A LONGITUDINAL STUDY OF THE RELATIONSHIP BETWEEN PERCEIVED SOCIAL SUPPORT AND PSYCHOLOGICAL WELL-BEING OF ADOLESCENTS FROM LOW SOCIOECONOMIC STATUS

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ABSTRACT

A Longitudinal Study of the Relationship between Perceived Social Support and Psychological Well-Being of Adolescents from Low Socioeconomic Status

by

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The aim of the study was to investigate the relationship between perceived social support and psychological well-being defined by - psychological adjustment and depressive symptoms - of adolescents between ages 14-16 years old (*n*=237) from low socioeconomic status (SES). The study also examined the probable changes in perceived social support and psychological well-being of adolescents between two time periods, more specifically from October 2005 to May 2006 and possible predictors of these changes in Time 1 and Time 2.

Perceived Social Support Scale-Revised (Yıldırım, 2004) Personality Assessment Questionnaire (Rohner, 1971), Beck Depression Inventory (Beck, 1961) and Demographic Information Form developed by the researcher, were the instruments of the current study.

A significant relationship was found between perceived social support and psychological adjustment both in Time 1 ($r = .30$, $p<.01$) and Time 2 ($r = .23$, $p<.01$) and between perceived social support and depressive symptoms both in Time 1 ($r = -.34$, $p<.01$) and Time 2 ($r = -.31$, $p<.01$).

The changes in the seven-month period demonstrated that there was a significant decrease in perceived social support [$t(236) = 4.33$; $p<.001$] and psychological adjustment [$t(236) = 3.06$; $p<.01$] and an increase in depressive

symptoms of adolescents coming from low SES. Additionally, gender and depressive symptoms were found to be significant predictors of perceived social support both in Time 1 and in Time 2 but not psychological adjustment.

In the light of the study results, preventive counseling might be regarded as an important intervention for improving the psychological well-being of adolescents especially those coming from low SES.

ÖZET

Düşük Sosyoekonomik Düzeyden Gelen Ergenlerin Algıladıkları Sosyal Destek ile Ruh Sağlıkları Arasındaki İlişki Üzerine Boylamsal Bir Çalışma

by

Melisa Sayar

Bu araştırmanın amacı; 14-16 yaş aralığındaki düşük sosyoekonomik düzeyden gelen ergenlerin (*n*=237) algıladıkları sosyal destek ile ruh sağlıkları - psikolojik uyum ve depresif semptomlar - arasındaki ilişkiyi incelemektir. Bu çalışma ayrıca Ekim 2005 den Mayıs 2006 ya kadar ki zaman aralığında ergenlerin algıladıkları sosyal destek ve ruh sağlıklarında olan değişiklikleri ve son olarak algılanan sosyal desteğin birinci zaman ve ikinci zamandaki yordayıcılarını araştırmıştır.

Algılanan Sosyal Destek Ölçeği-Revize (Yıldırım, 2004), Kişilik Değerlendirme Ölçeği (Rohner, 1971), Beck Depresyon Envanteri (Beck, 1961) ve araştırmacı tarafından geliştirilen Demografik Bilgi Formu, bu araştırmada kullanılan ölçme araçlarıdır.

Hem birinci hem de ikinci zamanda, algılanan sosyal destek ve psikolojik uyum ($r= .30$, $p<.01$; $r= .23$, $p<.01$) ayrıca algılanan sosyal destek ve depresif semptomlar ($r= -.34$, $p<.01$; $r= -.31$, $p<.01$) arasında anlamlı bir ilişki bulunmuştur.

Yedi aylık süreçteki değişiklikler göstermiştir ki düşük sosyoekonomik düzeyden gelen ergenlerin algıladıkları sosyal destek [$t (236) = 4.33$; $p<.001$] ve psikolojik uyumları [$t (236) = 3.06$; $p<.01$] anlamlı ölçüde azalırken depresif semptomlarında artış olmuştur. Bunun yanı sıra, cinsiyet ve depresif semptomlar,

algılanan sosyal desteğin hem birinci hem de ikinci zamandaki anlamlı yordayıcıları olarak bulunmuş fakat psikolojik uyum bulunmamıştır.

Araştırma sonuçlarının ışığında; özellikle düşük sosyoekonomik düzeyden gelen ergenlerin ruh sağlıklarının iyileştirilmesi için önleyici danışmanlık önemli bir müdahale yöntemi olarak ele alınabilir.

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I. INTRODUCTION

Individuals who get enough perceived social support during their lives, especially in their childhood and adolescence periods, have a tendency to be more resilient to stressful, negative life events (Sarason, Sarason and Pierce, 1990). Similarly, Gottlieb (1994) suggests that perceived social support is not only a critical resource to prevent stressful and negative life events but also it contributes to individuals' general well-being and life satisfaction. Additionally, he argues that individuals, who believe they receive social support, have a lower risk for physical and/or psychological problems than individuals, who believe they do not receive social support. In terms of this perspective, it is assumed that there is a relationship between social ties / support and decreased risk of physical and/or psychological well-being. Also, Clark, Beck and Alford (1999) agree that some social factors such as lack of support and negative experiences in close relationships are related to an increased risk for depressive symptoms.

From early on, researchers discussed the relationship between perceived social support and psychological well-being. For instance, Cobb (1976) claims that perceived social support could protect individuals from an extensive range of pathological situations from low birth weight to death, from depression to alcoholism and other psychiatric problems.

Perceived social support plays a significant role in adolescents' lives (Laugesen, Dugas, and Bukowski, 2003). It is suggested that social support prevents both children and adolescents from psychological and physical problems as a protective factor (Bender and Losel, 1997; Chen, 1997; Jackson and Warren, 2000). For instance, the study conducted by Kaltiala-Heino, Rimpela, Rantanen, Laippala

(2001) showed that high rates of perceived social support from family were related to decreased levels of depressive symptoms for community sample aged 14-16.

According to Beam, Gil-Rivas, Greenberger and Chen (2002), the presence of supportive people in adolescents' lives are related with better affective outcomes, mainly fewer number of depressive symptoms and lower risk for problematic behaviors.

It can be concluded that psychological well-being, which is described as satisfaction and happiness with one's life as a whole (Schwarz and Strack, 1991), is associated with perceived social support.

A. Current Study

The purpose of the study was mainly to investigate the relationship between perceived social support and psychological well-being of adolescents from low socioeconomic status (SES) as defined by the designated school environment and neighborhood. Since this study aimed to examine the changes in perceived social support (social support in total, family, friend and teacher support) and psychological well-being of adolescents between two time periods, more specifically from October 2005 to May 2006, the design was longitudinal as expected.

The current study also aimed to investigate the possible predictors of perceived social support in Time 1 (October, 2005) and Time 2 (May, 2006). In literature, generally the impacts of perceived social support on psychological well-being were studied (Seltzer, 1981; Gottlieb, 1994; Bowen and Chapmen, 1996; Wentzel, 1998; Haan and MacDermid, 1998; Helsen, Vollebergh and Meeus, 2000; Greenberger, Chen and Tally, 2000; Bao, Whitbeck and Hoyt, 2000; Yarcheski, Mahon and Yarcheski, 2001; Ray, 2002; Way and Robinson, 2003; Laugesen,

Dugas, Bukowski, 2003; Yıldırım, 2004; Gençöz and Özlale, 2004). However, the relationship between perceived social support and psychological well-being are probably reciprocal over time, in other words, the direction of causality between the study variables is not very clear. Some researchers suggest that individuals, who show depressive symptoms or mental health problems, perceived less social support than individuals, who do not have emotional problems. Accordingly, the mental condition, which depressed individual has, might cause a withdrawal from social contacts of this individual, therefore his/her interpersonal relations would consequently deteriorate (Blazer, 1983; Billings, Cronkite and Moos, 1983; Nelson, 1989; Krause, Liang and Yatomi, 1989; Mahon and Yarcheski, 2001; Stice, Ragan and Randall, 2004). Therefore, the present study examined whether the possible changes in perceived social support in time was affected by psychological well-being of adolescents although the literature review emphasis is on the reverse direction.

The study focused on Lycèe 1 adolescents (ninth graders) who had not yet gotten used to their new school environment and thus who might not have had enough friend (peer) and teacher support at the beginning of the first semester (October, 2005). It was expected that the level of perceived social support would increase at the end of the second semester, which was on May 2006. Therefore, the relationship between perceived social support and psychological well-being was examined at two different points in time so that there would be a possibility to see the changes in perceived social support and psychological well-being. It was assumed that the level of perceived social support would have a tendency to rise in time because the students would get used to their new school, teachers and friends, which might lead to maintenance of closer relationships and building up new relations.

B. Research Questions

1. What is the relationship among the following variables; perceived social support, psychological adjustment and depressive symptoms among adolescents between ages 14-16 from low socioeconomic status in Time 1 (October 2005)?

2. What is the relationship between following variables; perceived social support, psychological adjustment and depressive symptoms among adolescents between ages 14-16 from low socioeconomic status in Time 2 (May 2006)?

3. Do adolescents between ages 14-16 from low socioeconomic status show any significant difference in perceived social support from Time 1 (October, 2005) to Time 2 (May, 2006)?

4. Do adolescents between ages 14-16 from low socioeconomic status show any significant difference in psychological adjustment from Time 1 (October, 2005) to Time 2 (May, 2006)?

5. Do adolescents between ages 14-16 from low socioeconomic status show any significant difference in depressive symptoms from Time 1 (October, 2005) to Time 2 (May, 2006)?

6. Which if any of the factors; namely psychological adjustment, depressive symptoms, and gender, do additively and uniquely predict perceived social support of adolescents between ages 14-16 from low socioeconomic status in Time 1 (October 2005)?

7. Which if any of the factors; namely psychological adjustment, depressive symptoms, and gender, do additively and uniquely predict perceived social support of adolescents between ages 14-16 from low socioeconomic status in Time 2 (May 2006)?

8. Which if any of the factors; namely psychological adjustment, depressive symptoms, and gender both in Time 1 (October, 2005) and Time 2 (May, 2006), do additively and uniquely predict perceived social support of adolescents between ages 14-16 from low socioeconomic status in Time 2 (May, 2006)?

II. REVIEW OF LITERATURE

A. Perceived Social Support

Social support can be defined as the kind of help an individual receives or perceives from social network members (U.S Department of Health and Human Services, 2004). Several authorities define and operationalize social support in different ways (Cobb, 1976; Caplan, 1981, cited in Özcan, 1997; Cohen and Wills, 1985; Miller, 1991; Gottlieb, 1994). For example, Cobb (1976) sees social support as:

1. Information leading the subject to believe that s/he is cared for and loved
2. Information leading the subject to believe that s/he is esteemed and valued
3. Information leading the subject to believe that s/he belongs to a network of communicated and mutual obligation (Cobb 1976, p. 300)

Also, Caplan (1981, cited in Özcan, 1997) defines social support as the feedback and guidance given by other people; which helps a person overcome a stressful life episode. Cohen and Wills (1985) describe social support as interpersonal processes like individuals emotionally reassuring another, giving advice, helping discuss troubles, providing material goods and services, and enabling the other feel part of a social system. According to Miller (1991), social support is a concept that includes a set of individual contacts through which the individual sustains his/her social identity. Gottlieb (1994) suggests that social support is a course of interaction in relations, which develop self-esteem, capability, coping and belonging.

The relationship between perceived social support and children's and adolescents' functioning might be explained by two theoretical orientations, namely main effect model and buffering effect model (Demaray and Malecki, 2002a). The main effect model proposes that social support has almost the same positive effect on

psychological well-being under both high and low stress conditions (Cohen and Wills, 1985) whereas buffering effect model claims that social support has a larger positive effect under high stress than lower stress; in other words, under high level of stress, buffering occurs (Krespi, 1993) and the adverse effects of stress for individuals, who have high levels of social support, are reduced or eliminated (Dolbier and Steinhardt, 2000).

In the literature, several types of support are determined in terms of their meanings such as esteem support, practical or instrumental support, companionship, emotional support, instrumental support, informational support, tangible support, appraisal and expressive support (Hamburg, Mortimer, and Nightingale, 1991; Krespi 1993; Gottlieb, 1994; Güngör, 1997; Kaymakçıoğlu, 2001; Öztürk-Tüter, 2003; Malecki and Demaray, 2003). Some types of support, which are outlined above, may be used interchangeably or some of them may cover other ones. According to the U.S Department of Health and Human Services (2004), social support can be divided into four main categories; emotional support, instrumental support, appraisal support and informational support. As the first category, *emotional support* can be considered to be the things, which others do, that make a person feel cared for, loved, understood, and it encourages a sense of self-worth (e.g., giving positive feedback & providing encouragement). It is usually provided by an intimate other for the subject. It is also identified as esteem support, confidant support, or attachment. Secondly, *instrumental support* can be described as a help or assistance with concrete needs (e.g. shopping, paying bills, cleaning, childcare). It is also known as material aid, tangible support, or behavioral assistance. Thirdly, *appraisal support* is the help in decision making and giving proper feedback. And

lastly, *informational support* is seen as providing guidance or advice regarding potential solutions to a problem.

Besides the types of support outlined above, Sarason, Sarason, Pierce (1990) divide social support into two different sub-types, namely; received versus perceived social support. Received social support concentrates on what the person actually received or reported to have received whereas perceived social support is concerned with the kind of support the person believes to be available if s/he should need it. Ray (2002) states that perceived social support is more powerfully associated with psychological well-being than actual/received one. Moreover, perceived social support has significant effects on youngsters' psychological well-being. Similarly, it is claimed that individual's perception of social support; rather than received support has been found to be related with less depressive symptoms, less distress and pathological problems (Procidano and Heller, 1983)

In this study, the term perceived social support was used as an individual's perception that there are other people available to her/him who would provide support if needed (the U.S Department of Health and Human Services, 2004).

Sources of Support

In this study, perceived social support sources were determined in terms of the study results of Yıldırım (1997) as follows: family, friends (peers), and teachers. The sources are explained separately below.

Family Support

Human beings have a need for continued relationships and to get in touch with other people throughout their lives. It is claimed that socially isolated

individuals are less healthy and more susceptible to psychological and physical disorders than individuals who are socially integrated (Hamburg, Mortimer, and Nightingale, 1991). At that point, family is the basic social institution, which continues to provide support to the individual throughout his/her life span. The importance of the family can be seen as a unit in forming the earliest and most constant bond, which has an influence on an individual's life. One desired task of a family is to provide emotional, nutritional, economic, educational and other types of support for the physical, emotional and intellectual development of the adolescent. It is suggested that most of the individuals' patterns of personality are shaped in the family environment (Miller, 1991).

It is a fact that youngsters are in a transition period from childhood to adulthood and it is believed that although the bond between adolescents and parents become weaker during this period, insight and guidance of self-disciplined adults help alleviate the negative outcomes of harsh and sudden changes in adolescence and contribute to a healthy transition later on (Crow and Crow, 1965).

In adolescence, in spite of the increasing need for peer relationships, parents sustain their importance in shaping adolescents' cognition and behaviors (Hamburg, Mortimer, and Nightingale, 1991). In contrast, recent studies show that the impact of parents is not limited to childhood but they maintain a significant influence on the social functioning of adolescents (Engels, Dekovic and Meeus, 2002). Furthermore, increasingly through adolescence, peers provide support for the daily life of the adolescent (e.g. friendships, dating, leisure activities, etc.), whereas parents remain as the main support source for issues of long-term life style choices like career considerations and personal values (Jurkovic & Ulrici, 1985; O'Brien; 1990 cited in Covell, MacIntyre, and Wall, 1999). Also, Lan Liu (2002) states that although family

relations undergo significant changes during adolescence period, the family keeps playing a significant role for most adolescents. Similarly, according to Beest and Baerveldt (1999), perceived parental support is more significant than peer support on the development of adolescents and the lack of family support cannot be compensated by peer support. Moreover, Weigel, Devereux, Leigh, and Ballard-Reisch (1998) narrow the family support on parental level, especially mothers and they claim that mothers are the primary support source for adolescents and youngsters, who live in a supportive family environment, experience lower stress.

Friend (Peer) Support

For most youngsters, adolescence is a time of change and transition. In this period, peer groups become an increasingly crucial context in which adolescents spend time. They discover their sense of identity by gaining psychological and emotional independence from parents by the help of peer groups they are in (Steinberg, 1999). During adolescence, parental power over the adolescents diminishes whereas the general independence of the teenagers increases (Weisfeld, 1999). In other words, dependence of adult protection and direction turns into self-determination and self-direction of the adolescent due to the fact that freedom of decision, action, and self-expression are the strongest urges of this period (Crow and Crow, 1965). Also, it is assumed that separation from parents in this period is necessary and natural for preparing oneself to his/her new adult life (Weisfeld, 1999). Related with the transition issue, Friendenberg (1959, cited in Crow and Crow, 1965) defines adolescence as follows:

> Adolescence is the period during which a young person learns who he is, and what he really feels. It is a time in which he differentiates himself from the culture; though on the culture's terms. It is the age at which, by becoming a person in his own right, he becomes capable of deeply felt relationships to other individuals, perceived clearly as such. (Friendenberg, 1959, p. 9, cited in Crow and Crow, 1965)

In adolescence, peer groups are used for setting norms, socializing, and can be sources of both support and stress because being a member of a peer group satisfies an adolescent's urge for belonging and social acceptance (Sarason, Sarason, Pierce, 1990). It is stated that youngsters generally spend more time with friends (less with family), build a social life with peers and seek instrumental and emotional support from them (Brown and Klute, 2003). In other words, peer support begins to play an important role in adolescents' lives, so family members may turn into the second source of support for teenagers (Sarason, Sarason, Pierce, 1990). Furman and Buhrmester (1992) suggest that in adolescence period, the focus of attachment behavior turns from family members to peers. Although parental support remains constant or it decreases, generally peer support is elevates.

In addition to this, according to Değirmencioğlu, Urber, Tolson and Richard (1998), children are to get more family support whereas adolescents tend to receive more peer support. Also, Helsen, Vollebergh and Meeus (2000) conducted a study with 2,918 youngsters between the ages of 12 to 24. Study results showed that in adolescence, the direction of perceived social support shifted from family to friends. Although parental support remained the best indicator of psychological problems, the importance of family support weakened whereas peer support strengthened.

Teacher Support

In adolescence period, youngsters occasionally need adult identification figures outside the family who can serve as role models. These individuals can encourage independence from family or can help adolescents discover their personal competence areas as well. Most of the time, these figures are teachers who spend lots of time with them during school hours (Sarason, Sarason, Pierce, 1990). In terms of

the study conducted by Roeser, Eccles and Sameroff (1998), emotional adjustment and perception of positive teacher support were related for adolescents who attended secondary school. Also, Morrison, Laughlin, Miguel, Smith and Widaman (1997) found that teachers and parents were major sources of support and information, especially for the issues of schoolwork and relationships with peers. Peers were seen as support sources for nonacademic issues such as "looks" and getting along with other students.

In the literature, there is not clear enough evidence about the relationship between social support from teachers and students' psychological well-being. Instead, teacher support has been found to be related more with school-related adjustment outcomes (Demaray and Malecki, 2002b), students' engagement in academic activities and positive personal outcomes (Wentzel, 1998; Morrison, Laughlin, Miguel, Smith and Widaman, 1997) and also with students' social skills, academic competence and school adjustment (Malecki and Demaray, 2003).

Social Support for Adolescents from Low Socioeconomic Status

It is suggested that low socioeconomic status is a risk factor for emotional and physical problems, which may seriously affect adolescents' life (Miller, 1991). Crow and Crow (1965) claim that a family's socioeconomic status has a significant effect on a young person's developing personality due to economically underprivileged home environment.

The youngsters, who come from poverty, may be the most in need of social support interventions because they are highly vulnerable to a number of risk factors such as physical and mental health problems, dangerous environments, substance and alcohol abuse etc. (Hamburg, Mortimer, and Nightingale, 1991). Although providing

social support is not enough by itself to help the population of youngsters, it is an effective buffer for enabling adolescents to become productive, healthy and caring members of society (Hamburg, Mortimer, and Nightingale, 1991).

It is stated that children and adolescents who live in a poor environment are under risk for negative outcomes (Luthar and Zigler, 1991; Haan and MacDermid, 1998) and are under the increased risk for dysphoria and depressive symptoms (Clark, Beck, and Alford, 1999). The study conducted by Lempers, Clark-Lempers and Simons (1989) showed that financial problems were significantly related to depression and loneliness for adolescents. Also, the students who had more serious economic problems displayed higher levels of negative outcomes. On the other hand, Luthar and Zigler (1991) claim that not all students who live in impoverished regions are confronted with negative outcomes; some of them may cope with problems using certain individual and situational factors, such as social support from significant others. It is suggested that protective factors like perceived and/or received social support improve youngsters' adaptation to life with the help of resources, opportunities, facilities necessary to meet their psychological and physical needs (Bowen and Chapman, 1996).

Related with social support, Lempers, Clark-Lempers and Simons (1989) found a significant relationship between perceived parental support and economic problems, whereas Haan and MacDermid (1998) did not. Besides, Sandler (1980; cited in Bao, Whitbeck and Hoyt, 2000) showed that family support was related to lower levels of maladjustment for children from low socioeconomic status. Another study done by Seidman et al. (1999) displayed that different types of social support systems had different effects on urban adolescents in poverty. His study focused on economically disadvantaged students from the highest grade of public elementary

and junior high schools in three different states (n=972). He found six profiles of support, namely; detaching, enmeshing, hassling, functional-uninvolving, functional-involving, and dysfunctional support. Results demonstrated that functional-involving profile, which includes high social support between family members, had the least amount of depressive symptoms whereas dysfunctional profile, which involves low social support, had the most number of depressive symptoms.

B. Psychological Well-Being

Psychological well-being is an intriguing concept because it can cover many different images (Robbins and Kliewer, 2000). For example, Tomaka and Blascovich (1994) define psychological well-being as perception of control, positive self-esteem and optimism. Robbins and Kliewer (2000) conceptualize psychological well-being as effective functioning in different areas of life such as family, school, and work; coping with stress and adaptation to life events. Also, Veit and Ware (1983) define psychological well-being as a general positive affect (attitudes toward future and self-esteem) and the emotional bonds (social support) a person has.

Furthermore, different researchers operationalize the concept of psychological well-being in many ways. For instance, Gençöz and Özlale (2004) define it as having lessened depressive symptoms. Similarly, Serbest (1993) conceptualizes well-being as low levels of anxiety and depression. Also, Kostelecky and Lempers (1998) evaluate psychological well-being as the person's level of happiness, life satisfaction and life fulfillment.

In the present study, psychological well-being was measured by psychological adjustment and low level of depressive symptoms of an individual as well.

Psychological Adjustment

Although sometimes psychological well-being and psychological adjustment can be used interchangeably, in this study psychological well-being was assumed to be a broader concept which can cover psychological adjustment.

According to Berdie and Layton (1957), adolescents' psychological adjustment can be measured in seven areas, namely; emotional stability, adjustment to reality, social relationships, conformity, mood, leadership and family environment. Rohner (2005), on the other hand, determines seven personality dispositions, which are hostility and aggression, self-adequacy, dependency, self-esteem, emotional stability, emotional responsiveness and worldview to define the concept of psychological adjustment. These personality dispositions are based on his Parental Acceptance and Rejection Personality Theory (PARTheory), which suggests that individuals' well-being and emotional security is related with the perception of acceptance versus rejection by attachment figures. Also, this perception plays a crucial role on individuals' personality and psychological adjustment (Rohner, 2005).

As mentioned above, according to Rohner (2005), to understand one's overall psychological adjustment, seven personality dispositions are evaluated. First one is *hostility and aggression.* Aggression covers any behavior, which aims to hurt someone, something or oneself whereas hostility is an internal affect of resentment, anger and hostility. It can be said that hostility is the fundamental motivator to behave aggressively. Aggression is divided into three subparts in itself. The first one is physical aggression like biting, pushing, hitting, pinching, kicking; verbal aggression like cursing, humiliating, sarcasm, saying cruel, unkind things; and second one is symbolic aggression like rude hand gestures or facial aggression. Second personality disposition is *self-adequacy*, which refers to judgments one

makes about her/his own competence. It can also be seen as the ability to meet daily needs in order to live effectively. The person, who has the feeling of positive self-adequacy, can cope with his/her problems more efficiently and is able to do something successfully, on the other hand, the person with negative feeling of self-adequacy perceives herself/himself incompetent. Thirdly, *dependency* refers to an internal wish or yearning for care, attention, support, comfort and nurturance from someone who is important for the person. Dependency is also defined as offers to get positive response from others. These offers become more concrete for children, like seeking physical contact with parents when they return home whereas adults use more symbolic ones like seeking approval or support. Fourth one is *self-esteem*, which refers to a global emotional judgment the person makes about herself/himself according to value or worth. The person having positive self-esteem means that s/he is self-content and is comfortable with herself/himself; s/he accepts and approves of herself/himself. On the contrary, the person having negative self-esteem implies that s/he is not self-content and feels worthless. The fifth one is *emotional stability***,** which refers to a person's steadiness of mood and his/her ability to cope with difficulties, failures and stresses in an emotionally healthy way. The person, who is emotionally stable, can tolerate daily stresses without becoming upset. On the other hand, the unstable person is susceptible to unpredictable mood changes. S/he is vulnerable toward stressors. The sixth one is *emotional responsiveness.* It means individuals' ability to express emotions openly and freely. An emotionally responsive person feels comfortable and non-defensive in intimate and warm relationships. These kinds of people tend to sustain personal and close relationships successfully. On the other hand, having a close and intimate relationship is tough for emotionally unresponsive people. They become defensive and put strict limits on their relations. An important

point is that friendliness is not to be confused with this concept because although some people have lots of friends they may not get into close, intimate relationships. And finally, the sixth personality disposition is *worldview*, which means an individuals' overall evaluation of life, the universe, or the very essence of existence as being negative or positive. It is a judgment, which people make about the quality of existence. An individual, who has a positive worldview, sees life as basically good, unthreatening, secure and friendly. In contrast, the individual, who has a negative worldview, sees life as insecure, bad, threatening, hostile, unpleasant and full of many dangers (Rohner, 2005).

In the present study, the concept of psychological adjustment was used according to Rohner's Parental Acceptance and Rejection Personality Theory and its seven personality dispositions, which are outlined above.

Depressive Symptoms

The term depression is used in different ways, for describing mood, identifying a syndrome and as a psychiatric nosological concept (Rippere, 1994). Depressed mood can be defined as experience of unhappiness or distress, which may include feelings of guilt, worthlessness, being fed up, self-deprecation, apathy, and lethargy. On the other hand, depressive syndrome indicates a collection of common symptoms (Merrell, 2001). For instance, the combination of depressed mood, low self esteem, loss of appetite, anxiety, sleep disturbance, lack of energy, loss of interest, and suicidal thoughts would be displayed as a syndrome. And lastly, depression is also used as a nosological concept that has been categorized into bipolar (manic-depressive), endogenous, neurotic, reactive, and psychotic varieties on the basis of history and symptoms (Rippere, 1994).

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) defines Major Depressive Disorder (MDD) according to some diagnostic criteria as (APA, 2000):

> Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
> 1. Depressed mood most of the day, nearly every day, as indicated by either subjective report or observations made by others.
> 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
> 3. Significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day.
> 4. Insomnia or hypersomnia nearly every day.
> 5. Psychomotor agitation or retardation nearly every day.
> 6. Fatigue or loss of energy nearly every day.
> 7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
> 8. Diminished ability to think concentrate, or indecisiveness, nearly every day.
> 9. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. (APA, 2000)

When historical development of the concept of depression is examined, different descriptions are seen. For example, in the fourth century B.C.E, the term of depression was defined as melancholia by Hippocrates (Beck, 1967). Also, depression was seen to be a well-defined disease, not a normal mood or response by Kraepelin (Beck, 1967). In contrast, some researchers have seen depression as a normal reaction to sad events. Furthermore, Beck (1967) stated that depression has been used to point out a particular type of feeling or symptom, a symptom-complex (syndrome), and a disease entity. So, in the modern world, depression is considered as an unsuccessful response to developmental challenges, which people have to cope with during their entire lives (Seroczynski, Jacquez, and Cole, 2003).

Giving some definitions of depression, Beck's term (1967) was chosen to be the definition of "depressive symptoms" that is a particular feeling, which may manifest itself in many different patterns of symptoms. In order to operationalize depression, Beck (1967) has obtained some order and clarity and he divided the

symptoms of depression into three major categories. The categories of symptoms are as follows:

1. Emotional Manifestations: Dejected mood, self-dislike, loss of gratification, loss of attachments, crying spells, loss of mirth response.
2. Cognitive and Motivational Manifestations: Low self-evaluation, negative expectation, self-blame and self-criticism, indecisiveness, distorted self-image, loss of motivation, suicidal wishes.
3. Vegetative and Physical Manifestations: Loss of appetite, sleep disturbance, loss of libido, fatigability.

Also, Clark, Beck and Alford (1999) list the common symptoms of depression as follows: Unhappiness, sadness, loneliness, decreased activity, poor social skills, crying, restlessness, fatigability, general distress, insomnia, helplessness, low self-efficacy, difficulty concentrating, worry, long-term impairment in social and occupation functioning, decrease in well-being. These signs are the main symptoms of depression for the general population. In childhood and adolescence depression, two additional symptoms often play a crucial role in obtaining the problem. These are namely; irritability and complaints about physical symptoms like headaches, stomach pain, etc (Merrell, 2001).

There are several reasons, which may lead to elevate depressive symptoms. The main reasons can be categorized as follows: Biological influences (e.g. abnormalities in neurotransmission, temperament, problems in endocrine system), family dynamics (e.g. parental depression, poor family communication, insecure or separated family environment), genetics and family psychiatric history (e.g. having a family history of mood disorders), psychological stress and life events (e.g. exposure to highly stressful events, lack of social support), cognitive factors (e.g. distorted

thinking patterns, negative worldview), and behavioral influences (e.g. self-isolation, withdrawal) (Grabill, Griffith and Kaslow, Dong, 2001; Merrell, 2001).

Depressed mood, depressive syndromes, and depression are very widespread during adolescence period due to the increasing prevalence of stressful events in these years. Most of the adolescents display some symptoms of depression and as many as 10-20% of them experience major depression (Reynolds and Johnston, 1994b, cited in Mash and Wolfe, 2002). Likewise, Compas, Ey, Grant (1993) obtained the prevalence rates of significant depressed mood in 15% to 40% for adolescents. In addition, Peterson et. al (1993) estimated the prevalence rates of depression in children and teenagers between the ranges of 10% to 50%. Also, some researchers found that particularly among youngsters, there has been a significant increase in the prevalence of depression and the rate of depression increasing in each new generation (Lewinsohn, Rohde, Seeley and Fischer, 1993b). Furthermore, Radloff (1991) indicates that there has been a dramatic increase in depressive symptoms among adolescents between ages 13-15 and towards the ages of 17-18 depressive symptoms comes to a peak point.

According to Clark, Beck and Alford (1999), lifetime prevalence of some depressive symptoms like change in sleep and appetite, dysphoria and suicidal thoughts are 20% to 30% in the general population.

Hatzenbuehler, Parpal and Leroy (1983) conducted a study on 207 college students and they found that 22% of the students were moderately depressed screened with the Beck Depression Inventory and the Zung Self-Rating Depression Scale. According to the research conducted by Kessler and Walters (1998), the percentage of prevalence of depression was 25.2% among adolescents. Similarly,

Compas, Ey, and Grant (1993) state that approximately 25% of adolescents experience depressive symptoms in this period.

In addition to this, Achenbach (1991a, 1991b, 1991c; cited in Petersen et. al., 1993) found that, according to parents' reports, 15%-20% of females and 10%-20% of males; according to self-reports of adolescents' 25%-40% of females and 20%-35% of males experienced depressive symptoms in the six months before the study.

Even though most youngsters are able to handle the challenges of this period, not surprisingly, some are not able to (Larson and Ham, 1993). Also, Petersen, Compas, Brooks-Gunn, Stemmler, Ey, and Grant (1993) state that depression is an emotional and psychological problem, which has significant effects on adolescents' psychological functioning and adjustment and psychological well-being.

Depressive symptoms are generally seen in five different areas of functioning in children and adolescents (Oster and Montogomery, 1995, cited in Mash and Wolfe, 2002). The first area is *mood*. Children and adolescents, who suffer from depression; experience sadness, that is more constant and overstated than daily sad feelings. Other feelings, which may occur with depression, are shame, irritability, and guilt. Also, depressed youth exhibit fewer and more maladaptive emotion-regulation strategies (e.g. aggression or withdrawal). Second area is *behavior*. Adolescents and children may show elevated agitation and restlessness, reduced activity, excessive crying, or slowed speech. In company with decreased activity, generally a decline in social relations occurs. Third one is *changes in attitude*. Children and adolescents feel worthless because of depression. They regard themselves as insufficient and think that others see them this way. Their attitudes toward school might alter and academic failure may begin. They become pessimistic

regarding their future and when this attitude and feelings enhance, suicidal risk may rise. The fourth one is *thinking*. Adolescents and children are highly preoccupied with their thoughts. They can be tremendously self-conscious and self-critical. Thought patterns begin to show some problems and pessimistic views related to the future occur. They might have problems in making decisions, concentrating, and remembering. And the last one is *physical changes*. Children and adolescents experience problems related to eating and sleeping. Sleeping disturbance and appetite loss are seen often. Physical complaints like stomachaches and headaches, pains and loss of usual energy may be shown. There is usually a deficit in socialization, communication and daily living skills.

C. The Relationship between Perceived Social Support and Psychological Well-Being

There have been various studies conducted for the relationship between perceived social support and psychological well-being, also with psychological adjustment and depression. Generally, study results show that perceived social support has a positive effect on psychological well-being as a buffer effect. In other words, people, who report high level of perceived social support, have better mental health and decreased depressive symptoms than people who report low level of support. For instance, Yarcheski, Mahon and Yarcheski (2001) conducted a study with 142 seventh and eighth graders between ages 12-14. The findings displayed that there was a positive significant correlation between social support and psychological well-being. According to the study of Gençöz and Özlale (2004), appreciation-related social support (providing support) had a direct effect on psychological well-being among college students. Also, the relation between aid –related social support

(getting support when needed) and psychological well-being was partially mediated by life stress.

In addition to this, in terms of the findings of Kostelecky and Lempers (1998) social support is an effective key to reduce the stress among senior high school students. Also the study showed that social support from family provided positive significant changes on psychological outcomes. Strong family support enabled to decrease distress and help adolescents become happier and optimistic. Besides, Seltzer (1981) demonstrated that familial sources; especially, social support in interpersonal relationships had a positive effect on psychological well-beings of children and adolescents.

According to the longitudinal study (over a 2- year period) done by Way and Robinson (2003), high family support was related with greater decrease in depressive symptoms and increase in psychological adjustment over time. Also, post hoc analyses found that the decrease in depressive symptoms and increase in self-esteem were associated with a significant increase in family support over time among adolescents from low socioeconomic status. Similarly, Haan and Macdermid (1998) conducted a study with junior high school students living in urban poverty and the study results indicated that there was a clear positive relationship between parental treatment and psychological well-being. Moreover, Beam, Gil-Rivas, Greenberger, and Chen (2002) stated that greater parental warmth was related with fewer depressive symptoms for eleventh graders. Also, the research implemented with Chinese and American adolescents indicated that there was a significant relationship between the quality of family relationships and depressive symptoms (Greenberger, Chen, Tally, 2000). Another study done by Ray (2002) with 1,131 households including children between the ages of 10-17, demonstrated that perceived parental

support and positive attitude toward school had a significant positive effect on teenagers' psychological well-being when gender, age, SES, race/ethnicity, and status of mothers' employment were controlled. It was also found that adolescents from moderate SES levels got the highest scores on psychological well-being scales.

Rosenfeld and Richman (1999) conducted a study with two groups of high school students from low-income families. The first group consisted of academically "at risk" population whereas the other one was not identified "at-risk". Results showed that family support was the major source for both groups but at-risk students reported to get more peer support. According to Cornwell's (2003) findings, adolescents who experience decay of peer or family support showed higher level of depressive symptoms than the ones who experience stable or increasing amount of social support in time. Furthermore, the study done by Bao, Whitbeck, and Hoyt (2000) with 602 homeless and runaway adolescents obtained that friend support decreased depressive symptoms.

Laugesen, Dugas, Bukowski (2003) conducted a study in a sample of 237 seventh grade students. The findings indicated that adolescents' perception of social support from family was more highly related to anxiety and depression than adolescents' perception of social support from friends. Researchers suggested that in late adolescence period, the importance and effect of peer support might increase and it is a situation to be investigated. In terms of the study done by Malecki and Demaray (2003), even though early adolescent girls and boys perceived similar levels of all types of support (appraisal, instrumental, informational, and emotional) from their teachers and parents, girls perceived more support of most types from friends and classmates.

According to the study done by Yıldırım in 2004, family and teacher support predicted low level of depressive symptoms of eighth-eleventh grade students significantly, whereas peer support did not predict depressive symptoms. Also, Bowen and Chapman (1996) demonstrated that the psychological well-being of at-risk adolescents between the ages of 13-18 was associated with higher perceived social support from parents, teachers and neighborhood. In terms of the study results, social support from teachers exerted the strongest effect whereas parental support was the only common variable, which was statistically significant in the whole model for both psychological well-being and physical health. This study showed that teacher support might play a crucial role in psychological well-being of adolescents especially coming from low socioeconomic status.

Furthermore, findings of Stice, Ragan and Randall (2004) showed that in adolescence period, decrease in social support increased the risk of depression. Besides this, decrease in parental support may be more destructive than decrease in peer support. Colarossi and Eccles (2000) showed that there was a negative correlation between depression and peer support in a sample of 285 non-clinical adolescents between ages 11 to 15. Similarly, Merrell (2001) suggested that difficulties in peer relations could probably be both a cause and effect of depression.

According to Wentzel's study results (1998), relationships with parents and peers obviously had a potentially powerful influence on students' psychological well-being at school for sixth grade students. Furthermore, Demaray and Malecki (2002b) found that there was a significant negative correlation between depression and support from both parents and peers. Also, the longitudinal study of Galaif, Sussman, Chou and Wills (2003) demonstrated that adolescents (n=646) who looked for social support from their parents and peers were less likely to undergo stress or to

use maladaptive anger coping techniques to cope with their problems. Moreover, getting social support from others obviously protected them from tension.

Lan Liu (2002) conducted a study with 458 seventh graders from eastern Taiwan. Study results showed that perceived social support from peers moderated the relationship between depression and dysfunctional attitudes. In other words, when peer support increased, the relationship between the depression and dysfunctional attitudes also decreased.

In sum, according to the research results outlined above, it can be stated that there is a relation between perceived social support and psychological well-being of adolescents. More specifically, perceived social support from family, friends and teachers make significant changes in mental health problems (Cobb, 1976; Gottlieb, 1994; Chen, 1997; Bender and Losel, 1997; Jackson and Warren, 2000). However, perceived social support such as family support can act as a preventive factor in diminishing negative outcomes in youth (Bowen and Chapman, 1996; Rosenfeld and Richman, 1999; Beest and Baerveldt, 1999; Ray, 2002; Beam, Gil-Rivas, Greenberger, and Chen, 2002; Way and Robinson, 2003; Yıldırım, 2004). But again, peer support has positive effects on adolescents' well-being generally as an additional preventive factor to parental support (Wentzel, 1998; Bao, Whitbeck and Hoyt, 2000; Colarossi and Eccles, 2000; Lan Liu, 2002; Demeray and Malecki, 2002b). On the other hand, some researchers did not find any significant relation between peer support and psychological well-being (Bowen, and Chapmen, 1996; Yıldırım, 2004) in contrast to expectations due to increased importance of peer relations in adolescence period. And lastly, teacher support also acts as additional preventive factors to prevent youth from psychological problems (Bowen and

Chapman, 1996; Morrison, Laughlin, Miguel, Smith and Widaman, 1997; Malecki and Demaray, 2003; Yıldırım, 2004).

In the present study, the relation between perceived social support from family, friends and teachers and psychological well being (psychological adjustment and depressive symptoms) of adolescents was examined in a longitudinal context. So, it was assumed that even though family support would remain constant, peer and teacher support would increase from Time 1 (October, 2005) to Time 2 (May, 2006). In other words, the scores in perceived social support would increase between two time periods, which might have a relationship with the well-being of adolescents.

III. METHOD

A. Participants

The target population of the proposed study was adolescents between ages 14-16 from low socioeconomic status (SES) in İstanbul metropolitan area. To implement the study, convenient clustered sampling method was used. In other words, not the students but the classes were selected randomly from low SES as defined by the designated school environment and neighborhood.

The school, which was chosen from Ümraniye region, reflects low socioeconomic status. This information was gathered by personal communication. An officer from the Director of National Education (Milli Eğitim Müdürlüğü) mentioned that Ümraniye is a region with low socioeconomic status so the students who attend this school mostly come from low socioeconomic status and researcher's observation supports this information.

In Ümraniye region; which is divided into seven education areas; there are 85 elementary and 25 high schools in total. The school, where the study was conducted, is located in the fourth education area, which has ten elementary and six high schools.

The chosen school is a high school, which consists of only ninth, tenth, eleventh and twelfth graders. There is no secondary school level. In the school year of 2005-2006, in total there were 120 teachers and 2,136 students, who attended the school.

Lycèe 1 students (ninth graders) were selected for the sample group to examine the changes between Time 1 (October, 2005) and Time 2 (May, 2006). All of these students were new comers. This means that there were no students who repeated the ninth grade because the education system was changed in 2005 (Journal

of Announcement [Tebliğler Dergisi], 2005) and Turkish government allowed all unsuccessful students to pass on to the upper grade.

In the school, there were 16 Lycèe 1 classes and 8 of them (half of the Lycèe 1 students) were selected randomly to conduct the study. In Time 1 (October, 2005), the sample population was made of 242 male (80.9%) and 57 female (19.1%) students with a total of 299 adolescents, whereas the subject number decreased to 237 participants consisting of 184 male (77.6%) and 53 female (22.4%) students in Time 2 (May, 2006). The reason for the decrease in numbers of participants was school dropouts. A number of students in every class quit the school because of academic failure during the year, so the number of the participants was altered from Time 1 to Time 2.

B. Instruments

Four instruments were used in the study. These instruments are as follows:

Demographic Information Form

Demographic information was collected by a form (see Appendix B) developed by the researcher, which consists of questions related to student number, gender, educational levels, occupations and working status of the parents.

Perceived Social Support Scale-Revised (PSSS-R)

Perceived Social Support Scale (PSSS-R) was developed by Yıldırım in 1997 and revised again by Yıldırım in 2004 (see Appendix C). PSSS-R is a paper-pencil inventory, which aims to determine the levels of perceived social support from family, from friends, and from teachers for eight grade and high school students (Yıldırım, 1997).

PSSS-R has a total of 50 items and three subscales (ss): The family support subscale (FSss, 20 items), the peer support subscale (PSss, 13 items), and the teacher support subscale (TSss, 17 items). It has a 3-point Likert Scale answer format (Suitable To Me = 3 point, Partially Suitable To Me = 2 point and not Suitable To Me = 1 point). Participants put a sign (X) inside the parentheses according to his/her view. The minimum score, which can be obtained from the instrument, is 50 and the maximum score is 150. High points mean high perceived social support (Yıldırım, 2004).

The validity and reliability studies of PSSS-R were carried out with a sample of 660 students (345 male and 315 female) and 20.6% of the students were from eighth grade, 19.6% from ninth grade, 25.4% from tenth grade, and 34.2% from eleventh grade. The ages of students were between 14 and 17 years with a mean age of 15.73 years (Yıldırım, 2004).

The reliability coefficients of PSSS-R and its subscales in terms of temporal stability were carried out by test-retest technique with a four-week interval and the internal reliability was calculated by Cronbach Alpha method. The Alpha values and test-retest coefficients were α=.93, r =.91; α=.94, r =.89; α=.91, r=.85; α=.93, r=.86; for the total PSSS-R, for family, friend, and teacher support, respectively (Yıldırım, 2004).

Construct validity of PSSS-R and its subscales were calculated by principle component analysis (PCA). In terms of the results, FSss had three factors: (1) Social companionship and emotional support (9 items; e.g.: listen to me when I am mad). (2) Advice and information support (7 items, e.g.: give me good advice). (3) Appraisal support (4 items, e.g.: say nice things to me when I have done something well). PSss had one factor: (1) Emotional and appraisal support (13 items, e.g.: do

nice things for me). TSss had two factors: (1) Emotional support (11 items, e.g.: understands me). (2) Information and appraisal support (6 items, e.g.: explains things when I am confused) (Yıldırım, 2004).

Also, the construct validity of PSSS-R was examined by exploratory factor analysis. In terms of its results, the factors, which are outlined above, were obtained. Kaiser-Meyer-Olkin (KMO) coefficient was .93 and Barlett test was found significant for all PSSS-R. Also for FSss KMO coefficient was .94, Barlett test was found significant, for PSss KMO coefficient was .94, Barlett test was found significant and lastly for TSss KMO coefficient was .95, Barlett test was found significant (no p value was declared) (Yıldırım 2004).

Criterion validity of PSSS-R was calculated by correlating it with the Beck Depression Inventory (BDI-Turkish Form) and The Daily Hassles Scale (DHS) (Yıldırım, 2004). Negative significant correlations between PSSS-R / its subscales and BDI (PSSS-R and BDI= -.32; FSss and BDI= -.30; PSss and BDI= -.19; TSss and BDI= -.23, $p<.01$) and between PSSS-R / TSss and DHS (PSSS-R and DHS= -.36; TSss= -.34, $p<.01$) were found. On the other hand, there was no significant correlation between FSss / PSss and DHS (Yıldırım 2004).

Also, in the current study, very similar negative significant associations between BDI and PSSS-R / its subscales were found (PSSS-R and BDI= -.34; FSss and BDI= -.38; PSss and BDI= -.18; TSss and BDI= -.20, $p<.01$ in Time 1 and PSSS-R and BDI= -.31; FSss and BDI= -.41, $p<.01$; TSss and BDI= -.16, $p<.05$ in Time 2).

Personality Assessment Questionnaire (PAQ) – Turkish Form

Personality Assessment Questionnaire (PAQ) was developed by Rohner in 1971 and was translated into Turkish (see Appendix D) by Varan in 2000. The PAQ is a self-report inventory, which aims to measure individuals' perceptions of themselves according to seven personality dispositions, namely; hostility and aggression, self-esteem, dependency, self-adequacy, emotional stability, emotional responsiveness, and worldview (Rohner, 2005). The score obtained from these subscales of PAQ reflects psychological adjustment of the individuals.

PAQ has seven subscales each one of which consists of 6 items, so in total there are 42 items in the questionnaire. Response format is made up of 4-point scale that are almost always true (4 point), sometimes true (3 point), rarely true (2 point), and almost never true (1 point). The important point related with the scoring part is reversed items. The person who scores the inventory should pay attention to these items when calculating. The minimum score, which can be obtained from the questionnaire, is 42 and maximum point is 168. The higher score shows some degree of psychological maladjustment whereas low score is the sign of psychological adjustment, in other words, the lower score is indicator of mental health (Rohner, 2005).

The reliability coefficients of the original version of PAQ were examined by Cronbach Alpha method. The alpha values ranged from .46 to .74. And the internal consistency of the total PAQ was .88. Convergent and discriminant validity of PAQ was calculated by correlating several criterion scales like Buss and Durkee's Hostility, Rosenburg's Self-Esteem, Shostrom's Self-Regard, Help-Seeking (ISI), Lorr and Youniss' Relaxed vs. Trust. The results show that Hostility ($r = .68$, $p < .001$), Negative Self-Esteem ($r = -.75$, $p < .001$) and Dependency ($r = .78$, $p < .001$)

are the subscales, which correlates most highly with their criterion scales (Rohner, 2005).

The reliability study of the Turkish form of PAQ (Kendini Değerlendirme Ölçeği) was done by Erkman (2003). The research was conducted with 1821 children and adolescents between ages 10-14. The Cronbach Alpha coefficients ranged from .51 to 78. And total value of PAQ was obtained as .81 ($p<.001$). The validity study of the Turkish version investigated the relationship between PAQ with perceived paternal and maternal rejection since decreased mental health has been established as an outcome of parental rejection (Erkman, 2003; Rohner, 2005). It was found that PAQ was significantly correlated with both perceived paternal rejection ($r = .33$, $p<.001$) and perceived maternal rejection ($r = .33$, $p<.001$) (Erkman, 2003).

Beck Depression Inventory (BDI) - Turkish Form

Beck Depression Inventory (BDI) was developed by Beck in 1961 and adapted to Turkish (see Appendix E) by Teğin in 1980. BDI is a paper and pencil test, which aims to discriminate depressives from non-depressives on a continuum measuring the severity of depression.

It is composed of 21 categories (mood, pessimism, sense of failure, lack of satisfaction, guilt feeling, 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) of symptoms and attitudes. Each statement is given a value from 0 to 3. The minimum score is 0 whereas the maximum score is 63. There are several criteria against which the level of depression is set. For instance, Meites (1980) determined the cut-off points of depression for

BDI as: 0-10 refers to “mildly depressed”, 11-20 refers to “moderately depressed”, and 21-63 refers to “severely depressed” whereas Bryson (1984) put the cut-off points as: 0-9 refers to “not depressed”, 10-15 refers to “mildly depressed”, 16-23 refers to “moderately depressed” and 24-63 refers to “severely depressed”.

As indicated before, in this study Beck’s model was used associated with depression variable, so the severity of depressive symptoms was determined according to Beck’s original categorization system as follows: 0-13 refers to “not depressed”, 14-24 refers to “mildly depressed”, and 25-63 refers to “severely depressed”. Although there is no time limitation, 10 to 15 minutes are enough to answer the questions (Beck, 1967).

According to Beck (1967), the original sample consisted of two separate sample groups, namely the original group of 226 patients, and the replication group of 183 patients. The sample consisted of 60.9% female and 39.1% male participants with an age range between 15 and 44, and the high frequency of patients in the lower socioeconomic groups. Psychotic disorders were reported by 41% of the subjects, the psychoneurotic disorders made up 43% of the patients, and personality disorders comprised 16%.

Beck (1967) reported Pearson Product Correlation coefficient as $r = .86$ by using split-half reliability method and .93 with the Spearman-Brown formula. Miller and Seligman (1973) found test-retest reliability of BDI as $r = .74$ for 31 non-clinical sample with a 3-month interval.

For the concurrent validity, .72 correlation was found between the BDI and the clinicians’ depression ratings, and .14 was obtained between and the BDI and clinicians’ anxiety ratings ($p<.001$) in a sample of 606 patients (Beck, 1972). Moreover, Nussbaum and Michaux (1963, cited in Beck, 1967) found a significant

negative association between a sense of humor test and the BDI. Gottschalk, Glecer and Springer (1963, cited in Beck 1967) reported a significant relation of .47 between BDI and the hostility inward scale.

The Turkish sample comprised of 40 Social Science undergraduate students and 30 depressive patients between ages 17 to 23 (Teğin, 1980). Test-retest reliability was found to be .65 for 40 undergraduates with a 15-day interval (Teğin, 1980). Teğin (1980) found Cronbach values of .78 for the undergraduate students in terms of internal consistency and it was .61 for depressive patients with the split-half method ($p<.01$). Hisli (1989) reported the Pearson Product Moment Correlation coefficient between depression scale of MMPI and the Turkish form of the BDI to be $r = .63$ ($p<.001$).

The validity of the instrument for the Turkish version was determined concurrently. Teğin (1980) found correlation coefficients between BDI and the Scale of Cognitive Reactions in Depression (Depresyonda Bilişsel Tepkiler Ölçeği) as .20 for normals, .52 ($p< .01$) for depressives and –0.33 ($p<. 05$) for schizophrenics.

In 1999, Zengin conducted a study, which aimed to investigate and compare the two Turkish adaptations of BDI (Original BDI was adapted into Turkish by Teğin in 1980 and the revised BDI was adapted by Hisli-Şahin in 1988) in terms of their psychometric properties. Also, Zengin (1999) revised the short form of BDI [Beck Depresyon Envanteri-Kısa Form (BDE-KF)] with 161 Turkish undergraduate students to provide a more valid instrument.

C. Design

This was a field survey with a longitudinal structure. The data were collected at two different time points to assess the changes from Time 1 (October, 2005) to Time 2 (May, 2006).

D. Procedure

After taking permission from school administration to implement the study, an official consent (see Appendix A) was taken from the Province of İstanbul Governor's Office of the Director of National Education (İstanbul Valiliği İl Milli Eğitim Müdürlüğü).

The data were collected at two periods (in October, 2005 and May, 2006). In the implementation process, directions and ethical issues like confidentiality were explained to the adolescents and the folders of questionnaires were distributed to each of them by the researcher. The participants were asked to complete all four measures as honestly and carefully as possible. The measurements were given in two different orders to prevent carry on effect. When the questionnaires were collected, the researcher controlled each one to keep the implementation mistakes in minimum.

Before the study, a group of adolescents was asked to answer questions as a pilot study to define the necessary time to complete all questions. The group finished the questionnaires approximately in 25-30 minutes. So a class hour (40 minutes) was given to the adolescents but when the duration was not sufficient for some of the respondents, the researcher waited until everybody finished answering the measures.

E. Data Analyses

Data were analyzed by using SPSS 13.0 (Statistics Packages of Social Sciences) computer program. The significance level (α) was set at $p<.05$ unless

otherwise indicated. Initially, demographic characteristics were presented as percentages. They consisted of descriptive statistics including mean, standard deviation, maximum and minimum scores of the measures. Then, research questions 1 and 2 were analyzed by using Pearson Product-Moment correlation to test for concurrent associations between perceived social support and psychological adjustment and depressive symptoms at Time 1 and Time 2. The research question 3 was analyzed by using Paired Samples t-test to examine the changes in perceived social support from Time 1 (October, 2005) to Time 2 (May, 2006). The research question 4 was analyzed by using Paired Samples t-test to examine the changes in psychological adjustment from Time 1 (October, 2005) to Time 2 (May, 2006). The research question 5 was analyzed by using Paired Samples t-test to examine the changes in depressive symptoms from Time 1 (October, 2005) to Time 2 (May, 2006). And lastly, research questions 6, 7 and 8 were analyzed by using multiple regression analysis method to examine the predictors of perceived social support in Time 1 and Time 2.

IV. RESULTS

A. Overview: Organization of Results

Results are presented in five parts as follows: (1) demographic characteristics of the sample (2) descriptive results of the study variables and outcomes, (3) results examining the relationship between study variables in Time 1 (October, 2005) and Time 2 (May, 2006), (4) results addressing the changes in study variables from Time 1 to Time 2, (5) results examining the factors predicting perceived social support in Time 1 and Time 2, (6) summary of the results.

B. Presentation of Results

1. Demographic Characteristics of the Sample

Characteristics of the sample were presented according to gender of adolescents, educational levels and working status of their mothers and fathers. Table 1 shows the distribution of the adolescents' characteristics. The sample consisted of 53 females (22.4%) and 184 males (77.6%), in total 237 adolescents between ages 14-16. The adolescents and their families came from low socioeconomic status. Educational level of mothers was lower compared to the educational level of fathers. The percentage of mothers who have never had schooling was 23.1% (*n*=54) whereas this number was only 6.0% (*n*=14) for fathers. Also the percent of graduation from high school were 3.4% (*n*=8) for mothers and 12.4% (*n*=29) for fathers. A similar situation was seen between the working statuses of the parents. Only 10.2% (*n*=24) of the mothers worked at a job such as housekeeping, cooking, and sales. In other words, 89.8% (*n*=212) of them were housewives whereas 85.4% (*n*=199) of the fathers had a job and among them, 69.1% (*n*=159) worked as blue-collar worker.

Table 1. *Demographic Characteristics*

Characteristics	*n*	%
Gender		
Female	53	22.4
Male	184	77.6
Maternal Education		
No schooling	54	23.1
Elementary	149	63.7
Secondary	22	9.4
High School	8	3.4
University and over	1	0.4
Paternal Education		
No schooling	14	6.0
Elementary	142	60.9
Secondary	45	19.3
High School	29	12.4
University and over	3	1.3
Working Status of Mothers		
Not working	212	89.8
Working	24	10.2
Working Status of Fathers		
Not working	34	14.6
Working	199	85.4

2. Descriptive Results of Study Variables and Outcomes

Table 2 presents the mean scores and standard deviations of the participants from the measures of PSSS-R (Perceived Social Support Scale-Revised), PAQ (Personality Assessment Questionnaire) and BDI (Beck Depression Inventory) and their subscales in Time 1 (October, 2005). According to the results, the total mean score of Perceived Social Support was 126.31 (higher score is the sign of more perceived social support) and for family, friend and teacher support was 51.98; 32.00; 42.34, respectively. Also the minimum score of PSSS-R was 75 whereas maximum was 149.

The total mean score for adolescents for PAQ was 92.56 (higher score is the sign of maladjustment that means there are some problems concerning dealing with

and adaptation to life events and stress) and also the minimum score for PAQ was 57 and the maximum score was 131.

As seen in Table 2, the total mean score of BDI was 13.29 (higher score is the sign of more depressive symptoms), with a minimum score of 0 and a maximum score of 41 in Time 1. According to Beck's cognitive model of depression (1967), scores between 0-13 refers to "not depressed" category, scores between 14-24 refers to "mildly depressed" category and scores between 25-63 refers to "severely depressed" category.

Table 2. *Means and Standard deviations (in parentheses) of measures in Time 1*

Measures	M (SD)
PSSS-R Total (*n*=237)	126.31 (12.98)
Family Support	51.98 (5.96)
Friend Support	32,00 (4.89)
Teacher Support	42.34 (6.42)
PAQ Total (*n*=237)	92.54 (14.28)
Hostility and Aggression	11.51 (3.50)
Self-Esteem	11.13 (3.14)
Dependency	16.93 (3.22)
Self-Adequacy	11.43 (2.96)
Emotional Stability	16.45 (3.24)
Emotional Responsiveness	13.58 (3.36)
Worldview	11.54 (3.92)
BDI Total (*n*=237)	13.29 (7.99)

Note: PSSS-R (Perceived Social Support Scale Revised), PAQ (Personality Assessment Questionnaire), BDI (Beck Depression Inventory)

Table 3 displays the mean scores and standard deviations of the sample from the measures of PSSS-R (Perceived Social Support Scale-Revised), PAQ (Personality Assessment Questionnaire) and BDI (Beck Depression Inventory) and their subscales in Time 2 (May, 2006). In terms of the results, the mean score of perceived social support was 122.43 and for family, friend and teacher support, it was 50.76; 32.03; 39.63, respectively. Also the minimum point of the total score of

perceived social support was 77 whereas the maximum one was 150. The mean score for adolescents for PAQ was 94.81, with a minimum score of 61 and a maximum score of 133. Lastly, the mean score of BDI was 14.08, with a minimum score of 0 and a maximum score of 42 in Time 2.

Table 3. *Means and Standard deviations (in parentheses) of measures in Time 2*

Measures	M (SD)
PSSS-R Total (*n*=237)	122.43 (14.64)
Family Support	50.76 (6.77)
Friend Support	32.03 (5.02)
Teacher Support	39.63 (7.78)
PAQ Total (*n*=237)	94.81 (13.93)
Hostility and Aggression	11.81 (3.24)
Self-Esteem	11.72 (3.20)
Dependency	15.99 (3.32)
Self-Adequacy	11.80 (3.44)
Emotional Stability	16.81 (3.43)
Emotional Responsiveness	13.89 (3.64)
Worldview	12.85 (3.99)
BDI Total (*n*=237)	14.08 (9.93)

Note: PSSS-R (Perceived Social Support Scale Revised), PAQ (Personality Assessment Questionnaire), BDI (Beck Depression Inventory)

3. Results Examining the Relationship between Study Variables in Time 1 and Time 2

The aim of the first and second questions was to investigate the relationships among perceived social support, psychological adjustment and depressive symptoms of adolescents between ages 14-16 in Time 1 (October, 2005) and in Time 2 (May, 2006). For that purpose, Pearson Product-Moment correlations among all variables were conducted.

As it is seen in Table 4, there was a significant positive relationship between perceived social support and psychological adjustment ($r = .30$, $p<.01$) and significant negative association between perceived social support and depressive

symptoms (r = -.34, p<.01) in Time 1. As stated before, although psychological adjustment is a positive concept, which has a positive correlation with perceived social support, higher score in PAQ, which measures psychological adjustment, shows maladjustment. So, this is the reason of sign (+/-) differences in analyses related with psychological adjustment in the text and tables.

When the subscales of perceived social support were examined, it was observed that family support was the most significantly related subscale not only with psychological adjustment (r = .37, p<.01) but also with depressive symptoms (r = -.38, p<.01) in Time 1 as well.

Table 4. *Correlations between Perceived Social Support, Psychological Adjustment and Depressive Symptoms in Time 1 (October, 2005)*

Variables	1	2	3	4	5	6
1. PSSS-R	—	.76**	.69**	.79**	-.30**	-.34**
2. PssFamily		—	.31**	.37**	-.37**	-.38**
3. PssFriend			—	.34**	-.07	-.18**
4. PssTeacher				—	-.20**	-.20**
5. PAQ					—	.49**
6. BDI						—

Note: PSSS-R (Perceived Social Support Scale Revised), PssFamily (Perceived Family Support), PssFriend (Perceived Friend Support), PssTeacher (Perceived Teacher Support), PAQ (Personality Assessment Questionnaire), BDI (Beck Depression Inventory)
**p<.01.

Table 5 demonstrates that perceived social support and psychological adjustment were significantly positive associated (r = .23, p<.01) and also perceived social support and depressive symptoms were significantly negative related (r = -.31, p<.01) in Time 2. Similar to the results of Time 1, the family subscale of perceived social support was the most significantly correlated one with both psychological adjustment (r = .32, p<.01) and depressive symptoms (r = -.41, p<.01) in Time 2.

Table 5. *Correlations between Perceived Social Support, Psychological Adjustment and Depressive Symptoms in Time 2 (May, 2006)*

Variables	1	2	3	4	5	6
1. PSSS-R	—	.73**	.66**	.83**	-.23**	-.31**
2. PssFamily		—	.23**	.35**	-.32**	-.41**
3. PssFriend			—	.39**	-.09	-.11
4. PssTeacher				—	-.12*	-.16*
5. PAQ					—	.58**
6. BDI						—

Note: PSSS-R (Perceived Social Support Scale Revised), PssFamily (Perceived Family Support), PssFriend (Perceived Friend Support), PssTeacher (Perceived Teacher Support), PAQ (Personality Assessment Questionnaire), BDI (Beck Depression Inventory)
*p<.05. **p<.01.

In Table 6, the correlation matrix shows all the relations between three variables, namely; perceived social support, psychological adjustment and depressive symptoms both in Time 1 and in Time 2. The relation in perceived social support between Time 1 and Time 2 was .51 (p<.01), the correlation was .67 (p<.01) for psychological adjustment and .62 (p<.01) for depressive symptoms. Also, it is possible to examine the relations between one variable's Time 1 and another variable's Time 2 results.

Table 6. *Correlations between Perceived Social Support, Psychological Adjustment and Depressive Symptoms in Time 1 (October, 2005) and in Time 2 (May, 2006)*

Variables	1	2	3	4	5	6
1. PSSS-R	—	-.30**	-.34**	.51**	-.15*	-.17**
2. PAQ		—	.49**	-.20**	.67**	.41**
3. BDI			—	-.21**	.43**	.62**
4. PSSS-R2				—	-.23**	-.31**
5. PAQ2					—	.58**
6. BDI2						—

Note: PSSS-R (Perceived Social Support Scale Revised in Time 1), PAQ (Personality Adjustment Questionnaire in Time 1), BDI (Beck Depression Inventory in Time 1), PSSS-R2 (Perceived Social Support Scale Revised in Time 2), PAQ2 (Personality Assessment Questionnaire in Time 2), BDI2 (Beck Depression Inventory in Time 2)
*p<.05. **p<.01.

4. Results Addressing the Changes in Variables from Time 1 to Time 2

The aim of the third, fourth and fifth questions were to examine the changes in perceived social support, psychological well-being and depressive symptoms from Time 1 to Time 2, respectively. Paired Samples t-test method was used to see the differences in mean scores of the variables between two time periods.

First of all, for the third question, significant difference was found in perceived social support scores of Time 1 (October, 2005) and Time 2 (May, 2006) [t (236) = 4.33; p<.001]. The mean score was 126.31 in Time 1 whereas it was 122.43 in Time 2 as seen in Table 7. In other words, the mean score of perceived social support of adolescents decreased compared to beginning of the school year (2005-2006).

Table 7. *t-test Results of Perceived Social Support from Time 1 to Time 2*

	M (SD)	df	t
PSSS-R (*n*=237)	126.31(12.98)	236	4.33***
PSSS-R2 (*n*=237)	122.43(14.64)		

Note: PSSS-R (Perceived Social Support Scale Revised in Time 1), PSSS-R2 (Perceived Social Support Scale Revised in Time 2)
***p<.001.

When the subscales of perceived social support were examined it is seen that family support significantly decreased from Time 1 (October, 2005) to Time 2 (May, 2006) [t (236) = 3.02; p<.01] (Table 8).

Table 8. *t-test Results of Perceived Family Support from Time 1 to Time 2*

	M (SD)	df	t
PssFam (*n*=237)	51.98 (5.96)	236	3.02**
PssFam2 (*n*=237)	50.76 (6.77)		

Note: PssFam (Perceived Family Support in Time 1), PssFam2 (Perceived Family Support in Time 2)
**p<.01.

Table 9 shows that the mean score of friend support increased from 32.00 to 32.03 between two time periods; however, the difference was not significant.

Table 9. *t-test Results of Perceived Friend Support from Time 1 to Time 2*

	M (SD)	df	t
PssFre (*n*=237)	32.00 (4.89)	236	-.10
PssFre2 (*n*=237)	32.03 (5.02)		

Note: PssFre (Perceived Friend Support in Time 1), PssFre2 (Perceived Friend Support in Time 2)

Also, Table 10 presents that there was a significant difference between teacher supports from Time 1 (October, 2005) to Time 2 (May 2006) [t (236) = 5.81; p<.001] when teachers were perceived less supportive.

Table 10. *t-test Results of Perceived Teacher Support from Time 1 to Time 2*

	M (SD)	df	t
PssTea (*n*=237)	42.34 (6.42)	236	5.81***
PssTea2 (*n*=237)	39.63 (7.78)		

Note: PssTea (Perceived Teacher Support in Time 1), PssTea2 (Perceived Teacher Support in Time 2)
***p<.001.

In the fourth question, the differences between psychological adjustment scores were investigated. According to the results, there was a significant decrease in psychological adjustment from Time 1 (October, 2005) to Time 2 (May, 2006) [t (236) = 3.06; p<.01]. Table 11 demonstrates that the mean score of PAQ was 92.54 in Time 1 whereas 94.81 in Time 2 showing increase in feel maladjustment.

Table 11. *t-test Results of Psychological Adjustment from Time 1 to Time 2*

	M (SD)	df	t
PAQ (*n*=237)	92.54 (14.28)	236	-3.06**
PAQ2 (*n*=237)	94.81 (13.93)		

Note: PAQ (Personality Adjustment Questionnaire in Time 1), PAQ2 (Personality Assessment Questionnaire in Time 2)
**p<.01.

According to the results of the fifth question, the mean score of depressive symptoms also increased from 13.29 to 14.08 between the two time periods as it is seen in Table 12. It means that students' depression level elevated during the school year of 2005 –2006 yet this was not significant.

Table 12. *t-test Results of Depressive Symptoms from Time 1 to Time 2*

	M (SD)	df	t
BDI (*n*=237)	13.29 (7.99)	236	-1.53
BDI2 (*n*=237)	14.08 (9.93)		

Note: BDI (Beck Depression Inventory in Time 1), BDI2 (Beck Depression Inventory in Time 2)

5. Results Examining the Factors Predicting Perceived Social Support in Time 1 and Time 2

The aim of the sixth, seventh and eighth questions was to determine the factors that additively and uniquely predict perceived social support in Time 1 (October, 2005) and Time 2 (May, 2006). For that purpose, Multiple Regression analysis was conducted.

In question six, to find the predictors of perceived social support in Time 1, simultaneous multiple regression analysis was used. Gender, psychological adjustment scores in Time 1 and depressive symptom scores in Time 1 were entered into the equation. It was found that all of these variables were significant predictors for perceived social support in Time 1 (gender: β=.11, t=1.74, p<.05; psychological adjustment: β=.18, t=2.64, p<.01; depressive symptoms: β=-.26, t=-3.72, p<.001). It can be stated that being female affects perception of social support in a positive way. In other words, females perceived more social support than males.

As a result, these three predictors additively accounted for approximately 14% of the variance of the perceived social support scores in Time 1 (Table 19).

Table 13. *Summary of Simultaneous Regression Analysis for Variables Predicting Perceived Social Support in Time 1 (n=237)*

Variable	β	R^2
Gender	.11*	
PAQ	-.18**	
BDI	-.26***	.14

Note: Dependent variable: Perceived Social Support Scores
PAQ (Personality Assessment Questionnaire), BDI (Beck Depression Inventory)
*p<.05. **p<.01. ***p<.001.

In the seventh question to determine the predictors of perceived social support in Time 2, again, simultaneous multiple regression analysis was used. Gender, psychological adjustment scores in Time 2 and depressive symptom scores in Time 2 were entered into the equation. According to the results, gender and depressive symptoms were significant predictors of perceived social support in Time 2 (gender: β=.24, t=3.91, p<.001; depressive symptoms: β=-.29, t=-3.89, p<.001). In contrast to Time 1, psychological adjustment was not a significant predictor that explained perceived social support in Time 2 but similar to Time 1 results, females have a tendency to perceive social support higher than males in Time 2.

Table 14. *Summary of Simultaneous Regression Analysis for Variables Predicting Perceived Social Support in Time 2 (n=237)*

Variable	β	R^2
Gender	.24***	
PAQ	-.11	
BDI	-.29***	.15

Note: Dependent variable: Perceived Social Support Scores
PAQ (Personality Assessment Questionnaire), BDI (Beck Depression Inventory)
***p<.001

As seen in Table 14, gender and depressive symptoms additively explained approximately 15% of the variance of the perceived social support scores in Time 2.

In question eight, to obtain the best predictors of perceived social support in Time 2, stepwise regression analysis was used. Gender, perceived social support scores in Time 1, psychological adjustment scores in Time 1, depressive symptom scores in Time 1, psychological adjustment scores in Time 2 and depressive symptom scores in Time 2 were entered into the equation. In terms of the results, perceived social support scores in Time 1 (β=.49, t=8.61, p<.001), depressive symptom scores in Time 2 (β=-.37, t=-5.35, p<.001), gender (β=.19, t=3.51, p<.01)

and depressive symptom scores in Time 1 (β=.17, t=2.43, p<.05) were significant predictors of perceived social support scores in Time 2. Table 15, presents the contributions of each variable to explain the perceived social support scores in Time 2. According to this, the four variables, namely; perceived social support scores in Time 1, depressive symptom scores in Time 2, gender and depressive symptom scores in Time 1 additively explained approximately 34% of the variance of the perceived social support scores in Time 2. Separately, perceived social support scores in Time 1 predicted 25% of the perceived social support scores in Time 2. Also, depressive symptom scores in Time 2, gender and depressive symptom scores in Time 1 explained 4.9%, .3% and .1% of the model, respectively.

Table 15. *Summary of Stepwise Regression Analysis for Variables Predicting Perceived Social Support in Time 2 (n=237)*

Model	β	R^2	ΔR^2
1. PSSS-R	.50	.25	.25***
2. PSSS-R	.46		
BDI2	-.23	.30	.05***
3. PSSS-R	.45		
BDI2	-.27		
Gender	.19	.33	.03**
4. PSSS-R	.49		
BDI2	-.37		
Gender	.19		
BDI	.17	.34	.01*

Note: Dependent variable: Perceived Social Support Scores in Time 2
PSSS-R (Perceived Social Support Scale Revised in Time 1), BDI (Beck Depression Inventory in Time 1), BDI2 (Beck Depression Inventory in Time 2)
*p<.05. **p<.01. ***p<.001.

6. Summary of the Results

The summary of the results of the research questions is given in Table 16.

Table 16. *Summary of the Results*

Research Questions	Results
1. a) Relationship between perceived social support and psychological adjustment in Time 1 b) Relationship between perceived social support and depressive symptoms in Time 1	a) A significant positive relationship was found between perceived social support and psychological adjustment in Time 1 b) A significant negative relationship was found between perceived social support and depressive symptoms in Time 1
2. a) Relationship between perceived social support and psychological adjustment in Time 2 b) Relationship between perceived social support and depressive symptoms in Time 2	a) A significant positive relationship was found between perceived social support and psychological adjustment in Time 2 b) A significant negative relationship was found between perceived social support and depressive symptoms in Time 2
3. Changes in perceived social support from Time 1 to Time 2	There was a significant decrease in perceived social support scores from Time 1 to Time 2
4. Changes in psychological adjustment from Time 1 to Time 2	There was a significant decrease in psychological adjustment scores from Time 1 to Time 2
5. Changes in depressive symptoms from Time 1 to Time 2	There was an increase in depressive symptom scores from Time 1 to Time 2 but this was not significant
6. Predictors of perceived social support in Time 1	Gender, psychological adjustment scores in Time 1 and depressive symptom scores in Time 1 were significant predictors of perceived social support in Time 1
7. Predictors of perceived social support in Time 2	Gender and depressive symptom scores in Time 2 were significant predictors of perceived social support in Time 2
8. Best predictors of perceived social support in Time 2	Perceived social support scores in Time 1 were the best predictors of perceived social support in Time 2. Also, gender, depressive symptom scores in Time 1 and Time 2 were significant predictors of perceived social support in Time 2

V. DISCUSSION

The final part is presented in five sections: (a) restatement of the purpose of the study (b) review of the findings in terms of the research questions, (c) presentation of implications of the current study, (d) discussion of limitations of the current study and recommendations for future research, and (e) summary.

A. Purpose of the Study

The main purpose of the current study was to examine the relationship between perceived social support and psychological well-being of adolescents coming from low socioeconomic status. The associations between family, friend and teacher support and psychological well-being of adolescents were tested besides the relationship between the total score of perceived social support and psychological well-being.

The study also investigated the changes in perceived social support, psychological adjustment and depressive symptoms from Time 1 (October, 2005) to Time 2 (May, 2006). Additionally, possible predictors of perceived social support both in Time 1 and Time 2 and the best correlates of perceived social support in Time 2 were examined.

B. Review of Findings

Question One and Two – Relationship between Study Variables in Time 1 and Time 2

The first and second questions investigated the associations among the scores of perceived social support, psychological adjustment and depressive symptoms in Time 1 (October, 2005) and in Time 2 (May, 2006). In terms of findings,

a significant positive relationship was found between perceived social support and psychological adjustment both in Time 1 ($r= .30$, $p<.01$) and Time 2 ($r= .23$, $p<.01$). Also, correlation analyses showed that there was a significant negative association between perceived social support and depressive symptoms again both in Time 1 ($r =-.34$, $p<.01$) and Time 2 ($r= -.31$, $p<.01$). This means that the adolescents who get higher scores from social support show less depressive symptoms and feel more psychologically adjusted.

In the light of previous research, Yarcheski, Mahon and Yarcheski (2001) stated that there was a positive significant correlation between social support and psychological well-being of adolescents between ages 12-14 from middle SES and they added that perceived social support might be a critical element for psychological well-being of adolescents. In this study, psychological well-being of youngsters was measured by Adolescent General Well-Being Questionnaire whereas perceived social support was measured by Personal Resource Questionnaire. Also, Beam, Gil-Rivas, Greenberger and Chen (2002) reported that eleventh grade adolescents coming from middle SES, who had enough social support, displayed fewer numbers of depressive symptoms and lower risk for problematic behaviors with the measures of Perceived VIP Support Inventory, Center for Epidemiologic Studies Depression Scale (CES-D) and Adolescent Problem Behavior Scale. It was suggested that protective factors like perceived social support had a buffering effect against negative outcomes such as problem behaviors and depressive symptoms. Also, Stice, Ragan, and Randall (2004) stated that decrease in social support measured by Network of Relationships Inventory, increased the risk of major depressive symptoms (the Schedule for Affective Disorders and Schizophrenia for School-Age Children) for adolescent girls between ages 11-15 from public and private schools.

In the current study, family support, which was one of the three subscales of perceived social support, was the most significantly related one with psychological adjustment ($r= .37$, $p<.01$) and depressive symptoms ($r= -.38$, $p<.01$) in Time 1 and again it was the most significantly correlated one with psychological adjustment ($r= .32$, $p<.01$) and depressive symptoms ($r= -.41$, $p<.01$) in Time 2. Teacher support was the second associated subscale with psychological adjustment ($r= .20$, $p<.01$) and depressive symptoms ($r= -.20$, $p<.01$) in Time 1 and also with psychological adjustment ($r= .12$, $p<.05$) and depressive symptoms ($r= -.16$, $p<.05$) in Time 2. And lastly, in contrast to expectations due to increased importance of peer relations in adolescence period (Steinberg, 1999), similar to some literature findings (Bowen and Chapmen, 1996; Yıldırım, 2004), friend support was significantly related with only depressive symptoms in Time 1 ($r= -.18$, $p<.01$). In other words, peer support was not significantly associated with psychological adjustment in Time 1 and Time 2 and with depressive symptoms in Time 2.

As stated in the literature part, there are some contradictory findings about the relationship between friend support and psychological well-being. Some researchers did not find any significant association between the peer support and psychological well-being of adolescents (Bowen and Chapmen, 1996; Yıldırım, 2004). On the other hand, some of them did (Değirmencioğlu, Urber, Tolson and Richard, 1998; Bao, Whitbeck and Hoyt, 2000; Colarossi and Ecces, 2000; Demaray and Malecki, 2002b; Cornwell, 2003). The reason for the changes in friend support might be the sustained importance of family support on psychological well-being of adolescents. Not only the current study but also previous research found that although friend support had some positive effects on psychological well-being, family support continued to be the main support source for psychological well-being of youngsters (Kostelecky and

Lempers, 1998; Rosenfeld and Richman, 1999; Haan and Macdermid, 1998; Ray, 2002; Way and Robinson, 2003). For instance, Beest and Baerveldt (1999) reported that perceived family support was more important than friend support on the development of youngsters aged 14-16 from urban area and lack of perceived parental support could not be compensated by support from friends. Similarly, it was demonstrated that decrease in family support was more damaging than decrease in friend support, especially in adolescence. Family support displayed higher negative association with depression because it was more stable than friend support (Stice, Ragan and Randall, 2004). Also, Helsen, Vollebergh and Meeus (2000) stated that although peer support got strengthened, parental support remained the best predictor of psychological problems in a sample of 2,918 adolescents between ages 14-24 from different SES levels. Results also showed that peer support was not significantly related with emotional problems whereas parental support was significantly correlated with them. Furthermore, Laugesen, Dugas and Bukowski (2003) found that family support was more highly associated with depression and anxiety than friend support for early adolescents in a normal population. The instruments used in the study were The Perceived Social Support from Friends and Family Scale, CES-D, The State-Trait Anxiety Inventory and The Penn State Worry Questionnaire for Children. Therefore, based on the studies outlined above, it might be argued that the importance of family support may affect the importance of friend support during adolescence period.

In addition to these, teacher support is a factor; which should be investigated in more detail. In the literature, for psychological well-being, generally two sources were studied, namely; family and friend support. Teacher support was usually examined more with school-related issues. In this study, Yıldırım's (2004)

categorization (family, friend and teacher support) was used due to the fact that teachers can be an important support source for student population because the school, where adolescents spend a lot of time, plays a crucial role in their lives. Similar to previous research, in the current study, it was found that there was a significant relationship between teacher support and psychological adjustment and depressive symptoms of adolescents from low socioeconomic status (SES). Also, Yıldırım (2004) reported that teacher support significantly predicted low level of depressive symptoms for eighth – eleventh grades. Moreover, Bowen and Chapmen (1996) demonstrated that teacher support played a crucial role in psychological well-being of adolescents especially coming from low SES.

Question Three – Changes in Perceived Social Support from Time 1 to Time 2

The third question examined the changes in perceived social support of adolescents from Time 1 (October, 2005) to Time 2 (May, 2006). The results show that the total mean score of the perceived social support was 126.31 with a minimum score of 75 and a maximum score of 149 in Time 1 whereas the mean score was 122.43, with a minimum score of 77 and a maximum score of 150 in Time 2. As it is seen, there was a significant decrease in perceived social support from Time 1 to Time 2 [$t(236) = 4.33$, $p<.001$], contrary to the expectations. At the beginning of the study, it was assumed that the mean score of perceived social support would have a tendency to increase in time because the adolescents (ninth graders) would get used to their new school, teachers and friends.

When the changes in subscales of perceived social support were investigated, it was seen that the mean score of family and teacher support significantly decreased [$t(236) = 3.02$, $p<.01$; $t(236) = 5.81$, $p<.001$] from Time 1 to Time 2, respectively.

On the other hand, the mean score of friend support increased from 32.00 to 32.03 but it was not a significant change. It can be said that friend support approximately remained the same. In contrast to findings of the present study, Way and Robinson (2003) found a significant decrease in the mean scores of depressive symptoms of adolescents coming from low SES over a 2-year period. And related with the decrease in depressive symptoms they also obtained an increase in the mean score of friend support from 13.17 to 14.63. On the other hand, family support approximately remained the same. In this study, perceived social support was measured by The Perceived Social Support from Friends and Family Scale whereas depressive symptoms were measured by Children's Depression Inventory. More similar to current study, Stice, Ragan and Randall (2004) demonstrated a significant decrease in the mean scores of parental support and a significant increase in the mean score of depressive symptoms and friend support in a sample of 496 girls from private and public high schools over a 2-year period.

A plausible explanation for the change in current study variables might be the new educational system of high schools, which was implemented in the year of 2005-2006 (Journal of Announcement [Tebliğler Dergisi], 2005). The school, where the study was conducted, was a vocational high school and up to the school year of 2005-2006, ninth graders chose a vocational section such as computer programming, furnishing and decoration during the registration period and their vocational teachers were responsible for everything related to their students during the whole year. However, in the year of 2005-2006, this system has changed. A common curriculum was accepted for all the ninth graders in Turkey so all the students took the same courses, including vocational high schools. As a result of this, the students, who

participated in the current study, did not have a strict vocational discipline as before and did not have close teacher supervision.

According to the observations of administration staff and the teachers of the school, where the study was conducted, the new system affected both the students' academic success and behaviors very negatively. It was suggested that the students became less responsible, showed more behavioral problems, violated the rules more often and more importantly their academic success seriously decreased. In terms of the students' transcript results in June 2006, approximately only one third of the students passed directly on to the next grade without taking any exam in August.

The important point is that all-ninth graders expected an amnesty during the whole year despite their teachers' warnings because it happened a year ago (in the school year of 2004-2005) when Turkish government allowed all unsuccessful students to pass to the upper grade. However, through the end of the school year of 2005-2006 like in April and May, the students realized that it would not happen and they could repeat ninth grade the next year if they had low grades at the end of the semester. This situation affected the morale of the students very much and they became very pessimistic. Some of them thought that they could not improve their grades at the last exams, they gave up studying and some of them decided to quit school. Also, Yeniçeri (1987) found that there was a negative significant correlation between depressive symptoms and grade point averages of high school students.

In addition to this, adolescents became afraid of their parents' negative attitudes, especially fathers, toward their grades. Unfortunately, physical abuse was one of the common ways, which parents used to educate their children in low SES regions (Polat, 2002). Furthermore, according to the observation of the researcher and personal communication with students, it can be stated that most of the

adolescents blamed the teachers because of low grades they got. The students expected the teachers to give high grades although they did not deserve them and they had negative feelings about their teachers because teachers did not allow them to cheat during exams. As a result, in May, when the study was conducted for the second time, there were lots of problems in the school related with ninth graders as the principal of the school declared in last teacher commission of the school year of 2005-2006.

Based on the situations outlined above, decrease in family and teacher support from Time 1 (October, 2005) to Time 2 (May, 2006) might be understandable.

Question Four – Changes in Psychological Adjustment from Time 1 to Time 2

The fourth question investigated the changes in psychological adjustment of adolescents from Time 1 (October, 2005) to Time 2 (May, 2006). In terms of the findings, there was a significant decrease in psychological adjustment from Time 1 to Time 2 [$t(236) = 3.06$, $p<.01$]. The mean score of PAQ was 92.54 in Time 1, with a minimum score of 57 and a maximum score of 131 whereas the mean score was 94.81 in Time 2, with a minimum score of 61 and a maximum score of 133 (in PAQ higher score means psychological maladjustment).

The decrease in scores of psychological adjustment from Time 1 to Time 2 might be explained with similar reasons in decrease in perceived social support. At that point, it should be noted that related to the decrease in perceived social support from Time 1 to Time 2, psychological well-being of adolescents deteriorated (there was an increase in PAQ and BDI scores from Time 1 to Time 2). In other words, the significant relationship among study variables was sustained in Time 2. The

adolescents, who reported perceiving less social support, also reported experiencing less psychological adjustment and more depressive symptoms in Time 2 similar to previous research (Bowen and Chapmen, 1996; Way and Robinson, 2000; Mahon and Yarcheski, 2001).

Question Five – Changes in Depressive Symptoms from Time 1 to Time 2

The aim of the fifth question was to examine the changes in depressive symptoms from Time 1 (October, 2005) to Time 2 (May, 2006). According to the analyses, there was an increase in depressive symptoms of adolescents from Time 1 to Time 2 but it was not statistically significant. The mean score of BDI was 13.29, with a minimum score of 0 and a maximum score of 41 in Time 1 whereas the mean score of BDI was 14.08 in Time 2, with minimum score of 0 and a maximum score of 42.

In the current study, Beck's (1967) original categorization system was used for cut-off points, which was determined as 0-13 points: "not depressed"; 14-24 points: "mildly depressed"; and 25-63 points: "severely depressed". According to study results, it can be stated that 55.3% of adolescents were "not depressed", 35.8% of them were "mildly depressed" and 8.9% of them were "severely depressed" in Time 1 (October, 2005). Also, in Time 2 (May, 2006), 57.8% of adolescents were "not depressed", whereas 25.7% of them were "mildly depressed" and 16.5% were "severely depressed". A considerable fact worth mentioning here is that "severely depressed" sample increased highly from Time 1 (8.9%) to Time 2 (16.5%). Also, there was a total increase in BDI scores between two time periods. Again, this can be associated with the problems; which ninth graders experienced because of new education system of high schools (Journal of Announcement [Tebliğler Dergisi],

2005) and academic failures of adolescents. Moreover, it may be caused by the characteristics of adolescence period. It is suggested that depressive symptoms and depressive disorders are very widespread during adolescence due to the increasing prevalence of stressful life events (Reynolds and Johns, 1994b, cited in Mash and Wolfe, 2002). Also Radloff (1991) reported that there has been a significant increase in depressive symptoms among youngsters between ages 13-15. The prevalence rates of depressive symptoms for non-clinical children and adolescents were found between the ranges of 10% to 50% (Peterson et. al, 1993).

However, studies conducted in Turkey have found lower mean scores for depressive symptoms than the current study has found. (Yeniçeri, 1984; Aytar, 1985; Kaymakçıoğlu, 2001; Şen, 2005). An important point is that all these studies measured depressive symptoms with the same measure (BDI), which was used in the current study so comparison between the studies could be more meaningful. Yeniçeri (1987) found the mean score of depression as 8.12 for high school students (*n*=124) from high SES. According to the findings, 66.1% of the sample was “not depressed”, 21.8% was “mildly depressed”, 8.9% was “moderately depressed” and lastly, 3.2% of them were “severely depressed”. Aytar (1985) indicated a mean score of 9.1 for the undergraduate students from İstanbul University (*n*=306). Also it was determined that 82.4% of the sample was “not depressed”, 13.4% was “mildly depressed” whereas 4.2% of them were “severely depressed”. In addition, Kaymakçıoğlu (2001) reported the mean score of depressive symptoms as 11.34 among undergraduate students from Boğaziçi University (*n*=220). Besides, Şen (2005) obtained the mean score of depressive symptoms as 11.44 for Boğaziçi University students (*n*=1089). In terms of the findings, 47.1% of the students were “not depressed”, 26.4% were

"mildly depressed", 18.6% were "moderately depressed" and 7.8% of them were "severely depressed".

The difference between the mean scores of the current study and previous studies may be explained by differences in study populations. It is suggested that depressive symptoms are more prevalent in adolescence than adulthood period (Radloff, 1991) and the studies in Turkey stated before generally focused on university populations except Yeniçeri's (1987) study. So, this might be a reason for lower mean scores of depressive symptoms in these studies. Besides, it is seen that the studies in 1980's have found lower mean scores for depressive symptoms compared to studies in 2000's. Some researchers stated that there has been a significant increase in the prevalence of depressive symptoms with the rate of depression increasing in each generation, especially among adolescents (Lewinsohn, Rohde, Seeley and Fischer, 1993b). Another reason may be the socioeconomic status (SES) of the sample group. The sample groups of the studies mentioned before were generally distributed normally in SES. In other words, the samples consisted of high, middle and low SES groups. However, the current study focused on only low SES. It is suggested that low SES might be a risk factor for physical and emotional problems and the adolescents coming from low SES need satisfactory social relations to cope with every day life more effectively (Miller, 1991). Lempers, Clark-Lempers and Simons (1989) demonstrated that economic problems significantly affected depression and loneliness and indirectly affected the rates of delinquency of 622 rural adolescents from grade 9 to 12.

Question Six, Seven and Eight – Factors Predicting Perceived Social Support in Time 1 and Time 2

The sixth, seventh and eighth questions investigated the factors that additively and uniquely predict perceived social support in Time 1 (October, 2005) and in Time 2 (May, 2006).

In question six, to name predictors of perceived social support in Time 1, gender, psychological adjustment scores and depressive symptom scores in Time 1 were entered into the equation. In terms of the findings, all of them were significant predictors of perceived social support scores in Time 1 (gender: $\beta = .11$, $t=1.74$, $p<.05$; psychological adjustment: $\beta = .18$, $t = 2.64$, $p<.01$; depressive symptoms: $\beta = -.26$, $t = -3.72$, $p<.001$). These three variables explained approximately 14% of the variance of the perceived social support scores in Time 1.

In the seventh question, to find the predictors of perceived social support in Time 2, gender, psychological adjustment and depressive symptoms of Time 2 were entered into the equation. Results show that these predictors additively accounted for approximately 15% of the variance of perceived social support scores in Time 2. Also, gender ($\beta=.24$, $t=3.91$, $p<.001$) and depressive symptoms ($\beta=-.29$, $t=-3.90$, $p<.001$) were significant predictors of perceived social support in Time 2.

Lastly, in the eighth question, to find the best predictors of perceived social support in Time 2, all study variables, namely; gender, perceived social support scores in Time 1, psychological adjustment scores in Time 1, depressive symptom scores in Time 1, psychological adjustment scores in Time 2 and depressive symptom scores in Time 2 were entered into the equation and stepwise regression was used. The findings demonstrated that four variables, namely; perceived social support scores in Time 1 ($\beta = .49$, $t = 8.61$, $p<.001$), depressive symptoms scores in

Time 2 (β= -.37, t= -5.35, p<.001), gender (β= .19, t= 3.51, p<.01) and depressive symptom scores in Time 1 (β= .17, t= 2.43, p<.05) additively explained approximately 34% of the variance of the perceived social support in Time 2. As expected, perceived social support scores in Time 1 were the best significant predictors of perceived social support scores in Time 2 and accounted for 25% of the variance in perceived social support scores in Time 2. Depressive symptom scores in Time 2, gender and depressive symptom scores in Time 1 predicted 4.9%, 0.3% and 0.1% of the perceived social support scores in Time 2, respectively.

Strikingly, although psychological adjustment was a significant predictor of perceived social support in Time 1, it was not a significant predictor of perceived social support in Time 2. This situation might be explained with the relationship between the scores of psychological adjustment and depressive symptoms. There was a significantly high correlation between these two variables. However, this association increased from Time 1 (r=.49, p<.001) to Time 2 (r=.58, p<.001). So, a possible cause might be the carry-on effect.

Although literature generally focuses on psychological well being outcomes with perceived social support as a predictor variable, the current study looked for a bi-directional relationship between the study variables. Consistent with previous studies, depressive symptoms were found to be a significant predictor of perceived social support (Blazer, 1983; Billings, Cronkite and Moos, 1983; Field, Diego and Sanders, 2001; Mahon and Yarcheski, 2001; Stice, Ragan and Randall, 2004). In the current study, higher depressive symptom scores in Time 1 and Time 2 predicted a significant decrease in perceived social support scores both in Time 1 and in Time 2. According to Blazer (1983), major depressive disorder was a significant correlate of perceived social support with 331 subjects over a 2-year period. Similarly, Billings,

Cronkite and Moos (1983) showed that depressed individuals had fewer social contacts, number of friends and supportive relations than non-depressed ones. Also, Field, Diego and Sanders (2001) stated that adolescents, who had depressive symptoms, had fewer friends and unhealthy peer relationships compared to their peers, who did not have emotional problems. Moreover, Mahon and Yarcheski (2001) indicated that depressed early adolescents were more susceptible to experience conflicts in their relations and perceived less social support. In terms of the study results of Stice, Ragan and Randall (2004), more depressive symptoms predicted less perceived friend support but not family support with a sample of 496 girls between ages 11-15 from public and private middle schools.

According to results of gender variable in regression analyses, females perceived higher social support than males in both Time 1 and Time 2. However, there are some mixed findings in the literature about this issue. The study conducted by Kostelecky and Lempers (1998) in a sample of 133 high school seniors from rural areas found that females perceived more social support from their mothers and siblings compared to males with a measure of Network of Relationship Inventory. Similarly, it was shown that female college students reported higher levels of social support and social intimacy than males according to the findings of Interpersonal Support Evaluation List. Additionally, social support was more related with the changes in psychological sense of health of females than males (Hale, Hannum and Espelage, 2005). However, it was also reported that males and females perceived similar levels of support from their family and teachers, but females got significantly more support from their peers (Helsen, Vollebergh and Meeus, 1999; Malecki and Demaray, 2003). Moreover, it was obtained that females got higher satisfaction of friend support than boys. However, no significant gender differences were found

between males' and females' perceptions of family support in a sample of adolescents between ages 11-15 from lower-middle and middle SES. Furthermore, perceived social support was indirectly related with depressive symptoms of males whereas it was directly associated with depressive symptoms and self-esteem of females (Colarossi and Eccles, 2000).

C. Implications of the Study

The results of the current study show that there was a significant relationship between perceived social support and psychological well-being (psychological adjustment and low level of depressive symptoms) of adolescents between ages 14-16 from low socioeconomic status (SES). Especially, depressive symptoms were found to be significant predictors for perceived social support. Also, in a seven-month period, there was a significant decrease in both perceived social support and psychological well-being of adolescents.

The sample of this study consisted of adolescents from low socioeconomic status because although there are some studies associated with perceived social support and psychological well-being in Turkey, there are limited studies on adolescents especially among the population coming from low SES. Generally, university populations, adults, the elderly and patients were examined (Krespi, 1993; Serbest, 1993; Güngör, 1997; Kaymakçıoğlu, 2001; Öztürk-Tüter, 2003). Therefore, the current study presents the picture of adolescents who live in a poor environment. The school, where the study was conducted, is not in the center of Ümraniye. The location of the school can be described as low-income housing and the students try to attend the school in very tough circumstances. As literature suggested, they may be the most in need of social support interventions because they are highly vulnerable to

a number of risk factors like psychological problems, drug and alcohol abuse (Hamburg, Mortimer and Nightingale, 1991).

Another importance of the study is because of its longitudinal design. The study variables were investigated at two different periods in the school year of 2005-2006, more specifically, in October 2005 and in May 2006. So, the information of changes in time, and other results of the current study may be used with the aim of preventive counseling. For instance, school counselors may develop different guidance programs in order to strengthen the adolescents' social support networks. These programs can be implemented with different groups like students, teachers and parents. For teachers and parents, seminars may be organized to increase their awareness and support because not only the current study but also previous research shows that family and teacher support were significantly associated with psychological well-being of adolescents (Bowen and Chapmen, 1996; Kostelecky and Lempers, 1998; Mahon and Yarcheski, 2001; Yıldırım, 2004). Especially to improve the family quality, more specific programs can be implemented (Weigel, Devereux, Leigh and Ballard-Reisch, 1998) like enhancing family communication and cohesion, coping strategies, mother-father education and anger-conflict management. Also, in order to raise and strengthen peer support among students, different activities related with teamwork and cooperation among students can be placed on annual guidance programs in schools.

The current study also demonstrated that there was a decrease in both family and teacher support from Time 1 and Time 2. Because of the fact that besides the prevention programs to increase the social support, it was stated that one reason for this situation might be the academic problems and new educational system of the high schools (Journal of Announcement [Tebliğler Dergisi], 2005). Therefore, the

students should be informed about academic issues more systematically and deeply to eliminate these kinds of problems.

D. Limitations of the Study and Recommendations for Further Research

First of all, the data of this study was collected with two different points in the school year of 2005-2006. It would be better to have a third set of data collected from the study sample after six months from the second set. This way, the changes between time periods would be based on more accurate results to see the pattern.

Secondly, convenient sampling method was used to obtain sample group of the current study. So, the results may not be generalized to all adolescents in Turkey. Further research is recommended to cover more than one school to increase generalizability. In addition, studies with different SES groups can be beneficial for comparison among SES levels.

Thirdly, the relationship between the study variables, namely perceived social support and psychological well-being seems to be reciprocal and it is difficult to find a clear answer to either cause or effect. Furthermore, in the current study, according to regression analyses results, study variables explained approximately 14% of perceived social support scores in Time 1 and explained approximately 15% of perceived social support scores in Time 2. Therefore, it is recommended to use Structural Equation Modeling and examine mediators and moderators of the relationship between perceived social support and psychological well-being. Also, different variables can be added to the analyses in order to get more accurate findings.

Lastly, in the study, gender differences were not examined except regression analyses because the number of females was approximately only one fourth of the

number of males. It would be better if the proportion of males and females could be more equal.

E. Summary

The aim of the present study was to investigate the relationship between perceived social support and psychological well-being (psychological adjustment and low level of depressive symptoms) in a sample of adolescents between ages 14-16 coming from low socioeconomic status. According to the study findings, a significant relationship was found between perceived social support and psychological adjustment and also between perceived social support and depressive symptoms both in Time 1 (October, 2005) and in Time 2 (May, 2006).

Family support, which is one of the three subscales of perceived social support, had the highest significant correlation with both psychological adjustment and depressive symptoms both in Time 1 and in Time 2, similar to previous studies (Kostelecky and Lempers, 1998; Rosenfeld and Richman, 1999; Haan and Macdermid, 1998; Beest and Baerveldt, 1999; Ray, 2002; Way and Robinson, 2003; Laugesen, Dugas and Bukowski, 2003; Stice, Ragan and Randall, 2004). Teacher support was also significantly related with psychological adjustment and depressive symptoms both in Time 1 and Time 2 whereas friend support was significantly related with only depressive symptoms in Time 1.

The changes in the seven-month period show that there was a significant decrease in perceived social support and psychological adjustment (increase in PAQ scores) and an increase in depressive symptoms of adolescents.

Multiple Regression Analyses results show that gender and depressive symptoms were significant predictors of perceived social support both in Time 1 and

in Time 2 whereas psychological adjustment was a significant predictor of perceived social support only in Time 1. Also, perceived social support in Time 1 was the best predictor of perceived social support in Time 2.

Perceived social support is an important concept, which plays a significant role in adolescents' lives (Laugesen, Dugas and Bukowski, 2003). In terms of the study findings, family support was highly correlated with psychological well-being, so further investigation is recommended in order to find out more about family support, for instance, who the major support source is in the family or what kind of support is more important for adolescents, etc. Also, teacher support is another issue, which should be examined in detail. It was obtained that high teacher support had a significant effect on psychological well-being of especially at-risk adolescents (Bowen and Chapmen, 1996).

As a result, despite its limitations, the study provided valuable information about perceived social support of adolescents coming from low socioeconomic status. Further research is important and necessary to collect more reliable data and increase the contributions to the area.

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VII. APPENDICES

APPENDIX A

Official Consent

APPENDIX B

Demographic Information Form

(Demografik Bilgi Formu)

Elinizdeki döküman, bir bilgi formu ve 3 anketten oluşmaktadır. Soruları dikkatlice okuyup eksiksiz olarak doldurun. Hiç bir sorunun doğru veya yanlış bir cevabı yok. Bu yüzden yanıtlarınızı kendi hissettiklerinize göre samimi ve içten bir şekilde cevaplayın. Sorulara yanıt verirken kendinize en uygun olan sadece tek bir seçeneği işaretleyin. Verdiğiniz tüm bilgiler gizli kalacaktır. Anlamadığınız ya da emin olmadığınız bir şey olduğunda çekinmeden sorabilirsiniz. Katıldığınız için teşekkürler.

Bilgi Formu

1- Okul No:

2- Cinsiyetiniz: K ( ) E ( )

3- Annenizin eğitim durumu:

a) Okur-yazar ( ) Okur-yazar değil ( )

b) Herhangi bir okul mezunu değil ( ) İlkokul( ) Ortaokul( ) Lise( ) Üniversite ve üstü( )

4- Babanızın eğitim durumu:

a) Okur-yazar ( ) Okur-yazar değil ( )

b) Herhangi bir okul mezunu değil ( ) İlkokul( ) Ortaokul( ) Lise( ) Üniversite ve üstü( )

5- Anneniz: Çalışıyor ( ) Çalışmıyor ( )

Çalışıyor ise mesleği: ……..

6- Babanız: Çalışıyor ( ) Çalışmıyor ( )

Çalışıyor ise mesleği: ……..

APPENDIX C

Perceived Social Support Scale-Revised (PSSS-R)

Algılanan Sosyal Destek Ölçeği-Revize (ASDÖ-R)

AİLEM	Bana Uygun	Kısmen	Bana Uygun Değil
1. Bana gerçekten güvenir	( )	( )	( )
2. Sorunlarımı çözmeme yardım eder	( )	( )	( )
3. Bir haksızlığa uğradığımda beni gerçekten destekler	( )	( )	( )
4. Bana gerçekten değer verir	( )	( )	( )
5. Bana doğru tavsiyelerde bulunur	( )	( )	( )
6. Doğru kararlar vermeme yardım eder	( )	( )	( )
7. Davranışlarımı takdir eder	( )	( )	( )
8. İlgi duyduğum şeyleri yapmama yardım eder	( )	( )	( )
9. Hatalarımı nazikçe düzeltir	( )	( )	( )
10. Beni gerçekten anlar	( )	( )	( )
11. Bana, aile gelirimize göre yeterince harçlık verir	( )	( )	( )
12. İyi ve kötü günlerimde yanımda olur	( )	( )	( )
13. Geleceğimle ilgili planlar yapmamda bana yardım eder	( )	( )	( )
14. Üstün, güçlü yanlarımı vurgular	( )	( )	( )
15. İyi ve kötü yönlerimle beni sever	( )	( )	( )
16. Başarılı olmam için bana destek olur	( )	( )	( )
17. Zaman ayırıp sıkıntılarımı gerçekten dinler	( )	( )	( )
18. Arkadaşlarımla ilişkilerimin güçlenmesini destekler	( )	( )	( )
19. Sosyal etkinliklere katılmamı destekler	( )	( )	( )
20. Başarılarımı takdir eder	( )	( )	( )

ARKADAŞLARIM	Bana Uygun	Kısmen	Bana Uygun Değil
21. Bana gerçekten güvenir	( )	( )	( )
22. İhtiyaç duyduğumda beni gerçekten dinler	( )	( )	( )
23. Sorunlarımı çözmeme yardım eder	( )	( )	( )
24. Bir haksızlığa uğradığımda beni gerçekten destekler	( )	( )	( )
25. Bana gerçekten değer verir	( )	( )	( )
26. Doğru kararlar vermeme yardım eder	( )	( )	( )
27. Hata yaptığımda bile beni kabul eder	( )	( )	( )
28. Hatalarımı düzeltmeme yardım eder	( )	( )	( )
29. Beni gerçekten anlar	( )	( )	( )
30. Gerektiğinde harçlığını benimle paylaşır	( )	( )	( )
31. Derslerle ilgili bilgilerini benimle paylaşır	( )	( )	( )
32. İyi ve kötü günlerimde yanımda olur	( )	( )	( )
33. Bir şeye sinirlendiğimde beni yatıştırır	( )	( )	( )

ÖĞRETMENLERİM	Bana Uygun	Kısmen	Bana Uygun Değil
34. Amaç, ilgi ve yeteneklerim konusunda benimle konuşur	( )	( )	( )
35. Bana gerçekten güvenir	( )	( )	( )
36. Sorunlarımı çözmeme yardım eder	( )	( )	( )
37. Bir haksızlığa uğradığımda beni gerçekten destekler	( )	( )	( )
38. Bana gerçekten değer verir	( )	( )	( )
39. Bana doğru tavsiyelerde bulunur	( )	( )	( )
40. Doğru kararlar vermeme yardım eder	( )	( )	( )
41. Hatalarımı nazikçe düzeltir	( )	( )	( )
42. Beni gerçekten anlar	( )	( )	( )
43. Üstün, güçlü yanlarımı vurgular	( )	( )	( )
44. Sıkıntılı durumlarımda zaman ayırıp beni gerçekten dinler	( )	( )	( )
45. Arkadaşlarımla ilişkilerimin güçlenmesini destekler	( )	( )	( )
46. Sosyal etkinliklere katılmamı teşvik eder	( )	( )	( )
47. Çok çalıştığım ya da başarılı olduğum zaman beni över	( )	( )	( )
48. Duygu, düşünce ve inançlarıma saygı duyar	( )	( )	( )
49. Derslerde sorularıma içtenlikle cevap verir	( )	( )	( )
50. Bana karşı genellikle adil davranır	( )	( )	( )

APPENDIX D

Personality Assessment Questionnaire (PAQ)

Kişilik Değerlendirme Ölçeği (KİDÖ)

Aşağıdaki cümleleri dikkatlice okuyun ve sizi ne kadar iyi anlattığını düşünün. Her madde için aklınıza ilk gelen düşünceye göre yanıt verin ve sonraki maddeye geçin. Bütün maddeler için dört kutu var. Her maddedeki cümlenin sizi ne kadar anlattığına göre o dört kutudan birinin içine X işareti koyun. Hiçbir ifadenin doğru veya yanlış bir yanıtı yok; onun için mümkün olduğu kadar dürüst ve samimi olun. Her ifadeyi olmak istediğiniz kişi gibi değil, gerçekte olduğunuz kişi gibi yanıtlayın.
Örnek: Eğer kendiniz hakkında hemen hemen her zaman iyi duygular besliyorsanız, "hemen hemen her zaman" kutusuna X koyun.

	BENİM İÇİN DOĞRU		BENİM İÇİN DOĞRU DEĞİL	
	Hemen hemen her zaman doğru	Bazen doğru	Nadiren doğru	Hemen hemen hiçbir zaman doğru değil
Kendim hakkında iyi duygular beslerim	X	☐	☐	☐

Şimdi aşağıdaki soruları kendinize göre yanıtlayın

	BENİM İÇİN DOĞRU		BENİM İÇİN DOĞRU DEĞİL	
	Hemen hemen her zaman doğru	Bazen doğru	Nadiren doğru	Hemen hemen hiçbir zaman doğru değil
1.İçimden kavga etmek veya birine bir kötülük yapmak geliyor.	☐	☐	☐	☐
2.Hastalandığımda annemin benim için üzülmesi hoşuma gider	☐	☐	☐	☐
3.Kendimi beğenirim.	☐	☐	☐	☐
4.Yapmak istediğim şeyleri herkes kadar iyi yapabilirim.	☐	☐	☐	☐
5.İnsanlara duygularımı göstermekte zorlanırım.	☐	☐	☐	☐
6.Yapmaya çalıştığım bir şeyi yapamayınca kendimi kötü hisseder yada sinirlenirim.	☐	☐	☐	☐
7.Yaşamın güzel olduğunu düşünüyorum.	☐	☐	☐	☐
8.İçimden bir şeye veya birisine vurmak geliyor.	☐	☐	☐	☐
9.Anne ve babamın bana çok sevgi göstermelerini isterim.	☐	☐	☐	☐
10.Bir işe yaramadığımı ve hiçbir zaman da yaramayacağımı düşünüyorum.	☐	☐	☐	☐
11.Birçok şeyi iyi yapamadığımı hissediyorum.	☐	☐	☐	☐
12.Anne ve babama sevgimi göstermek benim için kolaydır.	☐	☐	☐	☐
13.Önemli bir neden olmamasına rağmen sinirli ve aksiyim.	☐	☐	☐	☐
14.Yaşamı tehlikelerle dolu görüyorum.	☐	☐	☐	☐

	BENİM İÇİN DOĞRU		BENİM İÇİN DOĞRU DEĞİL	
	Hemen hemen her zaman doğru	Bazen doğru	Nadiren doğru	Hemen hemen hiçbir zaman doğru değil
15.Öyle sinirlenirim ki, bir şeyleri fırlatır ya da kırarım.	☐	☐	☐	☐
16.Mutsuz olduğum zaman sorunlarımı kendim çözmekten hoşlanırım.	☐	☐	☐	☐
17.Tanımadığım biri ile tanıştığımda, onun benden daha iyi olduğunu düşünürüm.	☐	☐	☐	☐
18.İstediğim şeyler için başarılı bir şekilde mücadele edebilirim.	☐	☐	☐	☐
19.İyi arkadaşlıklar kurmak ve bu arkadaşlıkları sürdürmekte zorlanıyorum.	☐	☐	☐	☐
20.İşler ters gittiğinde canım sıkılır.	☐	☐	☐	☐
21.Dünyanın iyi ve mutlu bir yer olduğunu düşünüyorum.	☐	☐	☐	☐
22.Aptalca şeyler yapan insanlarla dalga geçerim.	☐	☐	☐	☐
23.Annemin benimle çok ilgilenmesini isterim.	☐	☐	☐	☐
24.İyi bir insan olduğumu düşünüyor ve başkalarının da öyle düşünmesini istiyorum.	☐	☐	☐	☐
25.Başarısız biri olduğumu düşünüyorum.	☐	☐	☐	☐
26.Aileme sevgim göstermek benim için kolaydır.	☐	☐	☐	☐
27.Bir an neşeli ve mutlu oluyorum, bir sonraki an üzgün ve mutsuz.	☐	☐	☐	☐
28.Benim için dünya mutsuz bir yerdir.	☐	☐	☐	☐
29.Kızdığım zaman suratımı asar, somurturum.	☐	☐	☐	☐
30.Bir şeyde zorlandığımda, birinin bana moral vermesini isterim.	☐	☐	☐	☐
31.Kendimden oldukça memnunum.	☐	☐	☐	☐
32.Yapmaya çalıştığım birçok şeyi beceremediğimi düşünüyorum.	☐	☐	☐	☐
33.Hoşlandığım birine duygularımı göstermeye çalışmak benim için zordur.	☐	☐	☐	☐

	BENİM İÇİN DOĞRU		BENİM İÇİN DOĞRU DEĞİL	
	Hemen hemen her zaman doğru	Bazen doğru	Nadiren doğru	Hemen hemen hiçbir zaman doğru değil
34.Kolay kolay ne kızarım ne de bir şeye canım sıkılır.	☐	☐	☐	☐
35.Dünyayı tehlikeli bir yer olarak görüyorum.	☐	☐	☐	☐
36.Kızgınlığımı kontrol etmekte zorlanırım.	☐	☐	☐	☐
37.Canım yandığında ya da hastalandığımda annemle babamın üzerime düşmeleri hoşuma gider.	☐	☐	☐	☐
38.Kendimden memnun değilim.	☐	☐	☐	☐
39.Yaptığım şeylerde başarılı olduğumu düşünüyorum.	☐	☐	☐	☐
40.Arkadaşlarıma onları gerçekten sevdiğimi göstermek benim için kolaydır.	☐	☐	☐	☐
41.Zor sorunlarla karşılaştığımda hemen canım sıkılır.	☐	☐	☐	☐
42.Benim için yaşam güzel bir şeydir.	☐	☐	☐	☐

APPENDIX E

Beck Depression Inventory (BDI)

Beck Depresyon Envanteri (BDE)

Aşağıda gruplar halinde bazı cümleler yazılı. Her gruptaki cümleleri dikkatle okuyun. **Bugün dâhil, geçen hafta içinde** kendinizi nasıl hissettiğinizi en iyi anlatan cümleyi seçin. Seçmiş olduğunuz cümlenin yanındaki numarayı daire içine alın. Seçiminizi yapmadan önce her gruptaki cümlelerin hepsini dikkatle okuyun.

0 Kendimi üzüntülü ve sıkıntılı hissetmiyorum.
1 Kendimi üzüntülü ve sıkıntılı hissediyorum.
2 Hep üzüntülü ve sıkıntılıyım. Bundan kurtulamıyorum.
3 O kadar üzüntülü ve sıkıntılıyım ki artık dayanamıyorum.

0 Gelecek hakkında umutsuz ve karamsar değilim.
1 Gelecek hakkında karamsarım.
2 Gelecekten beklediğim hiç bir şey yok.
3 Geleceğim hakkında umutsuzum ve sanki hiç bir şey düzelmeyecekmiş gibi geliyor.

0 Kendimi başarısız bir insan olarak görmüyorum.
1 Çevremdeki birçok kişiden daha çok başarısızlıklarım olmuş gibi hissediyorum.
2 Geçmişime baktığımda başarısızlıklarla dolu olduğunu görüyorum.
3 Kendimi tümüyle başarısız bir kişi olarak görüyorum.

0 Birçok şeyden eskisi kadar zevk alıyorum.
1 Eskiden olduğu gibi her şeyden hoşlanmıyorum.
2 Artık hiçbir şey bana tam anlamıyla zevk vermiyor.
3 Her şeyden sıkılıyorum.

0 Kendimi herhangi bir şekilde suçlu hissetmiyorum.
1 Kendimi zaman zaman suçlu hissediyorum.
2 Çoğu zaman kendimi suçlu hissediyorum.
3 Kendimi her zaman suçlu hissediyorum.

0 Kendimden memnunum.
1 Kendimden pek memnun değilim.
2 Kendime çok kızıyorum.
3 Kendimden nefret ediyorum.

0 Başkalarından daha kötü olduğumu sanmıyorum.
1 Zayıf yanlarım veya hatalarım için kendimi eleştiririm.
2 Hatalarımdan dolayı her zaman kendimi kabahatli bulurum.
3 Her aksilik karşısında kendimi kabahatli bulurum.

0 Kendimi öldürmek gibi düşüncelerim yoktur.
1 Zaman zaman kendimi öldürmeyi düşündüğüm oluyor fakat yapmıyorum.
2 Kendimi öldürmek isterdim.
3 Fırsatını bulsam kendimi öldürürüm.

0 Her zamankinden fazla içimden ağlamak gelmiyor.
1 Zaman zaman içimden ağlamak geliyor.
2 Çoğu zaman ağlıyorum.
3 Eskiden ağlayabilirdim, şimdi istesem de ağlayamıyorum.

0 Şimdi her zaman olduğundan daha sinirli değilim.
1 Eskisine kıyasla daha kolay kızıyor yada sinirleniyorum.
2 Şimdi hep sinirliyim.
3 Bir zamanlar beni sinirlendiren şeyler şimdi beni hiç sinirlendirmiyor.

0 Başkalarıyla görüşmek, konuşmak isteğimi kaybetmedim.
1 Başkaları ile eskisinden daha az konuşmak, görüşmek istiyorum.
2 Başkaları ile konuşmak ve görüşmek isteğimi kaybettim.
3 Hiç kimseyle görüşüp konuşmak istemiyorum.

0 Eskiden olduğu kadar kolay karar verebiliyorum
1 Eskiden olduğu kadar kolay karar veremiyorum.
2 Karar verirken eskisine kıyasla çok güçlük çekiyorum.
3 Artık hiç karar veremiyorum.

0 Aynada kendime baktığımda bir değişiklik görmüyorum.
1 Daha yaşlanmışım ve çirkinleşmişim gibi geliyor.
2 Görünüşümüm çok değiştiğini ve daha çirkinleştiğimi hissediyorum.
3 Kendimi çok çirkin buluyorum.

0 Eskisi kadar iyi çalışabiliyorum.
1 Bir şeyler yapabilmem için gayret göstermem gerekiyor.
2 Herhangi bir şeyi yapabilmem için kendimi çok zorlamam gerekiyor.
3 Hiç bir şey yapamıyorum.

0 Her zamanki gibi iyi uyuyabiliyorum.
1 Eskiden olduğu gibi iyi uyuyamıyorum.
2 Her zamankinden 1-2 saat daha erken uyanıyorum ve tekrar uyuyamıyorum.
3 Her zamankinden çok daha erken uyanıyorum ve tekrar uyuyamıyorum.

0 Her zamankinden daha çabuk yorulmuyorum.
1 Her zamankinden daha çabuk yoruluyorum.
2 Yaptığım hemen her şey beni yoruyor.
3 Kendimi hiç bir şey yapamayacak kadar yorgun hissediyorum.

0 İştahım her zamanki gibi.
1 İştahım eskisi kadar iyi değil.
2 İştahım çok azaldı.
3 Artık hiç iştahım yok.

0 Son zamanlarda kilo vermedim
1 İki kilodan fazla kilo verdim.
2 Dört kilodan fazla kilo verdim.
3 Altı kilodan fazla kilo verdim.
Daha az yiyerek kilo vermeye çalışıyorum. Evet ……. Hayır…….

0 Sağlığım beni fazla endişelendirmiyor.
1 Ağrı, sancı, mide bozukluğu gibi rahatsızlıklar beni endişelendiriyor.
2 Sağlığım beni endişelendirdiği için başka şeyleri düşünmek zorlaşıyor.
3 Sağlığım hakkında o kadar endişeliyim ki başka hiçbir şey düşünemiyorum.

0 Son zamanlarda cinsel konulara olan ilgimde bir değişme fark etmedim.
1 Cinsel konularla eskisinden daha az ilgiliyim.
2 Cinsel konularla şimdi çok daha az ilgiliyim.
3 Cinsel konulara olan ilgimi tamamen kaybettim.

0 Bana cezalandırılmışım gibi gelmiyor.
1 Cezalandırılabileceğimi seziyorum.
2 Cezalandırılmayı bekliyorum.
3 Cezalandırıldığımı hissediyorum