

THE RELATIONSHIP BETWEEN MARITAL ADJUSTMENT,
ATTACHMENT, HEALTHY LIFESTYLE BEHAVIOR AND
HEALTH CONCERNS IN PREGNANCY

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To My Dear Family

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The material included in this thesis has not been submitted wholly or in part for any academic award or qualification other than that for which it is now submitted.

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ABSTRACT

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THE RELATIONSHIP BETWEEN MARITAL ADJUSTMENT, ATTACHMENT, HEALTHY LIFESTYLE BEHAVIOR AND HEALTH CONCERNS IN PREGNANCY

This thesis aims to investigate the relationships between marital adjustment which is not studied much in psychology literature; adult attachment; health behavior; and current health status in pregnancy period. Data of the study was collected by a questionnaire via an online pregnancy forum on the internet. The questionnaire consisted of a demographic information form, The Pregnancy Health Status Checklist, Marital Adjustment Scale, Experiences in Close Relationships Inventory-II and Healthy Lifestyle Behavior Scale II. The present study was conducted with 195 pregnant women (mean age = 28.69, SD = 3.82). The data of the study was collected by a website which has online pregnancy forum. Participants answered all measures of the study.

According to the results of the study, the score of Healthy Lifestyle Behavior Scale-II was negatively associated with both anxious and avoidant adult attachment, and it was positively associated with marital adjustment during pregnancy period. Health complaints in pregnancy was significantly negatively associated with marital adjustment and positively associated with anxious attachment -but not avoidant attachment. A significant negative association was found between marital adjustment and both anxious and avoidant adult attachment styles.

According to hierarchical linear regression analyses, anxious attachment and avoidant attachment predicted the change in health behavior during pregnancy significantly, but only anxious attachment predicted the change in health status of pregnant women. In the independent samples t-test result, a significant difference was also found in marital adjustment score and avoidant attachment according to the working status of pregnant women.

Keywords: Marital adjustment, Attachment, Adult Attachment, Health, Health Behavior, Pregnancy

KISA ÖZET

Ebru YILDIRIMLI

Eylül, 2015

HAMİLELİKTE EVLİLİK UYUMU, BAĞLANMA, SAĞLIK ŞİKAYETLERİ VE SAĞLIKLI YAŞAM BİÇİMİ DAVRANIŞLARI ARASINDAKİ İLİŞKİ

Bu tezin amacı, hamilelik sürecinde psikoloji alanında fazla çalışılmamış olan evlilik uyumu, yetişkin bağlanması, sağlık davranışı ve sağlık durumu arasındaki ilişkiyi araştırmaktır. Çalışmanın verisi beş bölümden oluşan bir anket formu aracılığıyla internet üzerinden bir çevrimiçi hamile forumu aracılığı ile toplanmıştır. Çalışmanın ölçekleri, demografik form, Hamilelik Sağlık Durumu Listesi, Evlilik Uyum Ölçeği, Yakın İlişkilerde Yaşantılar Ölçeği II ve Sağlıklı Yaşam Biçimi Davranışları Ölçeği II'dir. Bu çalışma 195 hamile kadın ile yürütülmüştür (ortalama yaş = 28.69, SS = 3.82). Çalışmanın verisi çevrimiçi hamile forumu bulunan bir websitesi aracılığı ile toplanmıştır. Katılımcılar çalışmanın bütün ölçeklerini cevaplamıştır.

Çalışmanın sonuçlarına göre, hamilelik sürecinde Sağlıklı Yaşam Biçimi Davranış Ölçeği-II'nin skoru kaygılı ve kaçınmalı yetişkin bağlanması ile negatif yönde, evlilik uyumu ile ise pozitif yönde ilişkilidir. Hamilelikte sağlık şikayetleri evlilik uyumu ile negatif yönde, kaygılı bağlanma ile pozitif yönde ilişkilidir, fakat kaygılı bağlanma ile anlamlı bir ilişkisi bulunmamaktadır. Evlilik uyumu ile kaygılı ve kaçınmalı bağlanma stilleri arasında negative bir ilişki bulunmuştur.

Hiyerarşik doğrusal regresyon analizine göre, kaygılı bağlanma ve kaçınmalı bağlanma anlamlı şekilde hamilelik döneminde sağlık davranışını yordamaktadır, fakat sadece kaygılı bağlanma hamile kadınların sağlık durumu yordamaktadır. Bağımsız iki grup arası farkların t-testinde ise, hamile kadınların çalışma durumuna göre evlilik uyumu ve kaçınmalı bağlanma değişkenleri için anlamlı derecede farklılık bulunmuştur.

Anahtar kelimeler: Evlilik Uyumu, Bağlanma, Yetişkin Bağlanması, Sağlık, Sağlık Davranışı, Hamilelik

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LIST OF ABBREVIATIONS

MAS	Marital Adjustment Scale
HLBS	Healthy Lifestyle Behavior Scale
ECRI	Experiences in Close Relationships Inventory
PHSC	Pregnancy Health Status Checklist

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CHAPTER 1

INTRODUCTION

Pregnancy is a different and challenging period for many couples. Because of its different and sometimes hard nature, it can create new stress in marriages. According to Holmes and his colleagues' study (2013), though variations in families are important, many parents report declines in love and increases in conflict during transition to parenthood period. In another study (Lu, 2006), stress of expectant parents has been found to have negative effects on mental health and marital satisfaction. It has also adverse effects on postnatal mental health and marital satisfaction. In addition, social support and marital congruence has positive effects on the parenthood adjustment. If we compare men and women during this transition to parenthood period, women reports generally high levels of stress, more psychological symptoms, lower marital satisfaction than men, but they receive more social support in pregnancy (Lu, 2006).

The transition to parenthood may cause a decline in marital adjustment for the most of the expectant partners. The quality of the marriage before this special period is a strong predictor of how well partners adapt to this transition to parenthood period. Long before pregnancy and parenthood, this process may cause a decline in marital functioning -even among couples who have high marital satisfaction levels- but planning status and marital satisfaction before pregnancy protects marriages from these declines (Lawrence, Cobb, Rottman, & Rottman, 2008). This decline in marital functioning is greatest for especially highly anxious individuals when pregnant women

perceive their spouses less supportive and as acting more negatively toward them (Kohn et al., 2012).

Marital functioning is crucial in pregnancy, because it is related to many mental and physical outcomes such as depression, anxiety, and relationship related problems. According to Whishman et al. (2011), marital adjustment predicted both depressive symptoms and anxiety symptoms. Meanly, when marital adjustment of women was lower than usual, their depressive symptoms and anxiety symptoms become higher. Additionally, women who have stronger sense of family coherence, greater social support, and less stress during pregnancy experienced less decline in marital functioning at postpartum period (Ngai, & Ngu, 2014). Meanly, mental health of pregnant women is important for their well-being after delivery.

In pregnancy, marital functioning is also related to some physical problems. For instance, Hyperemesis Gravidorum (HG) is characterized by severe nausea and vomiting seen in the first trimester in pregnancy. It requires staying at hospital and though it has organic roots, there are strong psychological factors on HG. These psychological factors were explained as a result of ambivalence in emotions and marital conflict (Kuğu, & Akyüz, 2001). In another study (Bloch et al., 2010), women in poor relationships with their partners were more likely to have depressive symptoms, use drugs and smoke. Their babies also had the highest rate of low birth weight according to the same study. So, marital functioning and being in good relationships with partners during pregnancy period were important for both women and baby's health.

There are lots of distress resources during pregnancy period. According to Brown's (1994) study, expectant parents who have marital problems experienced less satisfaction with support of their partners, higher life stress, poorer overall health, lower well-being, and more somatic and psychological symptoms. Marital adjustment is an important factor in adaptation to pregnancy. Adaptation of pregnant women was lowest in situations where both expectant parents were more maritally stressed than only one of spouses experienced discord (Brown, 1994). Additionally, if pregnant women feel high levels of stress, it can cause some health related problems for themselves and especially for their unborn babies like preterm birth and low birth weight, because, it was found that maternal psychosocial stress, extensive physical activity and fasting are important risk factors for those problems of coming babies (Hobel, & Culhane, 2003).

The need for interpersonal attachment is a fundamental human need (Baumeister & Leary, 1995). As well known, according to Bowlby's (1973) attachment theory all children internalize "working models" of self and other based on repeated interactions with caregivers that serve as templates for navigating relationships throughout the lifespan (as cited in Williams and Riskind, 2004). He claims that interactions in childhood with caregivers strongly affect the formation of those internal working models such as self-perceptions of one's own value and worthiness of care, and perceptions of others' ability to provide this care when needed.

Attachment styles primarily have been defined by Ainsworth and Wittig (1969), they investigated attachment styles of infants. According to this point of view, there are three main attachment styles of children such as Anxious- Avoidant, Secure

and Anxious-Ambivalent/Resistant. Children who are in Anxious-Avoidant group (Group A) did not show distress on separation, and ignored the caregiver when they come back. Infants classified as Secure (Group B) were explorers when their caregivers were around so they used them as a safe base. Those infants protested when their caregivers depart, but calmed down sooner when they come back. Anxious-Ambivalent/Resistant (Group C), showed distress when the caregiver left, and were clingy and hard to calm down when the caregiver came back. Hazan and Shaver (1987) developed and adapted ideas of Bowlby in the context of adult relationships. They were first researchers in the development of adult attachment. According to them, the emotional bond that arises between two partners is nearly a function of the same motivational system between children and their caregivers.

Attachment styles have some important implications for mental and physical health of adults (Hunter & Maunder, 2001). Many studies suggest a link between adult attachment style and physical health, including some preventative health behaviors such as exercising and eating a healthy diet (Huntsinger & Luecken, 2004), physiological responses to stress (Hunter, & Maunder, 2008), and reports of pain, and fatigue (Feeney, 2000). According to McWilliams and Bailey's (2010) study, anxious attachment score was positively correlated with many health conditions like problems of cardiovascular system which are stroke, heart attack, and high blood pressure. Secure attachment score was unrelated to the health problems. There is a positive relationship between attachment styles and health condition, if one drops the other one seems to be affected from it.

Pietromonaco, Uchino and Schetter (2013) present an extensive theoretical model about attachment theory which integrates relationship constructs and processes with both biopsychosocial processes and health outcomes (See Figure.1). According to this model, attachment styles of both partners have relationship with dyadic processes. Those dyadic processes are called as “relationship behaviors, moderators and outcomes”. They influence and are influenced by physiology, affect, health behavior and overall health. In adult attachment, there are two main attachment styles like attachment avoidance and attachment anxiety (Mikulincer, & Shaver, 2007). According to Pietromonaco et al. (2013), there are three main types of adult attachment such as anxious attachment, attachment avoidance and attachment security. *Anxious attachment* means a pattern of hyperactivation in the face of threat, including heightened distress and persistently seeking proximity and reassurance from other people. *Attachment avoidance* means a pattern of deactivation in response to threat, including minimizing distress, turning attention away from the threat, and being overly self-reliant. *Attachment security* means the combination of lower levels of both anxiety and avoidance, characterized by feeling comfortable with closeness and trusting that a partner will be available and responsive in times of need (Pietromonaco et al., 2013).

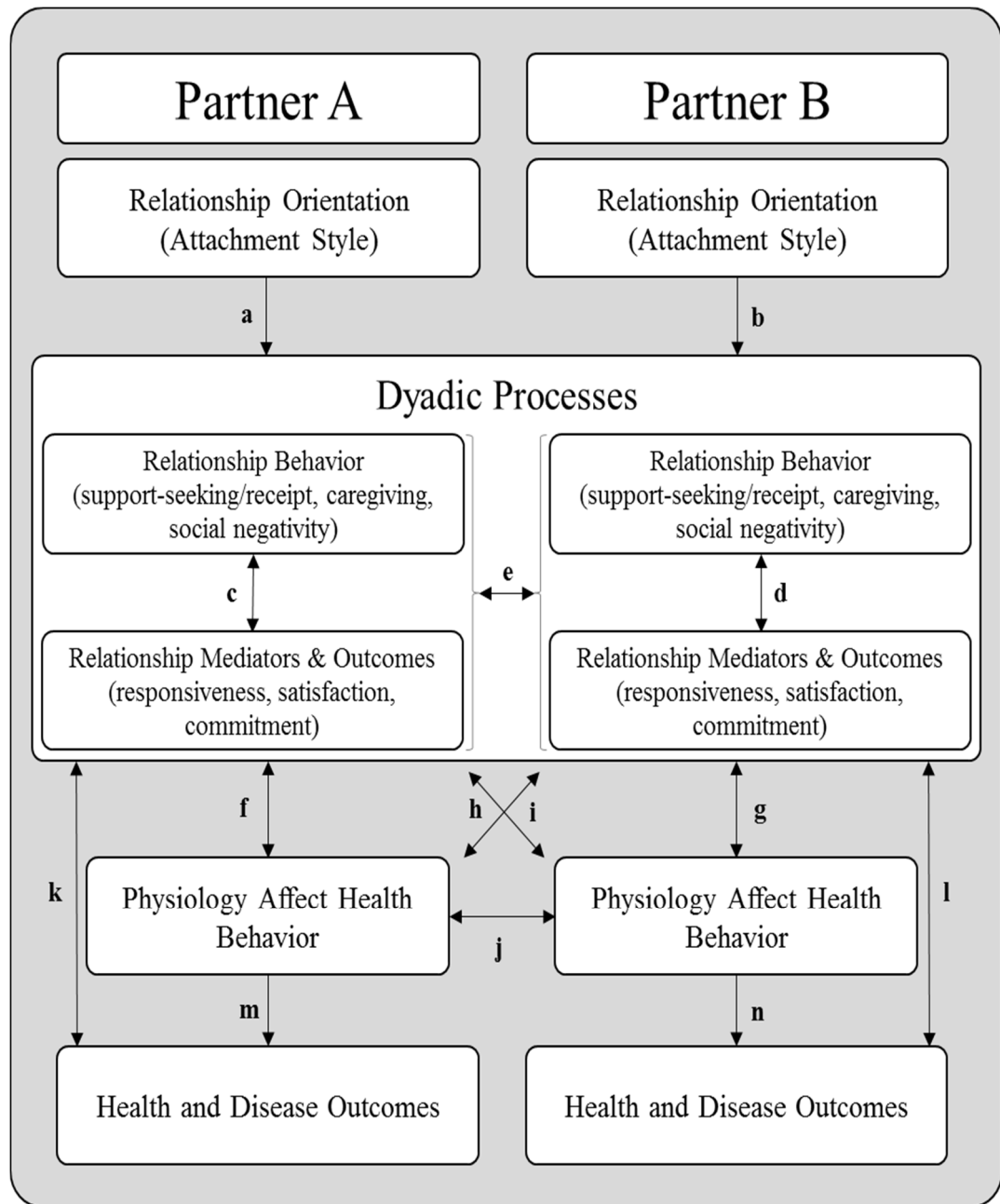


Figure 1. Dyadic Relationships and Health Processes (Pietromonaco, Uchino, & Schetter, 2013).

Pregnant women during the pregnancy period may have some health related problems special to their current condition. Sunal and Demiryay (2009) evaluated physical and emotional complaints of pregnant women. In their study, they presented

the most frequently seen complaints in pregnancy. In the present study, the Pregnancy Health Status Checklist was formed according to the findings of this study by the researcher.

1.1. Purpose and Significance of the Study

This study investigates the relationships between marital adjustment, adult attachment, health behavior and health status in pregnancy period. The present study aims to investigate to what extent adult attachment styles and marital adjustment predict healthy lifestyle behavior and health status during pregnancy after controlling for some crucial demographic variables. Pregnant women will be compared in terms of working status and education levels on main variables of the study. It is significant to investigate and show the relationships between those variables especially in the pregnancy period and compare the results with the insight of the literature, because variables of the present study were not studied all together in pregnancy period previously.

1.2. Definitions of Terms

In this section, the operational definitions of main variables of the study like marital adjustment, adult attachment, health and health behavior will be presented by referring to the literature.

Marital Adjustment: Thomas (1977) defines marital adjustment as “the state in which there is an overall feeling in husband and wife of happiness and satisfaction with their marriage and with each other”. It was also defined as the presence of some characteristics in a marriage like an attempt to avoid or resolve conflicts, a feeling

satisfied with the marriage and each other, the sharing of common interests and activities and the fulfilling of the marital expectations of spouses (Locke & Williamson, 1958). According to Locke and Wallace (1959) it is “accommodation of a husband and wife to each other at given time”. Marital adjustment in this study was measured by Marital Adjustment Scale which is generated by Locke and Wallace (1959). Though in the literature marital satisfaction and marital adjustment have been used interchangeably, in this particular study the concept of marital adjustment was preferred.

Adult Attachment: Adult attachment is described in terms of two independent dimensions like attachment anxiety and attachment avoidance (Brennan, Clark, & Shaver, 1998). Individuals who have high attachment anxiety tend to exaggerate negative experiences and are hyper vigilant to potential threat. Individuals who have high attachment avoidance levels tend to minimize feelings of distress and direct attention away from potential threat by magnifying autonomous behavior strategies (Kidd, Hamer, & Steptoe, 2013). In this study, adult attachment was measured by Experiences in Close Relationships Inventory-II which is developed by Fraley et al. (2000).

Health: The World Health Organization (1946) originally defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity”. In this study, current health status and health related complaints of pregnant women were evaluated by Pregnancy Health Status Checklist which is generated according to the findings of Sunal and Demiryay’s (2009) study.

Health Behavior: Health behavior is every activity which people perform to maintain or improve their health status, regardless of their perceived health status or whether the behavior actually cause improvement in health. An example of health behavior is using bikes to maintain or improve health and avoid illness (Sarafino & Smith, 2011). In the present study, it was measured by Healthy Lifestyle Behavior Scale-II which is developed by Walker et al. (1996). This scale was developed according to the Pender's Health Promotion Model (Pender, 1996) that underlines biophysical processes that motivate people to develop their health.

CHAPTER 2

LITERATURE REVIEW

In this section, the definition, types, and theories of marital adjustment, attachment and health behavior will be explained. Then, factors influencing marital adjustment, adult attachment and health behavior will be discussed. Finally, previous studies about marital adjustment, adult attachment and health behavior will be presented in detail.

2.1. Marital Adjustment

Marital adjustment is defined as “the state in which there is an overall feeling in husband and wife of happiness and satisfaction with their marriage and with each other” (Thomas, 1977). It is generally categorized as low or high and important for married couples because, couples high in marital adjustment are more likely to understand one another and less likely to misunderstand one another than other couples low in marital adjustment (Noller, & Fitzpatrick, 1988). In addition, factors that negatively affect marital adjustment prevent partners from happiness and affect negatively their physical and spiritual satisfaction (Sis, & Pasinlioğlu, 2013).

According to Tutarel-Kışlak and Çabukca (2002), marital adjustment is generally established when there is a balance between compulsory and voluntary aspects of a marriage, and when partners who have different personality characteristics complement each other as a whole to be happy and reach their shared goals.

Additionally, marital adjustment determines happiness and satisfaction levels in marriages (Tutarel-Kışlak & Çabukca, 2002). Mainly, in determination of married couples' happiness and satisfaction, marital adjustment has a significant role.

Marital adjustment is related with another main variable of the study which is “health status” in the literature. In Burman and Margolin's (1992) model, marital factors have relationship with stress and support, psychological processes like cognitions, affect and health behavior, coping strategies, physiological consequences and finally health status. As seen in the Figure 2, stress and support main factors on other dimensions according to this model. In addition, people who have high marital adjustment level has lower distress level, employs more number of coping strategies and uses more frequently coping strategies than people in low marital adjustment group (McLaughlin et al., 1988). In a study (Akdeniz Babaoğlu, 2012) done with women who have breast cancer can cope more effectively when they have high marital adjustment level.

2.1.1. Marital Adjustment in Pregnancy

This particular study investigates marital adjustment levels of Turkish pregnant women. Marital adjustment in pregnancy is important for psychological wellbeing of pregnant women. Pregnancy may become stressful and challenging period for couples and aggravate anxiety for both partners. During pregnancy and postpartum period, relationship adjustment, depression and anxiety symptoms were found to be associated with each other. For example, according to a study (Whishman et al., 2011) marital adjustment predicted some psychological problems like depressive and anxiety

symptoms. It means, if women's marital adjustment scores were lower than usual, they had higher levels of depression and anxiety symptoms.

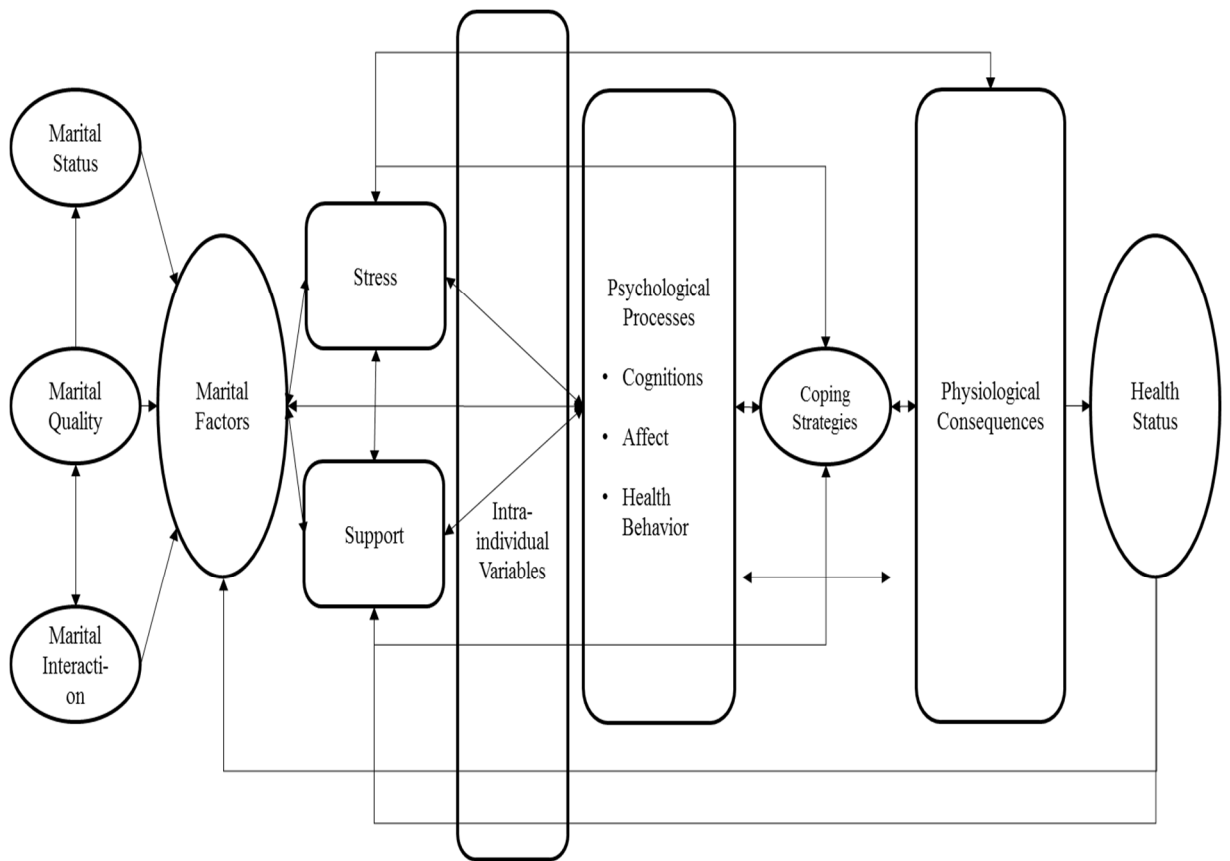


Figure 2. Hypothetical Model of the Relationship between Marital Variables and Health Status (Burman, & Margolin, 1992).

Another important factor for marital adjustment in pregnancy may be the quality of sexual life. Generally, a decline of sexual activity during pregnancy period could be seen in marriages. In a study, it is shown that there is a positive relationship between sexual quality and marital adjustment of pregnant women (Kısa, Zeyneloğlu, Yılmaz, & Guner, 2013). In the same study, % 30 of the pregnant women reported problems during sexual intercourse and % 50 of the pregnant women had painful

intercourse. In another study (Galazka et al., 2014), sexual activity before and during pregnancy were investigated, and dissatisfaction in partner relationships was found as an important factor affecting sexual quality during pregnancy period. Additionally, to decrease anxiety toward sexual intercourse during pregnancy, counseling women and reassuring them that intercourse is safe if pregnancy is healthy are important (Babazadeh, Mirzaii, & Masomi, 2013).

Increasing collaboration between expectant fathers and mothers and giving beneficial education regarding the health of pregnant women may also be important for marital functioning in this special period. According to Latifses et al. (2005), giving education to fathers about massaging and practicing relaxation techniques with their pregnant wives can be an important way to increase marital satisfaction and decrease depressive symptoms which may arise later and improve the life of both parents and their children. In another study (Pryor et al., 2014), nearly one third of expectant fathers changed their dietary and smoking behaviors during this transition to the parenthood period. This contribution of fathers is important for the health and well-being of their wives and unborn babies.

When pregnant women have relationship related problems, the intensity of complaints seen in the pregnancy can be increased. In the pregnancy, marital adjustment is important for the somatic complaints of pregnant women. According to Yekenkunril and Mete (2012)'s study, there is a relationship between marital adjustment and nausea and vomiting in pregnancy. In their study, pregnant women who have high marital adjustment have less nausea-vomiting complaints than pregnant women who have low marital adjustment. It is congruent with the findings of another

study which indicates that infectious diseases are significantly negatively associated with relationship satisfaction during pregnancy period (Henriksen et al., 2015).

In this section, the importance of marital adjustment during pregnancy period and its relations with other factors like mental and physical well-being, sexual activity and collaboration between couples were presented. In the following section, another main variable of the study which is attachment will be mentioned with the literature about it.

2.2. Attachment

Human beings need to attach strongly to someone from birth on. According to Bowlby (1960), being away from the primary caregiver would serve as an anxiety source and it is important for attachment. According to this point of view, Ainsworth and Wittig (1969) examined individual differences in the responses of 56 middle-class non-clinical infants aged 11 months to the departure of a caregiver in their structured laboratory. They called this work as the “Strange Situation Procedure”. They investigated children’s behavior when they were with and without their caregivers. Firstly two categories were established by Ainsworth and Wittig (1969) for categorizing patterns in infant responses to their procedure. Infants in Anxious-Avoidant group (Group A) did not show distress when separated from their caregivers, and ignored them when they returned. Infants in Secure group (Group B) used the caregiver as a safe base, they were exploring when their caregivers were around, protested at their departure but sought the caregiver came back. Ainsworth and Wittig noted, a third category of behavior in a minority of cases. These infants, classified as

Anxious-Ambivalent/Resistant (Group C), had distress on separation, and were clingy and difficult to comfort on the caregiver's return.

In Bowlby's (1973) attachment theory, experiences with caregivers in early childhood have a significant effect on the formation of internal working models like self-perceptions of one's own value and worthiness of care, and perceptions of others' ability to provide this care when needed. Bowlby put forward the idea that human beings like other animals are programmed to survive by this way which makes critical establishing bonds between infant and caregivers, and persisting this caregiving attitudes (Bowlby, 1982).

2.2.1. Adult Attachment

Hazan and Shaver (1987) expanded thoughts of Bowlby in the context of adult relationships. In this point of view, the emotional bond which developed between couples was a function of the attachment between children and their caregivers. So, both of these bonds have the same root and motivational system which is the "attachment behavioral system". The bonds between infants and caregivers and the bonds between adult couples have some shared characteristics like:

- both feel secure when the other is close and responsive to them
- both engage in close, intimate, bodily contact
- both feel insecure when the other is inaccessible
- both explore with another one
- both deal with mimics of other and show a mutual attraction and preoccupation together

- both engage in "baby talk".

About these similarities, Hazan and Shaver (1987) claimed that relationships of adult couples are attachments like the relationships between infant and caregiver. In addition, love of adult couples is a feature of the attachment behavioral system and also the motivational systems that are the bases of caregiving and sexuality.

There are three important implications of this opinion. Firstly, if the relationships between adult couples are attachment relationships, then we should observe the same kinds of individual differences in adult relationships like observed in infant-caregiver relationships. Second, if the relationships between couples are attachment relationships, then the way romantic relationships work should be similar to the way infant and caregiver relationships work. Finally, if an adult is secure or insecure in his or her romantic relationships may be a partial reflection of his or her experiences with his or her caregivers in childhood period (Fraley, 2010).

Bowlby believed that the mental representations or working models like “expectations”, “beliefs”, “rules” or “scripts” for behaviors and thoughts that an infant holds regarding relationships are a function of his or her caregiving experiences (as cited in Fraley, 2010). Those experiences may have an effect on their romantic relationships in later lives. So, adult attachment at some points are similar to parent-child attachment, and at some points it may differ from it.

According to Hazan and Shaver (1987) the distribution of categories in adult romantic relationships was also similar to the relationships between infant and

caregiver, and about 60% of adults classified as secure (B), 20% classified as avoidant (A), and about 20% of adults classified as anxious-resistant (C).

A. "I am somewhat uncomfortable being close to others; I find it difficult to trust them completely, difficult to allow myself to depend on them. I am nervous when anyone gets too close, and often, others want me to be more intimate than I feel comfortable being."

B. "I find it relatively easy to get close to others and am comfortable depending on them and having them depend on me. I don't worry about being abandoned or about someone getting too close to me."

C. "I find that others are reluctant to get as close as I would like. I often worry that my partner doesn't really love me or won't want to stay with me. I want to get very close to my partner, and this sometimes scares people away."

Based on attachment theory and Bowlby's ideas, Bartheley (1991) generated four main adult attachment types. In this point of view, self image of a person is differentiated as positive or negative (the self as worthy of love and support or not) and person's image of the other is also differentiated as positive or negative (other people are seen as trustworthy and available vs. unreliable and rejecting). Then Bartheley (1991) established four combinations of those perceptions about self and the other. Table 1 shows those combinations which Bartheley conceptualized.

Table 1. *Bartheley's Model of Adult Attachment*

		Model of Self (Dependence)	
		Positive (Low)	Negative (High)
Model of Other (Avoidance)	Positive (Low)	CELL I SECURE Comfortable with intimacy and autonomy	CELL II PREOCCUPIED Preoccupied with relationships
	Negative (High)	CELL IV DISMISSING Dismissing of intimacy Counter-dependent	CELL III FEARFUL Fearful of intimacy Socially avoidant

In this table, Cell I indicates a sense of lovability and responsivity in others, so it draws a secure attachment style. Cell II indicates less sense of lovability of self and high responsivity in others, and it is preoccupied attachment style. Cell III appears when the person feels less worthy and perceives less acceptability from others. It is fearful attachment style. In Cell IV, the person feels worthy but others as less acceptive. So, it is dismissing attachment style which is characterized by dismissing of intimacy (Bartheley, 1991).

Adult Attachment has two main dimensions like attachment avoidance and attachment anxiety (Brennan, Clark, & Shaver, 1998). Individuals who have high attachment anxiety generally maximize negative experiences and are hyper vigilant to potential threat. Individuals who have attachment avoidance tend to minimize

emotions like distress and direct attention away from potential threat by maximizing autonomous behavior strategies (Kidd, Hamer, & Steptoe, 2013). Attachment anxiety and avoidance are signs of insecure adult attachment with different characteristics.

Experiences of careseeking and caregiving have their roots in infancy and shape our expectations and responses to careseeking and caregiving in adult life (Heard, McCluskey, & Lake, 2012). We seek the security, support, and comfort of friends and family. It is therefore not surprising that the field of close relationships has been a central and burgeoning area within psychology. Individuals commonly attach themselves to objects, concepts, and abstractions to serve attachment and belonging functions (Green, Mathews, & Foster, 2009).

Adult attachment styles are also very much related to daily functioning of human being. In Ergin and Dağ (2013)' study adult attachment styles of participants were evaluated. They found the anxious attachment styles had effects on ineffective interpersonal problem solving behaviors and the avoidant attachment styles had effects on lacking of self-confidence, unwillingness to take responsibility in interpersonal problem solving situations and negative effects on effective problem solving behaviors.

Until now, previous studies about attachment in general and adult attachment were presented with their theoretical roots. This particular study will investigate adult attachment styles of pregnant women, so it is important to mention adult attachment during pregnancy period. In the following section, studies about adult attachment in pregnancy period and their associations with other factors during pregnancy will be provided.

2.2.2. Adult Attachment in Pregnancy

There are conceptual distinctions between the two attachment dimensions, namely attachment anxiety and attachment avoidance. This difference points adult attachment as an important factor in understanding the ways women cope with the challenges during the transition to motherhood (Trillingsgaard, Elklit, Shevlin, & Maimburg, 2011). In a study by Trillingsgaard et al. (2011), attachment anxiety was associated with high pregnancy worry compared to attachment avoidance. None of the dimensions were associated with health care utility. Both attachment anxiety and attachment avoidance were associated with high parenting stress after the birth, while only attachment anxiety was associated with low relationship satisfaction.

Attachment styles between couples during pregnancy period are associated with mood problems. In Desrosiers and his colleagues' (2014) study, it is showed that avoidant attachment and anxious attachment were significantly positively related to depressive symptoms in pregnancy. Additionally, anxious attachment and depressive symptoms in partners were positively associated with depressive symptoms. After childbirth, Post Traumatic Stress Disorder (PTSD) may be seen and it can be associated with attachment issues. In a longitudinal study (Ayers et al., 2014), avoidant attachment style, operative birth and poor support during birth are related with postnatal PTSD. So, avoidant attachment style was seen as a risk factor especially if birth was an operative one.

Pain and analgesia consumption in labor may be related with attachment styles of pregnant women. According to a study (Costa-Martins et al., 2014) done with women an insecure attachment style were more likely to report higher pain before

patient-controlled epidural analgesia and higher analgesic consumption and to request supplemental analgesia during labor. The assessment of adult attachment may be necessary to identify women at high risk of poorly coping with pain during childbirth.

Adult attachment in pregnancy period is not a highly preferred topic in the literature. Some of the studies about this topic were presented previously. Next section will include another main variable of the particular study which is health. Its definition and models about health will be presented in this following section.

2.3. Health

The World Health Organization (1946) originally defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity”. The word health originally came from old English and it meant the state and the condition of being whole. It was associated with physiological functioning, mental soundness, and spiritual wellbeing (Boruchowitch, & Mednick, 2002).

The biomedical model governed the thinking of most health practitioners for the past 300 years and it maintains that all diseases can be explained on the basis of somatic bodily processes (Taylor, 2009). According to this model of health, biochemical explanations of especially ill health is important and it is the basis for treatment and intervention. In the social model, health is defined as a more holistic concept. It moves beyond the reductionist nature of biomedical view and realizes the dynamic interactions of social structures. So, this model presents a wider understanding of health (Yuill, Crinson, & Duncan, 2010).

After the biomedical model, George Engel (1977) formed biopsychosocial model of health, and it's more holistic than biomedical model, because it contains also social, psychological and biological dimensions of health and illness. Evans and his colleagues (1990) created a diagram of Engel's biopsychosocial model (See Figure 3). It includes social and physical environment and genetic endowment, individual responses like behavior and biology. They are all related with each other and also health, disease, health care and at the end, well-being and property. This model is formed because of reductionist view of biomedical model, and its limitations in regarding social, psychological, and behavioral side of health.

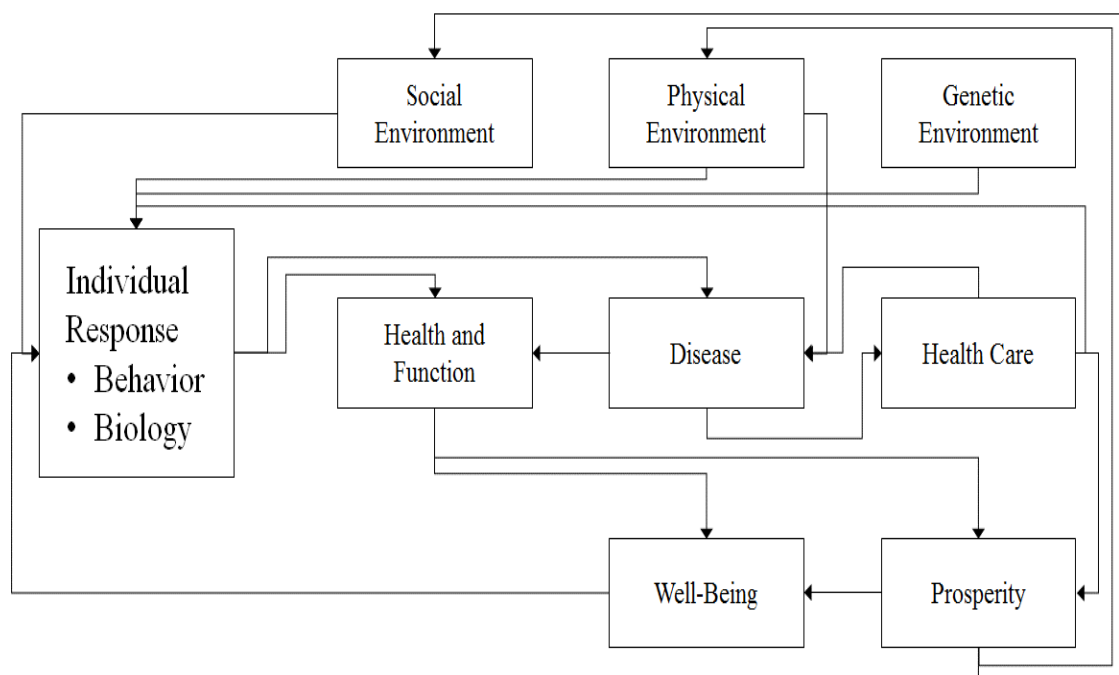


Figure 3. Evans and Stoddart's (1990) Biopsychosocial Model

2.3.1. Health in Pregnancy

There are lots of factors associated with health in pregnancy. Health of pregnant women is very crucial and there are some common health problems seen especially in pregnancy. In a study (Perlen et al., 2012) done with women in early pregnancy period, the five most commonly reported physical health problems were as follows: exhaustion, morning sickness, back pain, constipation and severe headaches or migraines. In addition, women reporting five or more physical health problems had a three-fold increase in likelihood of reporting depressive symptoms. So, health concerns in pregnancy have interactions with also mental health. According to Lukasse and his colleagues' (2009) study, pregnant women who abused sexually, physically and emotionally in their childhood reported more common health related complaints in pregnancy. Additionally, sociodemographic characteristics or other risk factors did not show such an impressive association. When evaluating health related complaints of pregnant women, childhood abuse may be an important issue that must be asked about.

Sex of fetus may also be associated with some complaints during pregnancy period. Behboodi, Moghadam and Rezaei (2014) evaluated associations of health related complaints and fetal sex in pregnancy. Their participants were pregnant women who suffer from sleep disorder. They found a significant association between fetal sex and backache and vomiting. Women with female fetus experienced more back pain and vomiting. Other complaints did not differ significantly according to fetal sex. In a study done with pregnant women who had asthma, their complaints increased if they had girl fetus rather than boys. Additionally, none of them did not know sex of fetus before delivery (Beecroft, N., Gochrane, G. M., & Milburn, H. J., 1998). Each

pregnancy may be unique even for the same women and complaints of women may change from one pregnancy to the other one. Additionally, it seems like characteristics special to the fetus like fetal gender may affect health and health complaints of pregnant women. Though this study investigates the relationship between marital adjustment, attachment, health behavior and health status in pregnancy, other specific factors may also be related to the health of pregnant women.

Health of pregnant women is very much related with health behaviors as it is expected. For example, nutrition in pregnancy is crucial because malnourished mothers give birth to underweight babies who further grow up to having higher incidence of health problems. If the mother is anemic and it is not treated properly, she has higher risks of spontaneous abortions, premature birth, low weight babies, and increased maternal morbidity/mortality (Mishra, 2014). In addition, folic acid supplementation is critical to prevent neural tube defects in pregnancy. It is also seen important to take folic acid to prevent some defects, but potential side effects of such dietary factors should be evaluated carefully by health professionals (Barua et al., 2014).

In this part, studies about health of pregnant women, and its associations with other factors like health behavior or environmental factors were given as a summary. In addition, the present study investigates also health behavior during pregnancy period. Health behavior in general will be mentioned with the “Health Belief Model” which is one of the most widely used model of health behavior research in the next section.

2.4. Health Behavior

According to Kasl and Cobb (1966) a health behavior was a behavior aimed to prevent disease, for instance eating a healthy diet. It is a broad concept and according to Gochman (1982, 1997, as cited in Glanz et. al, 2008), it is defined as personal attributes such as beliefs, expectations, motives, values, perceptions, and other cognitive processes, personality characteristics, behavior patterns, actions, habits, that relate to health maintenance, restoration, and improvement.

Health behaviors were further defined by Matarazzo (1984, as cited in Ogden, 2007) in terms of either:

- health-impairing habits, which he called ‘behavioral pathogens’ (e.g. smoking, eating a high fat diet), or
- health protective behaviors, which he defined as ‘behavioral immunogens’ (e.g. attending a health check).

In Matarazzo’s definition, health behavior may include both positive and negative features. Positive ones may be healthy diet, exercising and negative ones can be some habits like smoking or using drugs. In another definition, health behavior is any activity people perform to maintain or improve their health, regardless of their perceived health status or whether the behavior actually achieves the goal. An example of health behavior is using bikes to maintain or improve health and avoid illness (Sarafino & Smith, 2011).

In health behavior research, one of the most widely used model is the Health Belief Model (HBM) to explain health behaviors of individuals. Initially, Hochbaum (1958,

as cited in Glanz et. al., 2008) studied perceptions about whether individuals believed they were susceptible to tuberculosis and their beliefs about the personal benefits of early detection. According to HBM, if individuals regard themselves as susceptible to a condition, believe that condition would have potentially serious consequences, believe that a course of action available to them would be beneficial in reducing either their susceptibility to or severity of the condition, and believe the anticipated benefits of taking action outweigh the barriers to (or costs of) action, they are likely to take action that they believe will reduce their risks (See Figure 4).

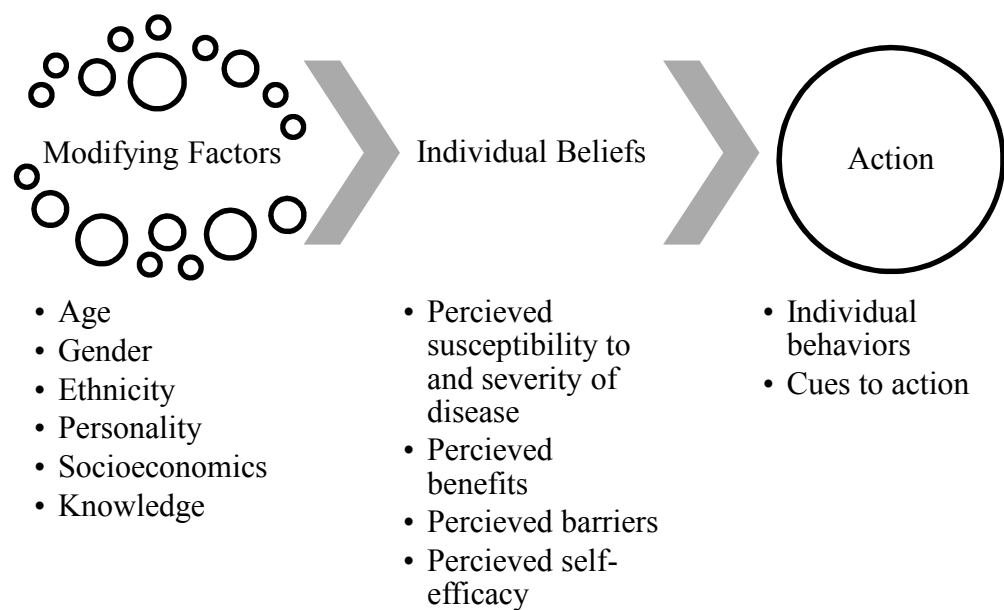


Figure 4. Health Belief Model of Glanz et al. (2008)

The present study's topic is related with marriage, so relations between marital status and health behavior were also investigated. In Umberson's (1992) study marriage is associated with more efforts to control health for men than women, females

attempt to control health of others than males, the transition from married to unmarried status is associated with an increase in negative health behavior and conversely the transition from unmarried to married status are associated with little effect on health behavior.

2.4.1. Health Behavior in Pregnancy

In pregnancy, giving proper knowledge to the pregnant women and educating them about health behaviors are important. Medical practitioners are the preferred source of health information, but they generally give insufficient information about health behavior during pregnancy (Smedley et al., 2014). According to Sayami and his colleagues' (2014) work, lack of proper knowledge about complications of pregnancy and birth is an important challenge in health seeking behaviors. In addition, lack of proper knowledge in pregnancy and delivery is an important problem, and raising awareness about its importance can improve maternal and child health. Therefore, increasing awareness and giving proper information to pregnant women is important for the health of mother and baby.

Health behavior of women may change in pregnancy period and they generally need to learn what is wrong and right to continue to do in pregnancy. Pregnant women may be confused about their health related behaviors and they may need education from professionals. Expectant women show a reduction in their level of physical activity, increase in consumption of fruits, vegetables and fiber, and decrease fast food consumption (Smedley et al., 2014). They can try to have a healthier diet during pregnancy, but they may need an education and assistance about exercising and weight control. Additionally, individual factors like having high health literacy are associated

with maternal health behaviors during this special period of women life (Lupattelli et al., 2014). Again, the importance of educating pregnant women about healthy behaviors seems crucial. The major source of knowledge for them are physician, increasing their knowledge and awareness on this topic may be beneficial for pregnant women's health literacy.

There can be some environmental factors which are effective on the health behavior of pregnant women. In the literature (Margerison-Zilko, 2014), findings suggest that exposure to extreme economic contraction during pregnancy may be associated with increased use of alcohol with differences by maternal race-ethnicity and educational attainment. Economic contraction was not found to be associated with other maternal pregnancy behaviors in this study. In a study done in the United States, foreign-born Black women were significantly less likely to engage in substance use like tobacco, alcohol, marijuana and had better self-rated physical and mental health than did US-born Black women (Elo, & Culhane, 2010). This study also shows effects of environmental factors on health behavior.

Sometimes, health behavior of partners and families may have a relationship with health behavior of pregnant women. People who have a contact with expectant women may affect health behavior of women in either positively or negatively. In Benneth and Clatworthy's (1999) study, having a partner who smoked had a relationship with continued smoking in pregnancy. The most significant determinant of continued smoking in pregnancy is nicotine addiction according to the same study. Health habits are generally much related to health behaviors of relatives, friends and

other people, and health behaviors of those people seem to have a crucial role on health habits of pregnant women like continued smoking during pregnancy.

Cognitions and beliefs have also influence on this behavior, because some smokers lessen smoking. Those women may feel some kind of risky status in pregnancy. In another study done with Turkish pregnant women, factors related to smoking status during pregnancy period were investigated. High educated women, and having someone who smokes at home were associated with smoking during pregnancy (Aslan et al., 2013). According to the same study, smoking prevalence during pregnancy was 11.4 %. Though it is risky for the health of both women and unborn babies, more than one of ten Turkish women continues smoking in pregnancy. Activities to prevent this negative health habit in pregnancy are needed for women in Turkey.

Hypotheses of the study:

Depending on the presented literature, following hypotheses were formed;

Hypothesis 1.a: There will be a positive relationship between marital adjustment and health behavior in pregnancy.

Hypothesis 1.b: There is a positive relationship between secure attachment style and health behavior in pregnancy.

Hypothesis 1.c: There is a positive relationship between marital adjustment and health status in pregnancy.

Hypothesis 1.d: There is a positive relationship between secure attachment style and health status in pregnancy.

Hypothesis 2.a: Marital adjustment and secure attachment together will significantly predict the change in health behavior during pregnancy.

Hypothesis 2.b: Marital adjustment and secure attachment together will significantly predict the change in health status during pregnancy.

CHAPTER 3

METHOD

3.1. Sample

The participants of this study were 195 pregnant women who completed questionnaires of the study via an online pregnancy forum on the internet. The participants ranged in age from 19 to 40 with a mean of 28.69 (SD=3.82). They were pregnant women whose pregnancy ranged from 3 weeks to 40 weeks of pregnancy. There were participants from 57 different job. Some characteristics of the sample in this study were presented in Table 2 and Table 3.

Table 2. *Characteristics of the Sample (N=195)*

N=195		M	SD
Age		28.69	3.82
Education		Frequencies	Percentages
	primary school	1	0.05
	secondary school	5	2.6
	high school	24	12.3
	associate degree	19	9.7
	undergraduate	115	59
	graduate and above	31	5.9
Working status			
	yes	130	66.7
	no	65	33.3
Getting pregnant			
	Willingly	172	82.2
	Unwillingly	5	2.6
	Indecisive	16	8.2
Number of children			
	1	158	81.0

	2	27	13.8
	3	6	3.1
	4 or more	2	1.0
Marriage type			
	Blind date	17	8.7
	Dating by self	151	77.4
	Through friends	25	12.8
	Other (Runaway match)	1	.5
Income level			
	Low	2	1.0
	Middle	149	76.4
	High	42	21.5
Cigarette and Alcohol Usage			
	Cigarette	15	7.7
	Alcohol	3	1.5
	Cigarette and Alcohol	2	1.0
	None of them	174	89.2

Table 2. *Continued*

3.2. Instruments

Participants were given a battery consisting of Marital Adjustment Scale, Experiences in Close Relationships Inventory-II, and Healthy Lifestyle Behavior Scale-II, a demographic form, Pregnancy Health Status Checklist which is a prepared form by the researcher to investigate physical complaints and health status of pregnant women. The demographic information including age, education level, the spouse's age, willingness for having baby, number of children, marriage duration, types of marriage, working situation, cigarette and alcohol usage, and income level were collected in the same online survey.

3.2.1. Marital Adjustment Scale

Marital Adjustment Scale was developed by Locke and Wallace (1959). It investigates adjustment levels of married couples. It has two factors like agreement-no agreement and relationship style. First factor includes first nine items those shows adjustments in situations like general adjustment, emotion, sexuality, and social rules. Second factor includes other six items look at relationship styles which has items about free time activities, resolving conflicts and trust. Its internal consistency score was .90, and test retest reliability score was not measured (Locke, & Wallace, 1959).

The validity and reliability study of its Turkish version was done by Tutarel-Kışlak (1999). It has 15 questions, and cut-off point of its Turkish version to discriminate adjusted and unadjusted couples is 43.5 in total. Thus, 43.5 point and its beyond indicates adjusted couples, under 43 indicates unadjusted couples (Tutarel-Kışlak, 1999). It has .90 internal consistency score, .84 split half reliability score, and .57 test-retest score. To determine its construct validity, Relationship Attribution Measure was used and they have -.54 correlation score (See Appendix D).

3.2.2. Experiences in Close Relationships Inventory-II

Brennan and his colleagues (1998) developed a measure called as “Experiences in Close Relationships” which has two factors like “attachment anxiety” and “attachment avoidance” to examine adult attachment styles. Later, Fraley, Waller, and Brennan (2000), revised ECR according to the basis of Item Response Theory. ECR-II has two factors such as 18 items about avoidance and 18 items about anxiety, 36

items totally. It has high internal reliability for anxiety and avoidance factors ($\alpha=0.94$, $\alpha=0.93$ respectively) (Fraley, et al., 2000).

The reliability and validity study of its Turkish version was done by Selçuk and his colleagues (2005). Both of two factors has high internal consistency ($\alpha=0.86$, $\alpha=0.90$) and test-retest reliability ($\alpha=0.82$, $\alpha=0.81$) (Selçuk, et al., 2005) (See Appendix E).

3.2.3. Healthy Lifestyle Behavior Scale-II

First version of HLBS-II, which is HLBS, had 48 items and six factors and it was generated to examine health behaviors (Walker et al., 1987). Walker and his colleagues (1996) revised HLBS according to Pender's Health Promotion Model to measure health behavior. HLBS-II had 52 items and six factors. Its reliability score for total scale is .94 and for its subdimensions ranged from .79 to .87. It has .89 test retest reliability score.

The reliability and validity study of its Turkish version was done by Bahar et al. in 2008. Cronbach Alpha coefficient of its Turkish version was .92 and the reliability coefficient was .77 for the subscale health responsibility, .79 for physical activity, .68 for nutrition, .79 for mental development, .80 for interpersonal relationships and .64 for stress management (Bahar et al., 2008) (See Appendix F).

3.2.4. Pregnancy Health Status Checklist

In Sunal and Demiryay's (2009) study, physical and emotional complaints of pregnant women were evaluated. According to this study, the most frequently seen

complaints were frequent toilet going, fatigue, nausea and resulting vomiting, lower back pain, sensitivity to odors, indigestion, irritability, worrying about birth and pregnancy, swelling, craving, decreasing in daily life activities, headache, decreasing of sexual desire, hot flash, cramp in legs, increasing in appetite, decreasing in appetite, feeling pessimistic and bad, feeling energetic and happy, constipation, toothache, difficulty in sleeping, feeling lonely, dissatisfaction of appearance, hemorrhoid, increasing in sexual desire, diarrhea, and increasing in daily physical activities. In the present study, these physical and emotional complaints were asked to pregnant women and a 5 level Likert scale was developed to evaluate the intensity of each symptom (See Appendix C). The psychometric qualities of this scale will be presented in the Results section.

3.2.5. Demographic Information Form

The demographic information including age, education level, the spouse's age, willingness for having baby, pregnancy week of the woman, number of children, marriage duration, types of marriage, working situation, occupation, tobacco and alcohol intake and income level were collected from the participants in a form which was prepared by the researcher (See Appendix B).

3.3. Data Collection Procedure

Before data collection, a written permission was obtained from Fatih University Ethic Committee. Quantitative data was collected with several questionnaires. The questionnaire of the study was transferred to a survey website and sent as a link to a popular online pregnancy forum. The data of the study has been collected by this website; <http://www.kadinlarkulubu.com>. This website was preferred

because it has most widely used a pregnancy forum by Turkish pregnant women. Via this online pregnancy forum, it was requested to fill the online questionnaire from pregnant women voluntarily.

Participants encountered with an informed consent and filled out demographic form and the other measures of the study. IP addresses were gathered from computers of all participants and it causes prevented recurrent answers.

3.4. Data Analysis

The statistical analyses were carried out by using the Statistical Package for Social Scientists 21. Frequency and the means of the variables were calculated for all the major variables. Construct validity and reliability analyses were performed to explore how much the Pregnancy Health Status Checklist was valid and reliable within the sample. Correlational analyses were also carried to explore the strength and direction of the relationship between the variables of the study.

Hierarchical multiple regression analyses were conducted to test some hypotheses such as hypothesis 2.a which is “marital adjustment and secure attachment together will significantly predict the change in health behavior during pregnancy”, and hypothesis 2.b which is “marital adjustment and secure attachment together will significantly predict the change in health status during pregnancy”.

One way analysis of variance test was also conducted to compare education levels with respect to main variables of the study. Independent samples t-test was carried to test whether main variables of the study differed according to working status of pregnant women.

CHAPTER 4

RESULTS

This study aims to investigate to what extent adult attachment styles and marital adjustment predict healthy life style behavior and health status during pregnancy after controlling for some crucial demographic variables. Within this purpose, first of all the psychometric properties of the survey developed which measures health status during pregnancy will be presented. Afterwards, the descriptive statistics concerning scale scores will be demonstrated. Thirdly, the correlational analysis with respect to study hypothesis will be evaluated which are followed by regression analyses.

4.1. Psychometric Properties of the Pregnancy Health Status Checklist

Construct Validity. In order to evaluate the construct validity of the Pregnancy Health Status Check list, firstly an item analysis was utilized. After item analysis, a factor analysis with principle axis factoring and oblique rotation method was conducted.

According to the item analysis, as item-total score correlations for item numbers 10, 12, 15, 18, 19, 21, and 29 were lower than .20, these items were excluded from the scale. The initial Cronbach's alpha value was observed to be .83 and item-total correlations were ranged from .27 (28th item), and .52 (2nd item).

Following item analysis, the factor analysis was conducted with this final version of the scale. As item numbers 4, 6, 8, 9, 11, 13, 14, 16, 17, 22, 23, 24, 26, 27,

28 had communality values lower than .30, and item numbers, they were not included at final step. The final solution revealed a three factor structure (emotional symptoms with items 7, 20 and 25; first trimester symptoms with item 3 and 5; and third trimester symptoms with items 1 and 2), explaining almost 70 % of the total variance (KMO=.76; Bartlett $\chi^2=947,108$, $p<.001$).

Reliability. The Cronbach's alpha values for subtests and the total scale were calculated for his final version. These values were .65 for emotional symptoms subscale, .74 for the first trimester symptoms subscale, .62 for the third trimester symptoms subscale, and .72 for the total scale.

Therefore, the final 7 item version of The Pregnancy Health Status Checklist with three factors was accepted to be a valid and reliable instrument that measures the most frequently experienced symptoms in this group of Turkish pregnant women. The item analysis, factor analysis and reliability results of the scale were summarized in Table 3.

Table 3. *The Item Analysis, Factor Analysis and Reliability Results of the Pregnancy Health Status Checklist*

Factors	Factor Loadings	Item-Total Score Correlations	Communality Values
Factor 1: Emotional Symptoms ($\alpha=.65$; Eigenvalue: 2.63; variance explained: 37.6 %)			
Item # 20 Feeling pessimistic and bad	.76	.53	.51
Item # 25 Feeling lonely	.59	.46	.45
Item # 7 Getting angry easily	.38	.41	.31
Factor 2: First Trimester Symptoms ($\alpha=.74$; Eigenvalue: 1.30; variance explained: 18.5 %)			
Item # 3 Nausea, vomiting	.78	.59	.64
Item # 5 Odor sensitivity	.76	.59	.71
Factor 3: Third Trimester Symptoms ($\alpha=.62$; Eigenvalue: 1.02; variance explained: 14.6 %)			
Item # 2 Feeling Fatigue	.87	.44	.86
Item # 1 Frequent toilet going	.49	.44	.39

* Total variance explained: 70.1 %; Total Cronbach's Alpha $\alpha=.72$

4.2. Descriptive Results

Within descriptive results, first of all means and standard deviations and minimum and maximum score values of the scales used in this study were calculated for the whole sample. These can be seen in Table 4.

Further descriptive analyses were conducted in order to observe whether all the scales' scores differed as a function of working status categories and education level. For this purpose, an independent samples t-test was administered to assess whether scores of main variables of the study differed according to working status of pregnant women. As it is seen in Table 5, there was a significant difference in the scores for avoidant attachment and marital adjustment. These results suggest that working status during pregnancy had an effect on avoidant attachment and marital adjustment. Specifically, pregnant women who worked had significantly lower avoidant attachment and higher marital adjustment scores.

Table 4. *Means and Standard Deviations of the Main Variables of the Study*

	M	SD	Range (Min-Max)
Marital adjustment	44,47	9,89	6-60
Anxious attachment	3,04	0,90	1,39-6,29
Avoidant attachment	2,70	0,94	1-5
Interpersonal relationships	27,61	4,15	17-36
Diet	23,71	4,20	13-35
Health responsibility	24,38	4,73	12-36
Physical activity	15,36	4,77	8-29
Stress management	19,93	4,12	11-32
Mental development	27,52	4,21	15-36
Total score of health behavior	138,51	19,42	99-202
Total score of health status	19,84	5,67	9-35

Table 5. *Independent Samples t-test between Main Variables as a Function of Working Status of Pregnant Women*

	Housewives			Working Women			t-test
	n	M	SD	n	M	SD	
Interpersonal Relationships	65 [§]	27,75	3,62	130	27,53	4,39	,34
Diet	65	23,06	4,63	130	24,03	3,93	-1,52
Health Responsibility	65	24,30	4,92	130	24,42	4,64	-,16
Physical Activity	65	15,03	4,53	130	15,53	4,88	-,68
Stress Management	65	19,89	4,40	130	19,94	3,99	-,08
Mental Development	65	27,60	4,39	130	27,47	4,12	,19
Total Health Behavior	65	137,64	20,27	130	138,94	19,04	-,44
Total Health Status	65	20,33	6,25	126	19,58	5,35	,86
Emotional Symptoms	65	8,49	3,26	127	8,07	3,09	,87
First Trimester Symptoms	65	5,35	2,71	129	5,06	2,41	,76
Last Trimester Symptoms	65	6,49	1,70	130	6,46	2,13	,10
Anxious Attachment	65	2,98	,89	130	3,06	,89	-,61
Avoidant Attachment	65	2,91	,98	130	2,59	,89	2,30*
Marital Adjustment	65	42,46	9,69	130	45,47	9,86	-2,02*

*p<.05, **p<.01, ***p<.001, [§]df=63

Secondly, a one-way analysis of variance test was conducted to see whether there was a significant difference among education levels with respect main variables

of the present study. No significant differences could be found among education levels in terms of interpersonal relationships, diet, health responsibility, physical activity, stress management, mental development, total health behavior, total health status, emotional symptoms, first trimester symptoms, last trimester symptoms, anxious attachment, avoidant attachment, and marital adjustment. These results can be seen in Table 6.

4.3. Correlational Analyses

Before testing the major hypotheses of the study an initial correlation analysis was conducted to whether the correlations of the dependent variables with the control variables, namely education, age and work status, and with the independent variables, namely attachment styles and marital adjustment were significant. According to Baron and Kenny (1986), this is a prerequisite for running regression analyses; that is, control variables and independent variables are entered into regression only if their correlations with the dependent variables are significant; moreover, the correlation coefficient values between the control and dependent variables should be at least .25.

For this purpose, binary Pearson correlation coefficients were computed to examine the relationships between the designated control variables and dependent variables of health behavior and health status in pregnancy which were measured by the total score and subtests of Healthy Lifestyle Behavior Scale-II and Pregnancy Health Status Checklist, respectively.

Table 6. *One-Way Analysis of Variance Results Comparing Education Levels with respect to Main Variables of the Study*

	Middle Education and Lower		High School		University Graduates		Masters and Above		
	M	SD	M	SD	M	SD	M	SD	F-test
Interpersonal Relationships	27,83 [§]	4,13	27,89	4,33	27,65	3,95	27,06	4,88	0,24
Diet	22,47	4,72	24,58	3,75	23,81	4,27	24,00	3,54	1,22
Health Responsibility	24,70	5,14	24,89	4,24	24,46	4,84	23,48	4,24	0,50
Physical Activity	14,07	4,03	15,79	5,36	15,47	4,83	15,97	4,85	0,97
Stress Management	19,10	4,10	20,53	3,56	20,21	4,19	19,32	4,22	0,94
Mental Development	26,90	4,32	28,32	4,22	27,44	4,22	27,90	4,13	0,54
Total Health Behavior	135,07	18,97	142,00	18,37	139,04	19,66	137,74	19,95	0,56
Total Health Status	20,37	5,51	20,83	6,46	19,88	5,94	18,55	4,08	0,77
Emotional Symptoms	8,83	3,11	8,32	3,54	8,16	3,21	7,72	2,72	0,64
First Trimester Symptoms	4,93	2,43	5,78	2,86	5,23	2,63	4,74	1,90	0,76
Last Trimester Symptoms	6,60	1,96	6,84	2,03	6,43	2,06	6,26	1,81	0,39
Anxious Attachment	2,98	0,93	3,33	0,69	3,03	0,91	2,92	0,92	0,87
Avoidant Attachment	3,01	1,00	2,94	0,83	2,61	0,89	2,61	1,08	2,00
Marital Adjustment	40,73	10,30	46,26	8,67	45,20	9,89	44,29	9,72	1,87

[§]df=1, 194

As presented in Table 7, neither work status nor any of the education level variables revealed significant correlations with dependent variables. On the other hand, age had significant negative correlations with total Pregnancy Health Status Checklist Score, First and Third Trimester Symptoms, Healthy Lifestyle Behavior Scale-II's Interpersonal Relationships and Mental Development subtests. In other words, as age increased, the scores of these scales decreased. However, none of these correlation values were above .25, therefore, these demographic variables were not controlled in further analyses.

Hypothesis 1.a & 1.b. A second correlation analysis was conducted to test hypothesis 1.a which is “there will be a positive relationship between marital adjustment and health behavior during pregnancy” and 1.b which is “there will be a positive relationship between secure attachment style and health behavior during pregnancy”. As presented in Table 8, marital adjustment, although low in magnitude, showed significant positive correlations with total score and interpersonal relationships, diet, stress management, and mental development subtests of Healthy Lifestyle Behavior Scale. On the other hand, both anxious attachment and avoidant attachment had low but significant negative correlations with interpersonal relationships, mental development and total score of Healthy Lifestyle Behavior Scale. Avoidant attachment was also significantly correlated with diet subscale as well.

Table 7. *Correlations Concerning Dependent Variables and Psychodemographic Variables*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1	1	.81***	.68***	.68***	-0.03	-0.08	0.12	0.00	-0.12	-0.08	-0.03	0.04	0.05	-0.09	-0.06	-0.06	-.22**
2		1	.26***	.39***	-0.12	-0.11	0.03	-0.02	-.22**	-.20**	-0.13	0.08	0.01	-0.06	-0.03	-0.06	-0.11
3			1	.25***	-0.00	-0.04	.15*	0.06	0.01	0.02	0.05	-0.03	0.07	-0.07	-0.08	-0.05	-.21**
4				1	0.09	0.01	0.08	-0.01	0.01	0.07	0.05	0.02	0.06	-0.04	-0.02	-0.00	-.19**
5					1	.33***	.46***	.30***	.46***	.64***	.71***	0.02	0.02	-0.05	0.06	-0.02	-.16*
6						1	.47***	.44***	.51***	.40***	.70***	-0.12	0.06	0.03	0.13	0.10	-0.00
7							1	.40***	.43***	.50***	.74***	0.02	0.03	-0.08	0.02	0.01	-0.04
8								1	.50***	.43***	.70***	-0.11	0.02	0.05	.15*	0.05	-0.06
9									1	.61***	.78***	-0.08	0.04	-0.06	0.12	0.00	-0.07
10										1	.79***	-0.06	0.06	0.04	0.04	-0.01	-.19**
11											1	-0.07	0.05	-0.01	0.12	0.03	-0.12
12												1	-0.14	-.18**	-0.12	-.33**	-0.13
13													1	-.14*	-0.08	0.04	-0.02
14														1	0.11	0.12	0.08
15															1	0.13	-0.04
16																1	.24**
17																	1

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

1: total health status, 2: emotional symptoms, 3: first trimester symptoms, 4: last trimester symptoms 5: interpersonal relationships, 6: diet, 7: health responsibility, 8: physical activity, 9: stress management, 10: mental development, 11: total score of healthy lifestyle behavior, 12: education level 1, 13: education level 2, 14: education level 3, 15: income level, 16: work status, 17: age

Therefore, Hypothesis 1.a was fully supported for total score of HLBS-II, Interpersonal relationships, stress management, mental development and diet subscales, but was not supported for physical activity and health responsibility subscales. For hypothesis 1.b, the same was true for avoidant attachment and almost for anxious attachment except for diet for which anxious attachment did not show significant correlation.

Table 8. *Correlation Matrix for Hypothesis 1.a and 1.b*

	1	2	3	4	5	6	7	8	9	10
1	1	,33***	,46***	,30***	,46***	,64***	,71***	-,19***	-,28***	,14*
2		1	,47***	,44***	,51***	,40***	,70***	-,13	-,17*	,24**
3			1	,40***	,43***	,50***	,74***	,01	-,11	,05
4				1	,50***	,43***	,70***	-,11	-,04	,06
5					1	,61***	,78***	-,17*	-,23***	,19**
6						1	,79***	-,20**	-,22**	,24**
7							1	-,17*	-,23**	,20**
8								1	,23**	-,19**
9									1	-,33***
10										1

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

1: interpersonal relationships, 2: diet, 3: health responsibility, 4: physical activity, 5: stress management, 6: mental development, 7: total score of healthy lifestyle behavior, 8: anxious attachment, 9: avoidant attachment, 10: marital adjustment

Hypothesis 1.c & 1.d The final correlation analysis was conducted to test hypothesis 1.c which is “there will be a positive relationship between marital adjustment and health status during pregnancy” and 1.d which is “there will be a positive relationship between secure attachment style and health status during pregnancy”. The results are summarized in Table 9. Both marital adjustment and anxious attachment revealed significant, although low, positive correlations with only total and emotional symptom subscale scores of Pregnancy Health Status Checklist. Emotional attachment was positively and significantly correlated with only First Trimester symptoms Subscale. Therefore, Hypotheses 1.c and 1.d were only partially supported.

Table 9. *Correlation Matrix for Hypothesis 1.c and 1.d*

	1	2	3	4	5	6	7
1	1	,81***	,68***	,68***	-,17*	,28***	,11
2		1	,26***	,39***	-,25***	,38***	,13
3			1	,25***	-,02	,09	,17*
4				1	-,03	,04	-,09
5					1	-,19**	-,33***
6						1	,23**
7							1

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

1: total health status, 2: emotional symptoms, 3: first trimester symptoms, 4: last trimester symptoms, 5: marital adjustment, 6: anxious attachment, 7: avoidant attachment

4.4. Regression Analysis

Hypothesis 2.a. To test hypothesis 2.a which is “marital adjustment and secure attachment together will significantly predict the change in health behavior during pregnancy”, regression analysis was needed. Before regression analysis, correlational analyses were conducted and according to their results appropriate regression analyses were conducted too. As it is seen in Table 8, interpersonal relationships, stress management and mental development subdimensions of Healthy Lifestyle Behavior Scale, and total score of HLBS-II are correlated with anxious attachment, avoidant attachment and marital adjustment. Diet subdimension of HLBS-II is correlated with only avoidant attachment and marital adjustment. Health responsibility and physical activity are not correlated with none of them. So, anxious attachment, avoidant attachment and marital adjustment were accounted as predictors of interpersonal relationships, stress management, mental development and total score of HLBS-II in hierarchical linear regression analysis. Another hierarchical linear regression analysis was conducted to see whether avoidant attachment and marital adjustment are predictors of diet. A regression analysis for health responsibility and physical activity subdimensions could not been calculated, because none of them were correlated with anxious attachment, avoidant attachment and marital adjustment. Therefore, as summarized in Table 10, 5 distinct regression analysis were conducted to test for hypothesis 2.a.

Table 10. *The Predictors of the Regression Analyses for each Dependent Variable with Respect to Hypothesis 2.a*

Dependent Variables	Predictors		
	Anxious Attachment	Avoidant Attachment	Marital Adjustment
Total HLBS-II*	X	X	X
Interpersonal Relationships*	X	X	X
Stress Management*	X	X	X
Mental Development*	X	X	X
Diet*	---	X	X
Health Responsibility***	---	---	---
Physical Activity***	---	---	---

*Regression analyses were conducted for these dependent variables.

**Blank spaces designate no predictors.

*** No regression analysis were conducted as none of the predictors were significantly correlated.

According to the first hierarchical linear regression analysis (See Table 11) which was conducted to test for the predicting effects of anxious attachment, avoidant attachment and marital adjustment on total health behavior score, anxious attachment explained 3 % of the variance ($F_{(1,193)}=6.03$, $p<.05$), avoidant attachment explained 4 % of the variance ($F_{(1,192)}=6.03$, $p<.05$), and marital adjustment explained only 1 % of the variance which was insignificant this time ($F_{(1,191)}=2.97$, $p>.05$).

Table 11. *Hierarchical Linear Regression Results: Anxious Attachment, Avoidant Attachment and Marital Adjustment on total score Healthy Lifestyle Behavior Scale-II*

Variables	Beta	T value	R ²	R ² Change	F Change
Step 1					
Anxious Attachment	-.17	-2.45*	.03	.03	6.03*
Step 2					
Anxious Attachment	-.12	-1.79	.07	.04	8.39**
Avoidant Attachment	-.20	-.2.89**			
Step 3					
Avoidant Attachment	-.10	-1.51	.08	.01	2.97
Anxious Attachment	-.16	-2.24*			
Marital Adjustment	.12	1.72			

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

Another hierarchical regression analysis was conducted to test for the predicting effects of anxious attachment, avoidant attachment and marital adjustment on interpersonal relationships (See Table 12). The analysis revealed that anxious attachment explained 3 % of the variance ($F_{(1,193)}=7.19, p<.01$), avoidant attachment explained 6 % of the variance ($F_{(1,192)}=12.91, p<.001$), and marital adjustment explained 0.1 % of the variance which was insignificant this time ($F_{(1,191)}=0.29, p>.05$).

Table 12. *Hierarchical Linear Regression Results: Anxious Attachment, Avoidant Attachment and Marital Adjustment on Interpersonal Relationships Subdimension of HLBS-II*

Variables	Beta	T value	R ²	R ² Change	F Change
Step 1					
Anxious Attachment	-.19	-2.68**	.03	.03	7.19**
Step 2					
Anxious Attachment	-.12	-1.82	.09	.06	12.91***
Avoidant Attachment	-.25	-.3.59***			
Step 3					
Avoidant Attachment	-.12	-1.74	.09	.001	.29
Anxious Attachment	-.24	-3.24**			
Marital Adjustment	.04	.54			

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

The third hierarchical linear regression analysis was conducted to test for the predicting effects of anxious attachment, avoidant attachment and marital adjustment on stress management (See Table 13). According to this analysis, anxious attachment explained 3 % of the variance ($F_{(1,193)}=6.19$, $p<.05$), avoidant attachment explained 3 % of the variance ($F_{(1,192)}=8.02$, $p<.01$), and marital adjustment explained 1 % of the variance which was not significant ($F_{(1,191)}=2.36$, $p>.05$).

Table 13. *Hierarchical Linear Regression Results: Anxious Attachment, Avoidant Attachment and Marital Adjustment on Stress Management Subdimension of HLBS-II*

Variables	Beta	T value	R ²	R ² Change	F Change
Step 1					
Anxious Attachment	-.17	-2.49*	.03	.03	6.19*
Step 2					
Anxious Attachment	-.12	-1.78	.07	.03	8.02**
Avoidant Attachment	-.20	-2.83**			
Step 3					
Avoidant Attachment	-.11	-1.58	.08	.01	2.36
Anxious Attachment	-.16	-2.23*			
Marital Adjustment	.11	1.53			

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

The fourth hierarchical linear regression analysis conducted to test for the predicting effects of anxious attachment, avoidant attachment and marital adjustment on mental development (See Table 14). This analysis revealed that anxious attachment explained 4 % of the variance ($F_{(1,193)}=8.42$, $p<.01$), avoidant attachment explained 3 % of the variance ($F_{(1,192)}=6.72$, $p<.05$), and marital adjustment explained 2 % of the variance ($F_{(1,191)}=5.39$, $p<.05$).

Table 14. *Hierarchical Linear Regression Results: Anxious Attachment, Avoidant Attachment and Marital Adjustment on Mental Development Subdimension of HLBS-II*

Variables	Beta	T value	R ²	R ² Change	F Change
Step 1					
Anxious Attachment	-.20	-2.90**	.04	.04	8.42**
Step 2					
Anxious Attachment	-.16	-2.24*	.07	.03	6.72*
Avoidant Attachment	-.18	-.2.59*			
Step 3					
Avoidant Attachment	-.14	-1.96	.10	.02	5.39*
Anxious Attachment	-.13	-1.78			
Marital Adjustment	.17	2.32*			

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

The final hierarchical linear regression analysis run to test for the predicting effects of anxious attachment, and marital adjustment on diet (See Table 15). It demonstrated that anxious attachment explained 3 % of the variance ($F_{(1,193)}=6.21$, $p<.05$), and marital adjustment explained 3 % of the variance ($F_{(1,192)}=7.80$, $p<.01$).

Table 15. *Hierarchical Linear Regression Results: Anxious Attachment and Marital Adjustment on Diet Subdimension of HLBS-II*

Variables	Beta	T value	R ²	R ² Change	F Change
Step 1					
Anxious Attachment	-.17	-2.49*	.03	.03	6.21*
Step 2					
Anxious Attachment	-.10	-1.43	.06	.03	7.80**
Marital Adjustment	.20	.20**			

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

Hypothesis 2.b. To test hypothesis 2.b which is “marital adjustment and secure attachment together will significantly predict the change in health status during pregnancy”, regression analysis was conducted. Before regression analysis, correlational analyses were conducted and according to their results appropriate regression analyses to test this hypothesis were conducted too. As it is seen in Table 9. Total health status and emotional symptoms were significantly positively correlated with anxious attachment and marital adjustment. First trimester complaints were only positively correlated with avoidant attachment. Last trimester complaints were not correlated with none of them significantly. Then, anxious attachment and marital adjustment were accounted as predictors of total health status and emotional symptoms. Avoidant attachment was accounted as the predictor of first trimester complaints. A regression analysis for last trimester complaints could not be calculated, because it was not correlated with anxious attachment, avoidant attachment

and marital adjustment. Therefore, 3 distinct regression analysis were employed which are summarized in Table 16.

Table 16. *The Predictors of the Regression Analyses for each Dependent Variable with Respect to Hypothesis 2.b*

Dependent Variables	Predictors		
	Anxious	Avoidant	Marital
	Attachment	Attachment	Adjustment
Total PHSC*	X	---**	X
Emotional Symptoms*	X	---	X
First Trimester Symptoms*	---	X	---
Third Trimester Symptoms***	---	---	---

*Regression analyses were conducted for these dependent variables.

**Blank spaces designate no predictors.

*** No regression analysis were conducted as none of the predictors were significantly correlated.

According to the first hierarchical linear regression analysis (See Table 17) to test for the predicting effects anxious attachment, and marital adjustment on total health status in pregnancy, anxious attachment explained 8 % of the variance ($F_{(1,189)}=17.24$, $p<.001$), and marital adjustment explained only 1 % of the variance which was insignificant ($F_{(1,188)}=3.59$, $p>.05$).

Table 17. *Hierarchical Linear Regression Results: Anxious Attachment and Marital Adjustment on Total Health Status in Pregnancy*

Variables	Beta	T value	R ²	R ² Change	F Change
Step 1					
Anxious Attachment	.28	4.15***	.08	.08	17.24***
Step 2					
Anxious Attachment	.26	3.79***	.10	.01	3.59
Marital Adjustment	-.13	-1.89			
*p<.05, **p<.01, ***p<.001					

According to the second hierarchical linear regression analysis (See Table 18) employed to test for the predicting effects anxious attachment, and marital adjustment on emotional symptoms, anxious attachment explained 14 % of the variance ($F_{(1,190)}=32.87$, $p<.001$), and marital adjustment explained only 3 % of the variance ($F_{(1,189)}=8.52$, $p<.01$).

According to the final hierarchical linear regression analysis (See Table 19) where the predicting effects avoidant attachment on first trimester complaints were investigated, avoidant attachment explained 3 % of the variance ($F_{(1,192)}=5.71$, $p<.05$).

Table 18. *Hierarchical Linear Regression Results: Anxious Attachment and Marital Adjustment on Emotional Symptoms*

Variables	Beta	T value	R ²	R ² Change	F Change
Step 1					
Anxious Attachment	.38	5.73***	.14	.14	32.87***
Step 2					
Anxious Attachment	.35	5.25***	.18	.03	8.52**
Marital Adjustment	-.19	-2.92**			
*p<.05, **p<.01, ***p<.001					

Table 19. *Hierarchical Linear Regression Results: Avoidant Attachment on First Trimester Symptoms*

Variables	Beta	T value	R ²	R ² Change	F Change
Step 1					
Avoidant Attachment	.17	2.39*	.03	.03	5.71*
*p<.05, **p<.01, ***p<.001					

CHAPTER 5

DISCUSSION

The first goal of the study was to investigate whether there is a relationship between marital adjustment, adult attachment, health behavior, and health status during pregnancy. The second goal of the study was to investigate if marital adjustment and adult attachment predict health behavior and also health status during pregnancy period. Finally, pregnant women were compared in terms of working status and education levels on the main variables of the study. The findings of the particular study were presented in the Results section previously. In this part, those findings will be discussed by referring to the literature related with them in detail and clinical implications, limitations of the study and suggestions for the future studies will be presented.

5.1. General Evaluation of the Results

According to the result of independent samples t-test, pregnant women who work during pregnancy have lower levels of avoidant attachment and higher levels of marital adjustment than housewives. There are different findings about this issue in the literature. In a study done with Nigerian women, it was not found an association between marital adjustment and working status of women (Jamabo, and Ordu, 2012). According to another study (Hashmi et al., 2007) which was done with Pakistani women, working married women may have more problems in their marriages than non-working women, however if working women were highly educated, they were not

much affected from this factor. In the present study, the sample was highly educated and working pregnant women were more securely attached to their partners in the findings and their marital adjustment levels were higher. It was consistent with Hashmi et al.'s (2007) study in some sense, because working women in the present study have higher education levels. Possibly different sample characteristics yield different results.

In the correlation analysis, whether there is a relationship between marital adjustment, adult attachment, and health behavior of pregnant women was tested. Emotional symptoms of pregnant women as measured by Pregnancy Health Status Checklist have negative relationships between stress management and mental development. Specifically when pregnant women feel “lonely” and “pessimistic and bad”, their stress management levels may decline according to the results. Emotions seem to be critical for coping behaviors in pregnancy, because pregnant women who have emotional problems cannot manage stress well. It may be due to several problems like they may have an additional depressive problems which were not studied in the present study. In a study, a significant association between perceived stress and especially emotional loneliness was found (McHugh, & Lawlor, 2013). Pregnant women who participated in this study may not be lonely, because they have generally their spouses. However they may have “emotional loneliness”. This issue has a strong association between their stress levels and coping with stress according to the findings of the study.

According to the results, when interpersonal relationships subscale of Healthy Lifestyle Behavior Scale-II increases, marital adjustment level increases, but anxious

and avoidant attachment scores decreases. Meanly, pregnant women who are good in interpersonal relationships are more securely attached to their partners and they have more adjusted marriages. It is consistent with the literature, because in Oktay and Batıgün (2014)'s study, people who have high anxious and avoidant attachment score have problems in interpersonal relationships. Their adult attachment styles might interfere with their behaviors in social context. This finding is also consistent with Jensen et al.'s (2015) study, because they found that adult attachment is acting as a significant mediator between interpersonal processes and marital outcomes.

According to the correlational results of the particular study, when total health behavior score, stress management, and mental development increase, marital adjustment level increases and insecure attachment level decreases. Both anxious and avoidant attachment styles have negative relationships with marital adjustment. Those findings are consistent with Burman and Margolin (1992)'s hypothetical model of the relationship between marital variables and health status (See Figure 2.). In this model, marital factors have relationship with stress and support, psychological processes like cognitions, affect and health behavior, coping strategies, physiological consequences and finally health status. As seen in the figure, stress and support are main factors on other dimensions according to this model. In addition, people who have high marital adjustment level has lower distress levels, employs more number of coping strategies and uses more frequently coping strategies than people in low marital adjustment group (McLaughlin et al., 1988).

In another correlation analysis to test hypothesis 1.c which is “there will be a positive relationship between marital adjustment and health status during pregnancy”

and 1.d which is “there will be a positive relationship between secure attachment style and health status during pregnancy”, those hypotheses were partially confirmed. When health complaints of pregnant women increase, marital adjustment level decreases, but anxious attachment score increases. However, it was not associated with avoidant attachment significantly. Emotional symptoms were associated with anxious attachment, whereas first trimester symptoms were associated with avoidant attachment style. It may be due to pregnant women who have emotional symptoms may have anxiety related problems, however pregnant women who have first trimester symptoms like nausea, and odor sensitivity may need to avoid from people for a while to prevent and show those physical complaints in public situations. In Trillingsgaard et al.’s (2011) study, attachment anxiety was associated with high pregnancy worry compared to attachment avoidance. This finding is consistent with the present study, and meanly when pregnant women have emotional problems during pregnancy, these problems interfere with attachment anxiety rather than attachment avoidance. In addition, attachment anxiety and avoidance were found as associated with high parenting stress after the birth according to the same study (Trillingsgaard et al., 2011). So, attachment styles during pregnancy are also critical for emotional issues of partners when they become parents.

According to the hierarchical linear regression analysis to test hypothesis 2.a which is “marital adjustment and secure attachment together significantly predict the change in health behavior during pregnancy”, both anxious attachment and avoidant attachment predicted the change in health behavior during pregnancy. However, marital adjustment did not significantly predict health behavior in the findings of the

study. It is consistent with Pietromonaco et al.'s (2013) study, because in their model, attachment styles of partners may shape relationship behaviors; and it may influence and be influenced by physiological responses, affect, health behavior, and finally health and disease outcomes. It was seen that insecure attachment styles but not marital adjustment are predictors of health behavior during pregnancy, however whether they predict health status in pregnancy or not will be discussed later on. In another study (Huntsinger, & Lueken, 2003), secure styles had better health behavior and there is no significant difference between other nonsecure groups. This is consistent with the present study, because pregnant women who have high anxious and anxiety scores have lower health behavior scores.

In hierarchical regression analyses, anxious attachment and avoidant attachment, but not marital adjustment predicted the change in both interpersonal relationships and stress management subscales of Healthy Lifestyle Behavior Scale-II. Anxious attachment, avoidant attachment and marital adjustment together predicted the change in mental development. Anxious attachment and marital adjustment were predictors of diet subscale according to the results. Interpersonal relationships, stress management, mental development and diet variables are factors of Healthy Lifestyle Behavior Scale-II as mentioned before. Their relationships with each other and main variables like attachment anxiety, attachment avoidance and marital adjustment were given before.

When the predicting effects of attachment styles on interpersonal relationships and stress management were evaluated, a thought about "people who have insecure adult attachment styles may have higher stress levels and at the end, their stress

management capabilities may be forced by this reason” can come to the minds. According to a study (Pietromonaco et al., 2013), this thought was supported, because it was found that “attachment insecurity predicts different cortisol patterns in response to stress than does attachment security, especially when the stressor potentially threatens the relationship”. Like a vicious cycle, couples who have insecure attachment may have more stress levels, and this stress may contribute to their insecurity. Hamarta, Deniz, and Sartalı (2009) found a significant positive association between subscales of emotional intelligence like interpersonal relationships, stress management, general mood and secure attachment style. This finding is also consistent with the results of the particular study, because it was found that attachment style predicted interpersonal relationships and stress management levels of pregnant women.

For testing the hypothesis 2.b, hierarchical regression analyses were conducted, and only anxious attachment predicted the change in total health status during pregnancy. Anxious attachment and marital adjustment predicted emotional symptoms. Avoidant attachment predicted first trimester symptoms. Though marital adjustment did not predict health status in pregnancy according to this study, in a study, poor marital adjustment is seen as a risk factor for poorer health (Whishman, & Uebelacker, 2012). According to Kiecolt-Glaser and Newton (2001)’s study, marital functioning is direct and indirect influences on health outcomes. Indirect influences are on depression and health habits and direct influences are on cardiovascular, endocrine, immune, neurosensory, and other physiological mechanisms.

Marital functioning of pregnant women is important for health behavior and current health status. According to Demir and Fişiloğlu (1997)'s study, loneliness was significantly and negatively correlated with marital adjustment especially for arranged type of marriages rather than self-selected marriages. Associations between feeling lonely and marital adjustment can be due to actual loneliness. In a study done with elderly couples it was found that as psychological well-being increases, marital adjustment increases too (Kumar, 2015). In another study (McWilliams & Bailey, 2010) which underlines the relationship of attachment and health, it is found that insecure attachment is an important risk factor for illnesses especially conditions related with cardiovascular system.

In the present study, participants were pregnant women and avoidant attachment score predicted first trimester symptoms like nausea and odor sensitivity. Its reason can be that insecure attachment styles are associated with physical problems which are commonly seen in the pregnancy period. An association between avoidant attachment and first trimesters complaints could not be found in the literature; however, in a study, it is asserted that if a woman is avoidant, she desires less to become mother during transition to parenthood period (Rholes et al., 2006). Avoidant women's point of view toward pregnancy may become more negative than secure women and this negativity may cause to an elevation of first trimester complaints or exaggeration of them. Desrosier et al.'s (2013) study may have a contribution to this idea so that according to their study, avoidant and anxious attachment of pregnant women was positively associated with mood problems. If pregnant women have emotional problems, then first trimester complaints nausea and vomiting can be seen

more (Kuğu, & Akyüz, 2001). As it was expressed, attachment styles of pregnant women, their mood, physical, and also emotional health status are interrelated much during pregnancy period.

5.2. Clinical Implications of the Study

High anxious and avoidant attachment scores are associated with low marital adjustment scores according to the findings of the present study. Based on this finding, some interventions for pregnant women and their spouses can be suggested. In transition to parenthood period, keeping marital functioning well is important. Interventions can start even before pregnancy, to begin this period healthy as much as possible. Psychological counseling and couples therapy in pregnancy and pre-pregnancy period may be done. It can help couples to keep marital adjustment levels high and attach themselves more securely. Additionally, learning effective coping strategies for both of partners can also be helpful to prevent negative issues that can appear during pregnancy and postpartum period. These interventions can also be beneficial when dealing with parenting stress after pregnancy period. In this way, couples can work together, and share housework and child rearing issues more effectively.

We know that health behaviors during pregnancy period are important for health of both women and her growing baby. To provide courses in which information about these issues are provided, can be very effective. It is helpful for pregnant women, to do milder exercises; as a secondary gain they socialize with the benefits of this way and they meet other pregnant women like support groups. Adding partners to

these activities can also be helpful for their attachment, marital functioning and preparation to the parenthood.

According to the results of the present study, health complaints of pregnant women are associated with anxious attachment score. Especially, when health professionals deal with health related issues like vomiting, constipation, backache they can mind attachment and marital functioning of pregnant women. In Kuğu and Akyüz (2001)'s study, severe nausea and vomiting during pregnancy period was associated with psychological and marital conflict. So, educating health professionals to be sensitive to familial concerns when evaluating health of pregnant women can be very helpful for the benefit of them. May be some couples who have severe distress can be referred to family therapy.

When we evaluate the relations between working or being housewives and marital adjustment in pregnancy according to the results; working women have more adjusted marriages. We can expect more stressful life for pregnant women who work, however, it is associated with adjusted marriages. Encouraging women to work with special rights to their special position during transition to parenthood and beyond can be important and beneficial for their psychology and marital functioning.

3.5. Limitations of the Study

First limitation of the study can be its application procedure. Because the data was collected via internet, we rely on the reports of the participants about their information and answers. Additionally, the sample consists of only pregnant women who use internet and online pregnancy forums which means at least they are a group

has internet literacy. We do not have information about pregnant women who do not use internet.

The sample of the study consists of highly educated participant group which makes it hard to generalize as well. A more balanced sample type can be helpful to generalize findings to Turkey conditions.

In the present study, health status of pregnant women were investigated with the items which were found in Sunal and Demiryay (2009)'s study. It was not evaluated that other health related complaints of pregnant women than those complaints. Additionally, if they have any chronic diseases or past operations were not also asked to the participants. In the future studies, researchers may add those variables to their studies to be able to know exact health status of pregnant women.

5.3. Suggestions for Future Studies

Because in the present study data gathered by an online pregnancy forum, participants were just women who use computer and internet, in future studies participants can be chosen from real life. They can also gather data from different socioeconomic status to reach more generalizable results.

In this study, only pregnant women answered the questions, not their spouses. In the future studies, their spouses can be included to the study to see their attachment and marital adjustment level. It can be beneficial when comparing which partners' scores are congruent or not. So, evaluating both of pregnant women and their spouses together may serve additional information. In future studies, increasing sample size is again important for generalization of results.

Health status of pregnant women were evaluated with Pregnancy Health Status Checklist which was generated according to the findings in Sunal and Demiryay (2009)'s study. Pregnant women may have other complaints than those restricted complaints, chronic diseases or operations. Those health concerns may also be related with other study variables. So, in the future studies wider examination of health status of pregnant women may be beneficial.

In this study, the relationship between marital adjustment, attachment, health status and health behaviors of pregnant women were evaluated. In the present studies, other measures that investigate marital functioning like marital satisfaction or suppose support can be used. By this way, effects of concept differences in pregnancy period and their relations with other measures can be seen.

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APPENDICES

APPENDIX A

Bilgilendirilmiş Onam Formu / Informed Consent

Sayın Katılımcı,

Bu çalışma Fatih Üniversitesi Sağlık Psikolojisi Anabilim Dalı bünyesinde yüksek lisans öğrencisi Ebru Yıldırımli tarafından yapılmaktadır. Çalışmanın amacı hamilelerde evlilik uyumu, bağlanma, sağlık davranışı ve sağlık durumu arasındaki ilişkiyi incelemektir.

Çalışmaya katılmak tamamen gönüllülük esasına bağlıdır. Çalışmanın herhangi bir rahatsızlığa sebep olacağı düşünülmemesine rağmen çalışmadan ya da başka bir sebepten dolayı rahatsızlık hissederseniz anketi cevaplamayı istediğiniz zaman bırakabilirsiniz. Çalışmanın sonucunda elde edilecek bilgiler toplu olarak değerlendirilecek ve gizli tutularak bilimsel araştırma kapsamında kullanılacaktır. Sizden istenen soruları size en uygun haliyle ve eksiksiz olarak cevaplamanızdır. Çalışmayı yanıtlamanız, araştırmaya katılım için onam verdiğiniz biçiminde yorumlanacaktır. Anketi cevaplamanız yaklaşık olarak 15 dakika sürmektedir. Çalışma ile ilgili sorularınız olursa ya da çalışmanın sonuçları hakkında bilgi edinmek isterseniz Ebru Yıldırımli (E-posta: yildirimli.ebru@gmail.com) ile iletişim kurabilirsiniz. Şimdiden çalışmaya zaman ayırdığınız için teşekkür ederiz.

APPENDIX B

Demografik Bilgi Formu / Demographic Information Form

Yaş:

Eğitim Durumu:

Okuryazar

İlkokul

Ortaokul

Lise

Önlisans

Lisans

Yüksek Lisans ve Üzeri

Çalışıyor musunuz:

Evet

Hayır

Mesleğiniz:

Hamile kalmayı istiyor muydunuz:

Evet

Hayır

Kararsızım

Kaç haftalık hamilesiniz:

Kaçıncı çocuğunuza hamilesiniz:

1

2

3

4 ve üzeri

Evlenme şekliniz:

Görücü usulü

Kendiniz tanışarak

Arkadaş vasıtasıyla

Diğer

Kaç yıllık evlisiniz:

Eşinizin yaşı:

Gelir durumunuz:

Çok düşük

Düşük

Orta

Yüksek

Çok yüksek

Sigara ve alkol kullanma durumunuz:

Sigara

Alkol

Sigara ve alkol

Hiçbiri

APPENDIX C

Hamilelik Sağlık Durumu Listesi / Pregnancy Health Status Checklist

1. Sık idrara çıkma

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
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2. Yorgunluk

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
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3. Bulantı, kusma

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
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4. Bel ağrısı

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
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5. Kokulara karşı hassasiyet

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
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6. Hazımsızlık

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

7. Gereksiz yere sinirlenme

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
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8. Şişkinlik

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

9. Gebelik ve doğum hakkında endişelenme

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

10. Aşırme

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

11. Günlük fiziksel aktivitelerde azalma

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

12. Günlük fiziksel aktivitelerde artma

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

13. Baş ağrısı

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

14. Cinsel istekte artma

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

15. Cinsel istekte azalma

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

16. Sıcak basması

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

17. Bacak krampları

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

18. İştah artma

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
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19. İştah azalma

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

20. Karamsar ve kötü hissetme

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

21. Enerjik ve çok mutlu hissetme

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

22. Kabızlık

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

23. Diş ağrısı

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

24. Uyumada güçlük

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

25. Kendini yalnız hissetme

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

26. Şimdiki görünüşünden mutlu olmama

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

27. Hemoroid/Basur

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

28. İshal

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
-----------------------	---	---	---	---	---	------------------------

29. Gebelik Diyabeti

Hiç şikayetçi değilim	1	2	3	4	5	Çok fazla şikayetçiyim
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APPENDIX D

Evlilik Uyum Ölçeği / Marital Adjustment Scale

1. Evliliğinizin mutluluk derecesi

0. Kötü
1. Çok mutsuz
2. Mutsuz
3. Fena değil
4. Mutlu
5. Çok mutlu
6. Aşırı mutlu

Lütfen evliliğinizi en iyi ifade ettiğine inandığınız bir cevabı işaretleyiniz

	Her zaman anlaşırsınız	Hemen her zaman anlaşırsınız	Ara sıra anlaşılamadığımız olur	Sıklıkla anlaşılamayız	Hemen her zaman anlaşılamayız	Hiç anlaşılamayız
2. Aile bütçesini idare etme						
3. Boş zaman etkinlikleri						
4. Duyguların ifadesi						
5. Arkadaşlar						
6. Cinsel ilişkiler						
7. Toplumsal kurallara uyma						
8. Yaşam felsefesi						
9. Eşin arkadaşlarıyla anlaşma						

10. Ortaya çıkan uyumsuzluklar genellikle:

- Erkeğin susması ile ()
Kadının susması ile ()
Karşılıklı tavizlerle anlaşmaya varılarak () sonuçlanır.

11. Ev dışı etkinliklerinizin ne kadarını eşinizle birlikte yaparsınız?

- Hepsini ()
Bazılarını ()
Çok azını ()
Hiçbirini ()

12. Boş zamanlarınızda genellikle aşağıdakilerden hangisini tercih edersiniz?

- Bir şeyler yapmayı ()
Evde oturmayı ()

*** Eşiniz genellikle aşağıdakilerden hangisini tercih eder?**

- Bir şeyler yapmayı ()
Evde oturmayı ()

13. Hiç evlenmemiş olmayı istediğiniz olur mu?

- Sık sık ()
Arada sırada ()
Çok seyrek ()
Hiçbir zaman ()

14. Hayatınızı yeniden yaşatabilseydiniz...

- Aynı kişiyle evlenirdiniz ()
Farklı bir kişiyle evlenirdiniz ()
Hiç evlenmezsiniz ()

15. Eşinize güvenir, sırlarınızı ona açar mısınız?

- Hemen hemen hiçbir zaman ()
Nadiren ()
Çoğu konularda ()
Her konuda ()

APPENDIX E

Yakın İlişkilerde Yaşantılar Envanteri II (YİYE-II) /Experiences in Close Relationships Inventory II

Aşağıdaki maddeler romantik ilişkilerinizde hissettiğiniz duygularla ilgilidir. Bu araştırmada sizin ilişkinizde yalnızca şu anda değil, genel olarak neler olduğuyla ya da neler yaşadığınızla ilgilenmekteyiz. Maddelerde sözü geçen "birlikte olduğum kişi" ifadesi ile romantik ilişkide bulunduğunuz kişi kastedilmektedir. Eğer halihazırda bir romantik ilişki içerisinde değilseniz, aşağıdaki maddeleri bir ilişki içinde olduğunuzu varsayarak cevaplandırınız. Her bir maddenin ilişkilerinizdeki duygu ve düşüncelerinizi ne oranda yansıttığını karşısındaki 7 aralıklı ölçek üzerinde, ilgili rakam üzerine işaret (X) koyarak gösteriniz.

1-----2-----3-----4-----5-----6-----7
Hiç katılmıyorum Kararsızım/ fikrim yok Tamamen katılıyorum

1. Birlikte olduğum kişinin sevgisini kaybetmekten korkarım.

1-----2-----3-----4-----5-----6-----7

2. Gerçekte ne hissettiğimi birlikte olduğum kişiye göstermemeyi tercih ederim.

1-----2-----3-----4-----5-----6-----7

3. Sıklıkla, birlikte olduğum kişinin artık benimle olmak istemeyeceği korkusuna kapılırım.

1-----2-----3-----4-----5-----6-----7

4. Özel duygu ve düşüncelerimi birlikte olduğum kişiyle paylaşmak konusunda kendimi rahat hissedirim.

1-----2-----3-----4-----5-----6-----7

5. Sıklıkla, birlikte olduğum kişinin beni gerçekten sevmediği kaygısına kapılırım.

1-----2-----3-----4-----5-----6-----7

6. Romantik ilişkide olduğum kişilere güvenip dayanmak konusunda kendimi rahat bırakmakta zorlanırım.

1-----2-----3-----4-----5-----6-----7

7. Romantik ilişkide olduğum kişilerin beni, benim onları önemsedığım kadar önemsemeyeceklerinden endişe duyarım.

1-----2-----3-----4-----5-----6-----7

8. Romantik ilişkide olduğum kişilere yakın olma konusunda çok rahatımdır.

1-----2-----3-----4-----5-----6-----7

9. Sıklıkla, birlikte olduğum kişinin bana duyduğu hislerin benim ona duyduğum hisler kadar güçlü olmasını isterim.

1-----2-----3-----4-----5-----6-----7

10. Romantik ilişkide olduğum kişilere açılma konusunda kendimi rahat hissetmem.

1-----2-----3-----4-----5-----6-----7

11. İlişkilerimi kafama çok takarım.

1-----2-----3-----4-----5-----6-----7

12. Romantik ilişkide olduğum kişilere fazla yakın olmamayı tercih ederim.

1-----2-----3-----4-----5-----6-----7

13. Benden uzakta olduğunda, birlikte olduğum kişinin başka birine ilgi duyabileceği korkusuna kapılırım.

1-----2-----3-----4-----5-----6-----7

14. Romantik ilişkide olduğum kişi benimle çok yakın olmak istediğinde rahatsızlık duyarım.

1-----2-----3-----4-----5-----6-----7

15. Romantik ilişkide olduğum kişilere duygularımı gösterdiğimde, onların benim için aynı şeyleri hissetmeyeceğinden korkarım.

1-----2-----3-----4-----5-----6-----7

16. Birlikte olduğum kişiyle kolayca yakınlaşabilirim.

1-----2-----3-----4-----5-----6-----7

17. Birlikte olduğum kişinin beni terkedeceğinden pek endişe duymam.

1-----2-----3-----4-----5-----6-----7

18. Birlikte olduğum kişiyle yakınlaşmak bana zor gelmez.

1-----2-----3-----4-----5-----6-----7

19. Romantik ilişkide olduğum kişi kendimden şüphe etmeme neden olur.

1-----2-----3-----4-----5-----6-----7

20. Genellikle, birlikte olduğum kişiyle sorunlarımı ve kaygılarımı tartışırım.

1-----2-----3-----4-----5-----6-----7

21. Terk edilmekten pek korkmam.

1-----2-----3-----4-----5-----6-----7

22. Zor zamanlarımda, romantik ilişkide olduğum kişiden yardım istemek bana iyi gelir.

1-----2-----3-----4-----5-----6-----7

23. Birlikte olduğum kişinin, bana benim istediğim kadar yakınlaşmak istemediğini düşünürüm.

1-----2-----3-----4-----5-----6-----7

24. Birlikte olduğum kişiye hemen hemen her şeyi anlatırım.

1-----2-----3-----4-----5-----6-----7

25. Romantik ilişkide olduğum kişiler bazen bana olan duygularını sebepsiz yere değiştirirler.

1-----2-----3-----4-----5-----6-----7

26. Başımdan geçenleri birlikte olduğum kişiyle konuşurum.

1-----2-----3-----4-----5-----6-----7

27. Çok yakın olma arzum bazen insanları korkutup uzaklaştırır.

1-----2-----3-----4-----5-----6-----7

28. Birlikte olduğum kişiler benimle çok yakınlaştığında gergin hissederim.

1-----2-----3-----4-----5-----6-----7

29.Romantik ilişkide olduğum bir kişi beni yakından tanıdıkça, “gerçek ben”den hoşlanmayacağından korkarım.

1-----2-----3-----4-----5-----6-----7

30.Romantik ilişkide olduğum kişilere güvenip dayanma konusunda rahatımdır.

1-----2-----3-----4-----5-----6-----7

31.Birlikte olduğum kişiden ihtiyaç duyduğum şefkat ve desteği görememek beni öfkelerir.

1-----2-----3-----4-----5-----6-----7

32.Romantik ilişkide olduğum kişiye güvenip dayanmak benim için kolaydır.

1-----2-----3-----4-----5-----6-----7

33.Başka insanlara denk olamamaktan endişe duyarım

1-----2-----3-----4-----5-----6-----7

34.Birlikte olduğum kişiye şefkat göstermek benim için kolaydır.

1-----2-----3-----4-----5-----6-----7

35.Birlikte olduğum kişi beni sadece kızgın olduğumda önemser.

1-----2-----3-----4-----5-----6-----7

36.Birlikte olduğum kişi beni ve ihtiyaçlarımı gerçekten anlar.

1-----2-----3-----4-----5-----6-----7

APPENDIX F

Sağlıklı Yaşam Biçimleri Davranışları Ölçeği II / Healthy Lifestyle Behavior Scale II

Bu ankette şu anki yaşam tarzınız ve alışkanlıklarınız ile ilgili sorular yer almaktadır. Lütfen soruları mümkün olduğu kadar doğru ve eksiksiz yanıtlayınız. Her alışkanlığınızın sıklığını uygun seçeneğe çarpı atarak belirtiniz. Hiçbir zaman, bazen, sık sık ve düzenli olarak değerlendirilmektedir.

1	2	3	4
Hiçbir zaman	Bazen	Sık sık	Düzenli olarak

1. Bana yakın olan kişilerle endişelerimi ve sorunlarımı konuşurum.

1	2	3	4
---	---	---	---

2. Yağı düşük, doymuş yağı düşük ve kolesterolü düşük bir diyeti tercih ederim.

1	2	3	4
---	---	---	---

3. Doktora ya da bir sağlık görevlisine, vücudumdaki olağandışı belirti ve bulguları anlatırım.

1	2	3	4
---	---	---	---

4. Düzenli bir egzersiz programı yaparım.

1	2	3	4
---	---	---	---

5. Yeterince uyurum.

1	2	3	4
---	---	---	---

6. Olumlu yönde değiştiğimi ve geliştiğimi hissedirim.

1	2	3	4
---	---	---	---

7. İnsanları başarıları için takdir ederim.

1	2	3	4
---	---	---	---

8. Şekerli ve şeker içeren gıdaları (tatlı vb.) kısıtlı tüketirim.

1	2	3	4
---	---	---	---

9. Televizyonda sağlığı geliştirici programları izler ve bu konularla ilgili kitapları okurum.

1	2	3	4
---	---	---	---

10. Haftada en az 3 kez 20 dakika veya daha uzun süreli tempolu egzersiz yaparım (hızlı yürüyüş, bisiklete binme, aerobik, dans ve step egzersiz gibi)

1	2	3	4
---	---	---	---

11. Her gün gevşemek için zaman ayırırım.

1	2	3	4
---	---	---	---

12. Yaşamamın bir amacı olduğuna inanırım.

1	2	3	4
---	---	---	---

13. İnsanlarla anlamlı ve doyurucu ilişkiler sürdürürüm.

1	2	3	4
---	---	---	---

14. Her gün ekmek, tahıl, pirinç ve makarnadan toplam 6-11 porsiyon yerim.

1	2	3	4
---	---	---	---

15. Sağlık personeline önerilerini anlamak için soru sorarım.

1	2	3	4
---	---	---	---

16. Hafif ve orta düzeyde fiziksel aktivitede bulunurum (Örneğin haftada 5 kez ya da daha

fazla, 30-40 dakika kesintisiz yürürüm.).

1	2	3	4
---	---	---	---

17. Yaşamımda değiştiremeyeceğim şeyleri kabullenirim.

1	2	3	4
---	---	---	---

18. Geleceğe umutla bakarım.

1	2	3	4
---	---	---	---

19. Yakın arkadaşlarıma zaman ayırırım.

1	2	3	4
---	---	---	---

20. Her gün 2-4 porsiyon meyve yerim.

1	2	3	4
---	---	---	---

21. Her zaman gittiğim sağlık personelinin önerileri ile ilgili kaygılarım olduğunda başka bir sağlık personeline danışırım.

1	2	3	4
---	---	---	---

22. Boş zamanlarımda yüzme, dans etme, bisiklete binme gibi eğlendirici fizik aktiviteler yaparım.

1	2	3	4
---	---	---	---

23. Uyumadan önce güzel şeyler düşünürüm.

1	2	3	4
---	---	---	---

24. Kendimle barışık ve kendimi yeterli hissederim.

1	2	3	4
---	---	---	---

25. Başkalarına ilgi, sevgi ve yakınlık göstermek benim için kolaydır.

1	2	3	4
---	---	---	---

26. Her gün 3-5 porsiyon sebze yerim.

1	2	3	4
---	---	---	---

27. Sağlık sorunlarımı sağlık personeliyle konuşurum.

1	2	3	4
---	---	---	---

28. Haftada en az 3 kere kas güçlendirme egzersizleri yaparım.

1	2	3	4
---	---	---	---

29. Stresimi kontrol etmek için uygun yöntemleri kullanırım.

1	2	3	4
---	---	---	---

30. Hayatımdaki uzun vadeli amaçlar için çalışırım.

1	2	3	4
---	---	---	---

31. Sevdiğim kişilerle kucaklaşıyorum.

1	2	3	4
---	---	---	---

32. Her gün 3-4 porsiyon süt, yoğurt veya peynir yerim.

1	2	3	4
---	---	---	---

33. Vücudumu fiziksel değişiklikler, tehlikeli bulgular bakımından ayda en az bir kez kontrol ederim.

1	2	3	4
---	---	---	---

34. Günlük işler sırasında egzersiz yaparım (örneğin, yemeğe yürüyerek giderim,asansör yerine merdiven kullanırım, arabamı uzağa park eder ve yürürüm.).

1	2	3	4
---	---	---	---

35. İş ve eğlence zamanımı dengelerim.

1	2	3	4
---	---	---	---

36. Her gün yapacak değişik ve ilginç şeyler bulurum.

1	2	3	4
---	---	---	---

37 Mahrem ihtiyaçlarımı karşılayacak yollar bulurum.

1	2	3	4
---	---	---	---

38. Her gün et, tavuk, balık, kuru bakliyat, yumurta, çerez türü gıdalardan sadece 3-4 porsiyon yerim.

1	2	3	4
---	---	---	---

39. Kendime nasıl daha iyi bakabileceğim konusunda sağlık personeline danışırım.

1	2	3	4
---	---	---	---

40. Egzersiz yaparken nabız ve kalp atışlarımı kontrol ederim.

1	2	3	4
---	---	---	---

41. Günde 15-20 dakika gevşeyebilmek, rahatlayabilmek için uygulamalar yaparım.

1	2	3	4
---	---	---	---

42. Yaşamımda benim için önemli olan şeylerin farkındayım.

1	2	3	4
---	---	---	---

43. Benzer sorunu olan kişilerden destek alırım.

1	2	3	4
---	---	---	---

44. Gıda paketlerinin üzerindeki besin, yağ ve sodyum içeriklerini belirleyen etiketleri okurum.

1	2	3	4
---	---	---	---

45. Bireysel sađlık bakımı ile ilgili eđitim programlarına katılırım.

1	2	3	4
---	---	---	---

46. Kalp atımım hızlanana kadar egzersiz yaparım.

1	2	3	4
---	---	---	---

47. Yorulmaktan kendimi korurum.

1	2	3	4
---	---	---	---

48. İlahi bir gücün varlığı ile ilişkim olduğunu hissederim.

1	2	3	4
---	---	---	---

49. Konuşarak ve uzlaşarak çatışmaları çözerim.

1	2	3	4
---	---	---	---

50. Kahvaltı yaparım.

1	2	3	4
---	---	---	---

51. Gereksinim duyduğumda başkalarından danışmanlık ve rehberlik alırım.

1	2	3	4
---	---	---	---

52. Yeni deneyimlere ve durumlara açığım.

1	2	3	4
---	---	---	---