.36	1.00	-42.58	53.18

*p<.05

The highest mean belonged to Faculty of Education ($\bar{x}$=136.59), followed by School of Applied Sciences ($\bar{x}$=129.80), Faculty of Engineering ($\bar{x}$=128.58), Faculty of Arts and Sciences ($\bar{x}$=127.38), Faculty of Foreign Languages ($\bar{x}$=124.50) and Faculty of Economics and Administrative Sciences ($\bar{x}$=123.21). However, the unequal faculty sizes must be considered with caution while interpreting these results.

Coping Styles (SBTÖ)

a) In Terms of Factors

One-way ANOVA conducted to figure out whether gender differences were statistically significant for factors of SBTÖ showed that except for "self-confidence" and "helpless" factors, all other differences between females and males were significant; meaning significant for "optimistic" (F(1,1087)=15.67, p=.00), "submissive" (F(1,1087)=7.182, p=.01) and "seeking social support" (F(1,1087)=42.39, p=.00) (See Table 45). Males used "optimistic" and "submissive" style significantly more than women did, whereas females used "seeking social support" style of coping more than men did.

Table 45: *One-way Analysis of Variance for SBTÖ in terms of Factors by Gender*

		SS	*Df*	*MS*	*F*	*P*
SBTÖ Optimistic	Between Groups	5.00	1	5.00	15.67	.00
	Within Groups	346.85	1087	.32		
	Total	351.85	1088			
SBTÖ Submissive	Between Groups	4.00	1	1.74	7.18	.01
	Within Groups	263.89	1087	.24		
	Total	265.63	1088			
SBTÖ Seeking of social support	Between Groups	16.08	1	16.08	42.39	.00
	Within Groups	412.43	1087	.38		
	Total	428.51	1088			

To test grade level differences for SBTÖ factors, one-way ANOVA was conducted. One-way analysis of variance showed that in terms of grade level, there was no significant difference between the grade levels for the factors of SBTÖ: “self-confidence”, “optimistic”, “submissive”, “helpless”, “seeking social support”.

In terms of faculty, one-way ANOVA results showed that there was a significant difference for “self-confidence” ($F(5,1083)=2.59$, $p=.03$), “helpless” ($F(5,1083)=3.13$, $p=.01$) and “seeking social support” ($F(5,1083)=2.50$, $p=.03$) factors; whereas for “optimistic” and “submissive” styles, there was no significant difference (See Table 46).

Table 46: *One-way Analysis of Variance for SBTÖ in terms of Factors by Gender*

		SS	*Df*	*MS*	*F*	*P*
SBTO Self-Confidence	Between Groups	3.70	5	.74	2.59	.03
	Within Groups	309.88	1083	.29		
	Total	313.58	1088			
SBTO Helpless	Between Groups	4.84	5	.97	3.13	.01
	Within Groups	335.17	1083	.31		
	Total	340.01	1088			
SBTO Seeking of social support	Between Groups	4.89	5	.98	2.50	.03
	Within Groups	423.63	1083	.39		
	Total	428.51	1088			

However, although ANOVA results yielded significant results, Post Hoc analysis for “self-confidence”, “helpless” and “seeking for social support” factors could not pinpoint any significant difference, again due to unequal group sizes for faculties.

b) In Terms of Dimensions

One-way ANOVAs conducted to figure out whether gender differences were statistically significant for dimensions of SBTÖ showed that for “emotion-oriented/ ineffective coping style” dimension, the difference was not significant; whereas for “problem-oriented/effective coping style” dimension, the difference was significant ($F(1,1087)=8.31$, $p=.00$) (See Table 47). Males used “problem-oriented/effective coping style” significantly more than women did.

Table 47: *One-way Analysis of Variance for SBTÖ: "Problem-Oriented" Dimension by Gender*

SBTÖ: "Problem-Oriented"	*SS*	*Df*	*MS*	*F*	*P*
Between Groups	2.05	1	2.05	8.31	.00
Within Groups	268.44	1087	.25		
Total	270.50	1088			

To test grade level differences for SBTÖ dimensions, one-way ANOVA was conducted. One-way analysis of variance showed that in terms of grade level, there was no significant difference between the grade levels for "problem-oriented/ effective coping style" dimension and "emotion-oriented/ ineffective coping style" dimension of SBTÖ.

In terms of faculty, one-way ANOVA results showed that there was a significant difference for "emotion-oriented/ ineffective coping style" dimension ($F(5,1083)=3.47$, $p=.00$); whereas there was no significant difference among faculties for "problem-oriented/effective coping style" dimension (See Table 48).

Table 48: *One-way Analysis of Variance for SBTÖ: "Emotion-Oriented" Dimension by Faculty*

SBTÖ: "Emotion-Oriented"	*SS*	*Df*	*MS*	*F*	*P*
Between Groups	3.54	5	.71	3.47	.00
Within Groups	221.34	1083	.20		
Total	224.94	1088			

However, again, although ANOVA results yielded significant results, post-hoc analysis for "emotion-oriented/ ineffective coping style" dimension could not pinpoint any significant difference, due to unequal group sizes for faculties.

Coping Strategies (RÖGÖ)

In terms of gender, one-way ANOVA results showed that there was a significant difference for coping strategies' scores ($F(1,1087)=10.42$, $p<.00$). Mean score of females were significantly higher than males'; in other words, females used more cognitive strategies for coping (See Table 49).

Table 49: *One-way Analysis of Variance for RÖGÖ by Gender*

RÖGÖ	*SS*	*df*	*MS*	*F*	*P*
Between Groups	2333.49	1	2333.49	10.42	.00
Within Groups	243524.30	1087	224.03		
Total	245857.80	1088			

To test grade level differences for coping strategies, measured by RÖGÖ, one-way ANOVA was conducted. One-way analysis of variance showed that in terms of grade level, there was no significant difference.

In terms of faculty, one-way ANOVA results showed that there was no significant difference among faculties for coping strategies, as measured by RÖGÖ. However, the unequal faculty sizes must be considered with caution while interpreting these results.

Perfectionism (ÇBMÖ)

In terms of gender, one-way ANOVA results showed that there was a significant difference for "socially-prescribed perfectionism" dimension *(F*(1,1087)=24.26, *p*=.00) of ÇBMÖ; whereas there was no significant difference for "self-oriented perfectionism" dimension and "other-oriented perfectionism" dimension of ÇBMÖ (See Table 50). Males experienced significantly more "socially-prescribed perfectionism" than females.

Table 50: *One-way Analysis of Variance for ÇBMÖ: "Socially-Prescribed Perfectionism" Dimension by Gender*

ÇBMÖ: "Socially-Prescribed"	*SS*	*Df*	*MS*	*F*	*P*
Between Groups	4090.58	1	4090.58	24.26	.00
Within Groups	183299.00	1087	168.63		
Total	187389.60	1088			

To test grade level differences for perfectionism dimensions, as measured by ÇBMÖ, one-way ANOVA was conducted. One-way analysis of variance showed that in terms of grade level, there was no significant difference between the grade levels for "self-oriented perfectionism", "other-oriented perfectionism" and "socially-prescribed perfectionism" dimensions.

In terms of faculty, one-way ANOVA results showed that there was a significant difference among faculties for "self-oriented perfectionism" (*F*(5,1083)=2.55, *p*=.03); whereas for "other-oriented perfectionism" and for

"socially-prescribed perfectionism" dimensions, there was no significant difference (See Table 51).

Table 51: *One-way Analysis of Variance for ÇBMÖ: "Socially-Prescribed Perfectionism" Dimension by Faculty*

ÇBMÖ: "Socially-Prescribed"	*SS*	*df*	*MS*	*F*	*P*
Between Groups	4010.18	5	802.04	2.55	.03
Within Groups	340101.95	1083	314.04		
Total	344112.13	1088			

However, although ANOVA results yielded significant results, post hoc analysis for "self-oriented perfectionism" could not pinpoint any significant difference, due to unequal group sizes for faculties.