

**NEAR EAST UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SCIENCES
CLINICAL PSYCHOLOGY
MASTER'S PROGRAMME**

MASTER'S THESIS

**THE FACTORS AFFECTING MATERNAL AND PATERNAL POSTPARTUM
DEPRESSION**

İrem Bengü ŞENSOY

**NICOSIA
2017**

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I İrem Bengü SENSÖZ, hereby declare that this dissertation entitled
 "The factors affecting maternal and paternal postpartum
 depression."

has been prepared myself under the guidance and supervision of
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İrem Bengü Şensoy

Haziran 2017, 102 Sayfa

Bu araştırmanın amacı annelerin ve babaların doğum sonrası depresyon (DSD) düzeylerini karşılaştırmak ve DSD düzeyini etkileyen faktörleri tespit etmektir. Araştırmanın örneklemi Giresun merkezde yaşayan, son 12 ay içinde bebek sahibi olmuş 70 çiftten (70 kadın ve 70 erkek) oluşmaktadır. Veri toplamak için sosyo-demografik bilgi formu, Evlilik Yaşam Ölçeği (EYÖ), Çok Boyutlu Algılanan Sosyal Destek Ölçeği Gözden Geçirilmiş Formu (ÇBASDÖ) ve Edinburgh Doğum Sonrası Depresyon Ölçeği (EDSDÖ) kullanılmıştır. DSD düzeyinin evlilik doyumu ve aileden algılanan sosyal destek ile anlamlı negatif ilişkisi olduğu, arkadaşlardan ve özel bir insandan algılanan sosyal destek ile anlamlı bir ilişkisi olmadığı saptanmıştır. Eşlerin DSD düzeyleri arasında anlamlı pozitif ilişki vardır. DSD düzeyleri ile eğitim düzeyi, gelir düzeyi, doğumdan sonra geçen süre, cinsiyet faktörleri arasında anlamlı ilişki olmadığı, kadınlarda yaş ve evlilik süresinin, erkeklerde evlilik yaşı, evde yaşayan kişi sayısı ve bakmakla yükümlü olunan kişi sayısının DSD düzeyleri ile anlamlı pozitif ilişkisinin olduğu bulunmuştur. Çalışmanın bulguları annenin DSD teşhisi aldığı ve takip edildiği klinik ortamda babanın ihmal edilmemesi gerektiğini ortaya koymaktadır.

Anahtar kelimeler: *Doğum sonrası depresyon, Evlilik doyumu, Algılanan sosyal destek.*

ABSTRACT**The Factors Affecting Maternal and Paternal Postpartum Depression****İrem Bengü Şensoy****June 2017, 102 Pages**

The aim of this study is to compare the postpartum depression (PPD) level of the mothers and fathers, and to determine the factors affecting PPD level. The sample of the study consists of 70 married couples (70 female and 70 male) who had a baby during the last 12 months and living in Giresun province, Turkey. Socio-demographical information form, Marital Life Scale (MLS), Multidimensional Scale of Perceived Social Support (MSPSS), and Edinburgh Postnatal Depression Scale (EPDS) were used for data collection. PPD level is found to have a negative significant relationship with marital satisfaction and perceived social support from the family but not from friends and significant other. There is a significant positive correlation between PPD levels of spouses. PPD level was found not to be significantly related to education level, income level, time passed since delivery, and genders, and to have significant positive relationship with age and years of marriage for women, and with age at marriage, number of people living in the house and number of dependants for men. The findings of the study suggest that fathers should not be neglected at the clinical setting when the mother is diagnosed and followed-up for PPD.

Keywords: *Postpartum depression, Marital satisfaction, Perceived social support.*

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LIST OF ABBREVIATIONS

APA: American Psychiatric Association

DSM: Diagnostic and Statistical Manual of Mental Disorders

ECT: Electroconvulsive therapy

EPDS: Edinburgh Postnatal Depression Scale

GRU: Giresun University

ICD: International Statistical Classification of Diseases and Related Health Problems

MLS: Marital Life Scale

MSPSS: Multidimensional Scale of Perceived Social Support

PPB: Postpartum blues

PPD: Postpartum depression

PPP: Postpartum psychosis

SPSS: Statistical Package for Social Sciences

USA: The United States of America

CHAPTER I

INTRODUCTION

1.1. Research Topic and Problem

Postpartum depression (PPD) is a mental disorder that develops due to biological, psychological and sociocultural factors, lasts for a long time, disrupts mother and family health, requires treatment and is often not recognized by health care workers (Cömert Okutucu, 2013).

The woman and her husband face physical and psychological changes with new roles and responsibilities in the postnatal period, and these changes can create stress in the emotional, behavioral and cognitive domains. Transition to parenting is a critical stage and women may experience emotional problems such as anxiety, stress and PPD (Forman et al., 2000; Soet et al., 2003).

Having a child is not only a gain for the woman, but also many of the losses and the changes related to identity such as changes in the form of body by pregnancy and birth, decreased sexual attractiveness, loss of personal space, the sense that there is a loss in memory, loss of job, occupational status or occupational expectations, loss of friends, the transition from the role of independent woman to the role of traditional woman which leads to some changes beyond personal relationships (Baor and Soskolne, 2010; Ulukavak, 2004). Accordingly, PPD can be regarded as a grief reaction against the losses which experienced with pregnancy and birth (MacArthur et al., 2002).

In this period, when many women believe they should be happy, they feel guilty because they carry depressed feelings, cause them to hide their symptoms and make the PPD easily unnoticed (Gülseren, 1999).

According to Wee et al. (2011), a result of widespread belief that only women are affected by PPD, and a large number of studies on this topic have focused on women. However, there are a number of problems that men have to overcome as well as women in this period. To create the necessary mental/emotional resources to establish a safe and supportive relationship with the child, helping the new baby care and supporting the mother in her new role, difficulty in adapting to the changes that will occur rapidly with the birth of the baby, and new requests to face with fatherhood are just some of the problems that the father has to overcome (Fletcher et al., 2006). For this reason, these and similar problems that must be overcome by men face men with a range of psychological disorders as well as women, and depression also occurs in pre- and post-partum periods on men (Wee et al., 2011).

Psychological situations of the parents have a major role in the social and cognitive development of children. In this direction, it is necessary to follow and support the fathers in the postpartum period. First of all, the knowledge and awareness of the health professionals should be increased and the situation of the fathers should be closely monitored in the postpartum period together with the mother in order to eliminate this problem.

1.2. Aim of the Study

The aim of this study is to compare the PPD levels of the mothers and fathers, to determine the relationship between the PPD levels of paired couples and the risk factors.

1.3. Research Questions

1. Is there a significant difference between PPD levels of women and men?
2. Is there a significant relationship between PPD levels of paired couples?
3. Is there a significant relationship between PPD and marital satisfaction?

4. Is there a significant relationship between PPD and social support?

1.4. Sub-Questions of the Research

1. Is there a significant relationship between marital satisfaction and social support?

2. Is there a significant relationship between PPD and age?

3. Is there a significant relationship between PPD and education level?

4. Is there a significant relationship between PPD and income level?

5. Is there a significant relationship between PPD and time passed since the delivery?

6. Is there a significant relationship between PPD and length of marriage?

7. Is there a significant relationship between PPD and number of people living in the house?

8. Is there a significant relationship between PPD and number of dependants?

1.5. The Importance of the Research

PPD is a serious family health problem. In the literature, it is stated that 2-25% of the parents experienced emotional problems after the birth (Zelkowitz and Milet, 2001; Tam et al., 2002; Gao et al., 2010; Wee et al., 2011; Matthey et al., 2003). Strikingly, studies have reported that nearly 60% of couples are found to have depressive symptoms in at least one partner in the last period of pregnancy or in the early postpartum period (Kim and Swain, 2007; Goodman, 2004).

Many studies on the subject over the past 60 years have focused on the negative effects of maternal PPD on child development (Kim and Swain, 2007). Prenatal anxiety and depression have been suggested to be one of the strongest predictors of PPD (Gotlib et al., 1989; Hannah et al., 1992). It has been detected that if not intervened during pregnancy, in the following years behavioral and emotional problems can be revealed in the children of the mothers whose depression continues during the postpartum period (Beck, 1998; Field, 2011).

Gao et al. (2009) reported that fathers experienced stress and depression as well as mothers in the postpartum period. In recent years, researchers have focused on studies that investigate the effects of paternal depression on the baby and child development. It is thought that paternal PPD may affect father-baby bonding negatively and may lead to psychopathology in childhood such as behavioral disorder, hyperactivity, anxiety, depression, delayed speech in the future period (Musser et al., 2013; Ramchandani et al., 2005; Goodman, 2004; Ramchandani et al., 2008a; Ramchandani et al., 2008b).

Unlike in maternal PPD, findings are not easily recognizable and progress is slow in paternal PPD. Depression is often seen at a later date than when it occurs in the mother. Stress due to changes in social and economic circumstances may mask the symptoms of depression (Schumacher et al., 2008). This can lead to the serious changes on fathers in the postpartum period to being overlooked and to inadequacy of screening, diagnosis and treatment of depression.

PPD, which may initially be insidious, may be overlooked, especially if it is mild to moderate, and the patient's search for help is not supported. In these cases, PPD may persist for a long time and eventually become more severe as hospitalization becomes necessary. For this reason early diagnosis is essential (Karamustafalıoğlu and Tomruk, 2000).

Diagnosis and treatment of paternal PPD is vital to prevent negative consequences that may be experienced. This study is important for determining the PPD levels of parents and risk factors of PPD.

1.6. Assumptions

In this study, the following assumptions were made.

1. In this study, it is assumed that the participants gave sincere and correct answers to the measuring instruments applied during the research.
2. Marital satisfaction of partners will be determined by Marital Life Scale (MLS), perceived social support levels by the revised form of Multidimensional Scale of Perceived Social Support (MSPSS), PPD levels by Edinburgh Postnatal Depression Scale (EPDS).
3. Perceived social support levels of partners are examined in three sub-dimensions; Family, friends, significant other.

1.7. Limitations

1. The current study is limited to women who gave birth between March 2016 and March 2017, and apply to the Giresun University (GRU) Gynecology, Obstetrics and Pediatrics Training and Research Hospital and to the family health centers in the province of Giresun and their husbands.
2. The variables are limited to PPD, marital satisfaction, and social support dimensions described in the theoretical section and socio-demographic information.
3. The research is limited to the information collected by the scales.

1.8. Theoretical Framework

1.8.1. Post-Partum Depression

The period that starts with the birth of the placenta, followed by the changes occurring in the mother's body reverting is called the "Puerperium". The postpartum period which includes the puerperium and also the breastfeeding period is an important process where psychiatric disorders can occur (Newport et al., 2002). This process is characterized with certain changes. Physiologically, the uterus, the vagina and other genital organs enter a regressing process and return to their pre-pregnancy states while the mother experiences a difficult and progressive process in which new

roles and responsibilities are gained. These newly gained roles create a certain degree of stress and anxiety in the mother (Mucuk and Güler, 2002). The mental state changes that may emerge during this period affect the person's life activities, social life and interpersonal relationships negatively after a certain point (Evans et al., 2001). First document that are still relevant belonged to Hippocrates and Tortula (Cömert Okutucu, 2013). In 1845, Esquirol attributed the etiology of postpartum mood disorders to different circumstances of lactation (Ayvaz et al., 2006). Pitt also suggested PPD is a different disorder from classical depressive disorders, and it is not hormonal changes accompanying birth but rather as a nonspecific stress response (Kocamanoğlu, 2008). Other researchers, such as Dalton, have argued that hormonal changes and especially the sudden drop of progesterone levels at birth are responsible for the development of PPD (Cömert Okutucu, 2013).

During the postpartum period, parents have to give child care, create a safe environment for the baby, communicate with the baby, learn new roles, develop family sensitivity and cope with the problems of the baby. Therefore, the postpartum period may turn into a crisis for the family. Many women easily adapt to physiological, psychological and social changes that come with pregnancy and birth. However, women who fail to adapt are prone to develop emotional problems (Büyükkoca, 2001; Walker and Wilging, 2000; Mucuk and Güler, 2002).

Depression, in both pre- and postpartum periods, is a serious disorder that can affect men just as it affects women (Wee et al., 2011). A father candidate to gather the mental and emotional resources to build a safe and supportive relationship with his child is at least as important as providing care to the newborn and supporting the mother with her new role. However, he faces fatherhood without being ready for the

changes that will come with the baby's birth and unbeknownst of the requests he will face (Fletcher et al., 2006).

The strong relationship of the father's depression with the mother's depression has significant effects on family's health and well-being (Goodman, 2004). A father with depression can increase the effect of the mother's depression on the child; two parents with depression can pose severe social, psychological and cognitive threats for the child. On the other hand, a healthy father can assume a protective role over the harmful effects of the mother's depression on the child (Fletcher et al., 2006).

1.8.1.1. Definition, Diagnosis Criteria, Differential Diagnosis

Postpartum period; is defined as a process that refers to a period of 6-8 weeks, starting from the separation of placenta (Ayvaz et al., 2006; Eren, 2007).

Depression is a term used in response to the Latin "depressus" connotation, which means downward suppression. In the medical literature, depression is a condition that includes general unhappiness, indifference, fatigue, excessive sadness and sorrow, loss of pleasure, introspection, social isolation, invalidity, feeling of ineffectiveness (Serhan, 2010).

With PPD several symptoms can be observed such as; feeling of worthlessness, anxiety and panic attacks, feelings of guilt, feeling like crying or uncontrollable crying, retardation in movement and speech, agitation or hyperactivity, eating disorders (eating too little or too much), sleep disorders, confusion, forgetfulness, loss of energy and motivation, feel of loneliness, fear of loss of control of fear of insanity, self-doubt, feeling helplessness, social withdrawal, loss of self-esteem, loss of energy and motivation, loss of libido, memory impairment, apathy towards the baby, worrying about the baby, harming the baby (Affonsoa et al., 2000; Uyar, 2005; Aktaş, 2008).

Current studies base their definition of paternal PPD on the definition of maternal PPD. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) defines PPD as major depressive episode that occurs in the mother in the first four weeks after birth. According to DSM-V, major depression diagnostic criteria can also be used for fathers (American Psychiatric Association- APA, 2013). For the same diagnostic criteria that are used with mothers to be used with mothers their validity must be tested, as risk factors differ between mothers and fathers. For example, it is documented that in fathers, PPD progresses more slowly and may occur within a year (Matthey et al., 2000). Consequently, the term “develops in the first four weeks after birth” may not be suitable for fathers (Kim and Swain, 2007).

Diagnosis of PPD requires clinical interview. However, due to conducting clinical interviews with all women in the postpartum period with psychiatric symptoms being both time consuming and economically costly, it is thought to be more appropriate to use the quick-and low-cost screening tools to address the problem (Evins and Theofrastous, 1997; Henshaw and Elliott, 2005). There are some standard self-report screening tools developed for this purpose that can be used to assess the mental state of a mother. These screening tools that aim to assess depressive symptoms can give information about the degree of the psychological discomfort and determine if the mother has PPD. Cox and Holden (1987) developed the EPDS with the idea that using a specific scale in studies on PPD would lead to more accurate results. In 1994, Cox stated that the scale could also be used to detect depression in fathers (Cömert Okutucu, 2013). EPDS has passed validity and reliability test in the United States of America (USA) and non-English speaking countries, and has been validated for men (Edoka and Petroub, 2011; Murray and Cox, 1990). In Turkey, validity and reliability study of the Turkish version of EPDS

was conducted by Engindeniz et al. (1997) who stated that it could also be used to determine depressive fathers but it would require reliability and validity studies to be conducted on this field.

The term used for psychiatric disorders with different clinical appearances is “Postpartum mood disorder”. Postpartum mood disorders are classified according to their severity, characteristics, treatment and prognosis as; postpartum blues (PPB), PPD and postpartum psychosis (PPP) (Gülseren, 1999; Robinson and Stewart, 1986).

It may be difficult to distinguish PPD in the first weeks because symptoms such as lack of libido, sleeping disorders may be seen in PPB. PPB generally emerges within the first three to five days after birth. Symptoms gradually fade and are expected to disappear after two weeks. If the symptoms persist after two weeks, and apathy towards the baby, loss of energy, alterations in the mood are added; the mother should be monitored and controlled regarding the PPD (Erdem and Bez, 2009).

In clinical picture of PPD, sadness and apathy towards the baby are preliminary and suicidal tendencies are less present in PPP. PPP is characterized with delusions and hallucinations. PPP is the most severe psychiatric disorder that occurs in the postpartum period (Gülseren, 1999). The mother may possess thoughts of harming her baby (Ahokas et al., 2000). It usually starts within 2-3 weeks following birth and lasts for 2-3 months and requires urgent treatment. The patient should be admitted to the hospital be ensured to not harm themselves or the baby.

1.8.1.2. Prevalence

In studies using standard diagnostic methods in the American and European populations, the prevalence of PPD has been reported as 3.5-17.5% (Evins and Theofrastous, 1997; Bashiri and Spielvogel, 1999) and in self-report scale studies, as

%3-42 (Georgiopoulos et al., 1999; Dennis et al., 2004). Yonkers et al. (2001) reported %5.2 prevalence of PPD in a study based on the DSM-IV criteria in postpartum period with 802 women in the USA. Chandran et al. (2002) found that the prevalence of PPD was 11% in a study conducted with 359 women in India according to International Statistical Classification of Diseases and Related Health Problems, Tenth Edition (ICD-10) diagnostic criteria. Kitamura et al. (2006) reported PPD prevalence as 5% in a study conducted with 290 women using DSM-III-R criteria in Japan.

In Turkey, the prevalence of PPD ranged between 21.2% and 54.2% in studies conducted with self-report scales (İnandı et al., 2002). In a group which was evaluated by EPDS, it was found that PPD affected 17.5% of participants (Eren, 2007). In another group, this rate was 35.5% (Gülнар et al., 2010). In a study conducted in Konya, the prevalence of PPD was 19.4% (Özdemir et al., 2008). In a study conducted in Trabzon province center, this rate was found as high as 28.1% (Ayvaz et al., 2006). In a similar study conducted in province center in Samsun, this rate was 23.1% (Sünter et al., 2002), in the province of Bornova, İzmir it was 29% (Çeber et al., 2002) in Sakarya it was 23.8% (Durat and Kutlu, 2010), and in a study conducted in a semi-urban area in Manisa, the prevalence was 36.9% (Erbay, 2002).

In the literature, the incidence of PPD in fathers varies significantly. In a study conducted on 312 Australian fathers, 18.6% exhibited depressive symptoms (Boyce et al., 2007) In studies evaluating the rate of depression in the first 12 months after birth in men who had new children in the USA, different results were obtained ranging from 4% (Ramchandani et al., 2005) to 25% (Soliday, 1999). In the study of Lane et al. (1997) in Ireland, rate of paternal PPD was 1.2% (Kim and Swain, 2007). In the compilation of 43 articles published by Paulson and Bazemore (2010),

prevalence of PPD was found to be 23.8% in father and 10.4% in mothers. These figures are the result of studies conducted up to a year after the birth. In the same compilation, the highest rates were found between 3-6 months postpartum, which is 26% for men and 41% for women. In the study conducted by Pinheiro et al. (2006) in Brazil, PPD was found in 26.3% of mothers and 11.9% of fathers (Kim and Swain, 2007). In the study conducted by Serhan et al. (2013) in Turkey PPD was seen in 9.1% of mothers and 1.8% of fathers who participated. Most of these studies were conducted on small sample sizes. From this perspective, the study of Rachandani et al. that was conducted on 12,884 fathers is of great importance.

1.8.1.3. Risk Factors

Although it is not known precisely in the literature, rapid physiological and hormonal changes, difficulty of adapting to changing family life, and to a new role psychologically and socially, history of depression or depression that starts with pregnancy and persists through postpartum period are thought to increase the risk of PPD. However, which risk factors are more effective depends on the individual (Amankwaa, 2003; Özdemir, 2007; Annagür, 2008).

One of the most comprehensive studies to reveal factors responsible for the occurrence of PPD was conducted by Beck (2001); after the meta-analysis of 84 studies, the most important risk factors of PPD were found as:

1. Presence of prenatal depression and anxiety
2. History of depression
3. Stress related to child care
4. Lack of social support
5. Stressful life events
6. PPB

7. Problems with spouse/partner
8. Low self-respect
9. Baby with difficult temperament
10. Marital satisfaction
11. Unwanted or unplanned pregnancy

Goodman (2004) defined three important markers that can be used to foresee paternal PPD:

- If the father has previously been diagnosed with depression,
- If the mother had depression in prenatal or early postpartum period
- Quality of the relationship between spouses especially in the first year after birth.

Having PPD in the partner is considered to be the most important risk factor for development of paternal PPD (Goodman, 2004). Other risk factors of paternal PPD include low socioeconomic status, being raised by a step-parent, being the partner of a single mother, becoming a father for the first time, and inadequate familial and community support systems (Kim and Swain, 2007; Goodman, 2004; Paulson and Bazemore, 2010; Letourneau et al., 2012).

1.8.1.3.1. Biological and Physiological Factors

Physiological and hormonal changes in women during pregnancy, childbirth and postpartum period develop rapidly enough to force the limits of physical adaptation capabilities of women. Many studies report that sudden changes in estrogen and progesterone levels affect PPD (Balkaya, 2002; Maurer-Spurej et al., 2007; Aktaş, 2008). In the postpartum period, hypofunction of the thyroid gland can also cause depression (Lucas et al., 2001; Wissart et al., 2005; Annagür, 2008). Similar

hormonal mechanisms are thought to be also relatable to the fathers (Kim and Swain, 2007).

Parents having history of depression have a high risk of relapse due to stress and anxiety (Atasoy et al., 2004; Taşdemir et al., 2006).

If the baby requires frequent feeding and care during the day, it will reduce the mother's chance of time allocation for resting and sleeping if the mother does not have social support. In a study, mothers reported fatigue, exhaustion and tiredness due to experiencing insomnia, difficulties on transition to sleep, and having less time to sleep, thus exhibiting more severe symptoms of depression (Posmontier, 2008).

1.8.1.3.2. Psycho-social Factors

Parent candidates experiencing severe anxiety about the baby, the childbirth or their roles after childbirth, being diagnosed with depression during any trimester of the pregnancy may pose a risk of PPD (Serhan, 2010; Miller et al., 2006; Limlomwongse and Liabsuetrakul, 2006; Henshaw et al., 2004).

Changes in the work life of the parents during pregnancy and after birth such as leaving work, change of job, change of position at work, increase of responsibilities and expenses, acquiring new roles as a parent and experiencing difficulties adapting to them, fulfilling the needs of their other children will cause parents to feel under pressure psychologically (Uyar, 2005; Türkistanlı et al., 2002).

The social support provided by social circles and relatives of the parents helps them to overcome pregnancy and postpartum periods without turning into a crisis. The lack of social support in the postpartum period may cause difficulties for parents to adapt to the new roles, problems in infant care, communication problems due to increased tension between partners (Amankwaa, 2003; Uyar, 2005; Limlomwongse and Liabsuetrakul, 2006).

If the pregnancy is unplanned, the parents will not be ready and have difficulties assuming their roles as mother and father, thus their relationship with the baby will suffer and they will struggle caring the baby resulting them to experience depressive symptoms. If the parents do not receive adequate counseling, training or support during the first pregnancies, if the mother has complaints such as nausea or vomiting during the pregnancy, if there is a risk of miscarriage or there are complications with the baby, if birth is difficult or premature, the parent will experience more stress and anxiety (Özdemir, 2007; Eren, 2007; Aktaş, 2008).

When pregnancy and childbirth are added to the stressful life of couples' due to mutual disagreements over marriage union, new marriage, lack of communication, and the existence of domestic violence, the situation will turn out to be a crucible in which more problems are experienced (Serhan, 2010; Uyar, 2005).

1.8.1.3.3. Genetic Factors

The fact that one of the first-degree relatives of a mother or father has a diagnosis of depression increases the risk of depression in them. In a study on this subject, 38.8% of individuals with history of depression within their family were diagnosed with depression (Eneç Can et al., 2005). Balcıoğlu (1999) reported that the presence of depression in one of the identical twins increases the risk of depression in the other by at least 50% and in non-identical twins by 25%.

1.8.1.4. Treatment

According to the severity of PPD, psychotherapy (interpersonal therapy, behavioral therapy, marriage and family therapies), psycho-social care, pharmacological treatment such as antidepressants, antipsychotic drugs, and electroconvulsive therapy (ECT) can be used (Uyar, 2005; Özdemir, 2007; Clark et al., 2008).

Psychotherapy; behavioral therapy, marriage and family therapies can be applied to the mother and father with PPD individually or together. Psychotherapy helps the mother or father to regain self-confidence, about their concerns and fears of self-harm and new roles and responsibilities, to understand their feelings and to express their inner conflicts (Barnesd, 2006). Marriage and family therapy can help parents understand their causes of depression and relieve their feelings of guilt and embarrassment. Psychotherapy and other therapies alone can accelerate the recovery process of mild depression. The combination of psychotherapy and pharmacological therapy is more effective in the treatment of depression (Özdemir, 2007; Eren, 2007; Aktaş, 2008).

When parents are diagnosed with PPD, antidepressant or antipsychotic drugs are used regarding the severity of the depression. Before treatment is initiated, parents should be informed about the benefits and harms of medications, which all psychiatric medications pass through breast milk, and depression may be progressive and recurrent if medication is not utilized. If the mother or father has depression history, prescribing the drug of the same antidepressant group that individual used in the previous treatment, may help speed up the healing process. In the studies of the use of antidepressants in the postpartum period, depressive symptoms in the mother decreased and maternal adaptation period was reported to be more favorable (Sharma, 2006; Özdemir, 2007; Eren, 2007; Logston et al., 2009).

1.8.2. Marital Satisfaction

Although marriage is only one of the important life experiences of an individual, the quality of this experience is directly related to the quality of life of the person (Hünler and Gençöz, 2003). Marital satisfaction is essential in terms of being happy and healthy for the individuals.

In the literature exists several different definitions of “marital satisfaction”.

Some of these are:

- Marital satisfaction is the level of meeting needs and expectations of marriage; or "the perception of the degree to which the individual meets the requirements of his marriage" (Bahr et al., 1983).
- Marital satisfaction is the psychological satisfaction obtained from the individual dimensions such as styles of love which spouses show towards each other in the institution of marriage, sexual satisfaction, styles of communication and the environmental dimensions such as sharing equality in given decisions, income, work and sharing of problems (Sokolski and Hendrick, 1999).
- Marital satisfaction is defined as the degree to which individuals are satisfied with their marriage-related desires. This also expresses the general satisfaction of marriage as well as the satisfaction of special situations in marital status, such as friendship in marriage and satisfaction from sexuality. As a whole, marital satisfaction or contention expresses the subjective satisfaction of spouses (Cingisiz, 2010).

There are many factors that affect satisfaction from marriage experience. For example, marriage age, type of marriage, financial status, whether or not having children, whether the spouses are from the same socio-economic level, and the age difference between spouses (Üncü, 2007).

Many research findings on the field suggest that there is a strong positive relationship between psychological health and marital satisfaction. It is shown that 40% of the persons who applied to the health institutions due to psychological problems apply to the clinic with marital problems; moreover, couples with low

marital satisfaction experienced more physical health problems compared to couples with high satisfaction (Güven, 2005). In the study of Levenson et al. (1993), those with low marital satisfaction reported more psychological and physical health problems than those with high marital satisfaction. Studies have shown that couples with high levels of mutual marital satisfaction have lower levels of stress, higher levels of joy of life, and higher levels of resistance to cope with adverse living conditions (Bradbury et al., 2000; Holman, 2002). Rust et al. (1988) found a strong association between unhappiness and sexual dysfunctions in marriage. In addition, the literature has shown that there is a significant relationship between marital satisfaction and anxiety and depression levels (Coughlin et al., 2000; Whisman et al., 2004; Kronmüller et al., 2011).

1.8.3. Social Support

Social support is often seen as help (material, spiritual) provided by people (such as spouse, family, friend) around the stressed or struggling individual. All interpersonal relationships, which have an important place in people's life and provide emotional, material and cognitive assistance when necessary, are considered as social support systems that help to maintain health (Sorias, 1988). Social support can change the link between the stressful event and its outcome by affecting ways of coping.

Many authors (Coyne and Downey, 1991; Ell, 1996; Hupcey, 1998; Winemiller et al., 1993) have pointed out that the focus shifted towards whether social relationships are supportive enough according to the individual's impression or in other words perceived support in recent studies about social support. According to this view, social support emphasizes the quality of the social relations of the individual rather than the quantity. In other words, social support consists of the

close bond he established with an important person that they can share their secrets and can trust rather than the number of the people he has in relation to (Yıldırım, 1997). Individual's general impression of whether the social support is adequate is defined as "perceived support". It is stated that, not the social activity itself, but the way it is perceived and interpreted is what protects health (Esmek, 2007).

The role of social support as a source of coping and protection against diseases draws considerable amount of attention. Numerous studies have been conducted showing that social support has a positive association with mental and physical health. Studies have shown that social support is effective in coping with stress (Cohen and Wills, 1985; Kessler et al., 1985; Coyne and Downey, 1991). Christenfeld et al. (1997) found that social support was effective on cardiovascular reactivity. Uchino et al. (1996) found that social support correlates with cardiovascular, endocrine, and immune system functions in an effort to investigate the effect of social support on physiological processes. Individuals with strong interpersonal relationships, family and friendship relationships were seen to return to their normal lives in less time and with less harm when there were traumatic events, sudden loss, unexpected events that would trigger a fluctuation in emotional state if they had social support (Uyar, 2005; Benoit et al., 2007; Özdemir, 2007). On the other hand, individuals with less or no social support experienced more anxiety, decrease in their life quality, and more severe and lasting symptoms of depression (Okanlı et al., 2003).

CHAPTER II

REVIEW OF RELATED LITERATURE

Although different ratios are given due to differences in methods used for the determination of prevalence of PPD, the most common complication of birth, research shows that PPD develops in about 10-15% of women who has recently given birth (Robertson et al., 2004; Bloch et al., 2006). Another reason for conflicting results in studies to determine the prevalence of PPD is that some studies revolves around the diagnostic assessment of depression and some aim to measure the severity of depressive symptoms (O'Hara et al., 1984; Robinson and Stewart, 1986; Eltutan and Öncüoğlu, 1997; Gülseren, 1999). It is stated that several physiological changes that occur during pregnancy and postpartum period are similar to symptoms of depression such as decrease in sexual interest, change in appetite, malaise, and sleep disorders; therefore studies that solely focus on symptoms may produce misleading results (O'Hara et al., 1984; Gülseren, 1999). The prevalence of PPD in studies performed varies with the timeframe that the patients were evaluated after birth, sample size, population variation and diagnostic tool (Evins and Theofrastous, 1997; Bashırı and Spielvogel, 1999; Georgiopoulos et al., 1999). According to DSM-V (APA, 2013), depression should be evaluated in terms of PPD, especially if it develops within four weeks after birth, whereas in some other studies, the baseline period may be at any time within one year, usually at 6-12 weeks (Evins and Theofrastous, 1997; Bashırı and Spielvogel, 1999; Georgiopoulos et al., 1999).

Paternal PPD mostly accompanies maternal PPD. Significant correlations were found between the spouses in terms of the risk of depression in all studies on PPD with women (Ballard et al., 1994; Kim and Swain, 2007; Musser et al., 2013; Goodman, 2004; Paulson and Bazemore, 2010; Cameron et al., 2016). Beck (1999)

evaluated 200 fathers of PPD using EPDS, he found that 9% of fathers during the sixth week of the postpartum period and 5.4% of fathers after six months were experiencing PPD and the main factor was the mother's depression. Similarly, according to Goodman's (2004) report, the occurrence of PPD in the first year after birth was reported to be between 1.2% and 25%, while it increased to 24-50% in men whose wives had depression at the same time. In a study conducted by Matthey et al., men whose wives were diagnosed with depression carried 2.5 times more risk than men whose wives were not diagnosed at six weeks after birth (Kim and Swain, 2007).

One of the most important risk factors for PPD is lack of social support. Many studies have found a relationship between PPD levels and social support (Beck, 2001; Robertson et al., 2004; Aydemir, 2007). In a study by Büyükkoca (2001) investigating the relationship between perceived social support and PPD, a significant relationship was found between PPD levels of the mothers and the level of social support perceived from significant other, family and friends. Ceyhun Peker et al. (2016) found that lack of social support increased the risk of depression by 25 times. According to Cutrano (1986), social support prevents depression by increasing the sense of competence related to the mother's role in the postpartum period. Serhan et al. (2013) reported that lack of social support, which is known to be a risk factor for maternal PPD, also plays an important role in the development of paternal PPD.

There are many studies in the literature that cited tension in marital dyad as a key psychosocial risk factor for the onset of PPD (Beck, 2001; Boyce and Hickey, 2005; Misri et al., 2000; O'Hara and Swain, 1996; Whiffen, 2004; Wilson et al., 1996; Aydemir, 2007). In literature, Wee (2011), Gawlik (2014), Matthey (2000), Girard (2013), and Schumacher (2008) underlined the effects the quality of marital

relationship on PPD and emphasized it as an important risk factor. Alkar and Gençöz's (2007) found that marital satisfaction was the main effect on depressive symptoms in the postpartum period. Feeney et al. (2003) in their longitudinal study of the relationship between adult attachment and depression, and Kargar et al. (2014) in their study where they compared Iranian women with and without PPD both found a significant relationship between marital satisfaction and PPD. Pollock et al. (2009) report that the frequency of PPD in women who are not satisfied with their marital relationship has increased in their study with Mongolian mothers.

Studies also show that there is a correlation between marital satisfaction and social support. Julien and Markman (1991) found that social support is strongly associated with marital satisfaction in their study. Acitelli and Antonucci (1994) investigated the relationship between marital satisfaction and social support, and found that even though women had more perceived support than men, there was a strong relationship between general well-being and marital satisfaction for both men and women. There are studies that show that levels of social support that spouses perceive in marital satisfaction are also important (Bryant and Conger, 1999; Julien and Markman, 1991; Pash and Bradbury, 1998).

CHAPTER III

METHOD

3.1. Study Model

Current study utilizes cross-sectional descriptive survey model.

3.2. Universe and Sample

The universe of the study is all women who gave birth between March 2016 and March 2017 and their husbands in Giresun province.

The sample of the study consists of 70 married couples (70 female and 70 male, total 140 participants) who apply to the Giresun University (GRU) Gynecology, Obstetrics and Pediatrics Training and Research Hospital and to the family health centers in Giresun. These were all the couples who had a baby between March 2016 and March 2017.

The survey was applied to the couples between their 2nd week and 12th month of delivery. The sample was investigated in two groups depending on their genders. Criterion sampling method, which is an application of purposive sampling, was used for the sample selection procedure.

3.3. Data Collection Tools

Data of the study were collected with a survey form that consists of socio-demographical information form, MLS, MSPSS, and EPDS.

3.3.1. Socio-Demographical Information Form

This section of the survey form was developed by the researcher and it gathers the information regarding the following variables: age, level of education, employment status, monthly income, age at marriage, years of marriage, time passed since the delivery, number of total births (for females), gender of the baby,

satisfaction from the gender of the baby, planned / unplanned pregnancy, pregnancy treatment, favored gender for the baby, history of curettage / miscarriage (for females), known chronic and psychiatric diseases, psychiatric diseases in the family, number of people living in the same house and number of dependants (for males).

3.3.2. Marital Life Scale (MLS)

The scale was developed by Tezer (1996) for measuring the satisfaction level of the spouses regarding their marital relationship. The scale covers a total of 10 items. The participants answer the items by using a 5 point Likert scale where 1: I absolutely do not agree and 5: I absolutely agree. The score of the scale is then calculated and it might change between 10 and 50.

To determine its validity, scale was administrated to divorced and married individuals. Significant differences were detected between the groups ($t= 6.23$, $p<0.01$). This finding provides an evidence of the scale's validity according to external criteria. Additionally, comparisons were made between the scores obtained from the Personal Behavior Survey, which was developed to measure social appreciation and to understand whether individuals were affected by social appreciation tendencies. The results showed that the MLS was affected by social appreciation tendencies to a very small extent ($r= 0.21$). This result was also presented as an indirect evidence of the scale's reliability. The reliability coefficient determined by means of the test-retest method was 0.85, while the Cronbach internal consistency coefficient was 0.88 for the male group and 0.91 for the female group. All these analyses show that the scale is reliable (Tezer, 1996).

The Cronbach Alfa internal consistency coefficient in this study was found to be 0.884.

3.3.3. Multidimensional Scale of Perceived Social Support (MSPSS)

MSPSS is a 12 item-scale developed by Zimet et.al. (1988) and it aims to measure the respondents' perception of social support from his/her family, friends, and significant others. These sources of support also constitute the MSPSS's subscales, namely family, friends or significant other. Ratings are made on a seven-point Likert-scale with 1: Very strongly disagree and 7: Very strongly agree.

Sample items include "There is a significant other who is around when I am in need." and "My family really tries to help me." The range of possible score varies from a minimum score of 4 to a maximum score of 28 for each subscale, higher scores reflecting more support from each support. Total score from the scale would range from 12 to 84.

Current study utilizes the Turkish validated version of the MSPSS (Eker and Arkar, 1995; Eker et al., 2001) and has a Cronbach Alpha coefficient of 0.890.

3.3.4. Edinburgh Postnatal Depression Scale (EPDS)

EPDS has been developed to assist primary care health professionals to detect mothers suffering from postnatal depression (Cox et al., 1987). It consists of ten short statements. The mother indicates which of the four possible responses is closest to how she has been feeling during the previous week. Each question was scored from 0 to 3 and the total score of the scale might vary between 0 and 30.

It was initially validated in the United Kingdom (Cox et al., 1987). Also, in one study, this scale was translated into Turkish and tested for reliability in Turkish women (Engindeniz et al., 1996). This study concluded that the sensitivity and specificity of the scale was found to be 84% and 88%, respectively, and the value of Cronbach's alpha was 0.79.

In current study, Cronbach Alpha coefficient is found to be 0.824.

3.4. Statistical Analysis

All statistical calculations and analysis were performed with Statistical Package for Social Sciences (SPSS) 21.0 software.

Frequency analysis was carried out to investigate the descriptive characteristics of study sample. For the continuous data such as MLS score, MSPSS scores and EDPS score, descriptive statistics such as arithmetic mean, standard deviation, median, minimum and maximum values were calculated.

To determine the statistical hypothesis testing methods, the distribution characteristics of the scale scores were investigated in terms of normality. For this purpose, Kolmogorov-Smirnov test of normality, Shapiro-Wilk test of normality, Q-Q plots, skewness and kurtosis values were all analyzed in each gender group. Additionally, Levene's test of homogeneity of variances was applied where required. Using all gathered information, non-parametric hypothesis tests were performed throughout the whole data analysis.

To understand the possible associations between scale scores and other continuous sociodemographic variables, Pearson correlation test was used.

Mann Whitney U test was applied for the comparison of all three scale scores between two gender groups. In addition, within each gender group, scale scores were compared with respect to the monthly income and time passed since the delivery groups of the participants with Mann Whitney U test.

Kruskal Wallis test was applied within each gender group to understand the significance of scale score differences between education levels, and age groups of

participants. This was due to the dependent variable having more than two independent categories. In case of statistical significance, Mann Whitney U test was applied to understand the pairwise comparisons between mentioned groups.

Linear regression analysis in each group was applied for understanding EPDS score (dependent variable) with respect to independent variables: age, MLS score, MSPSS subscales and scale scores and number of dependants (only in male group).

Cronbach Alpha was calculated to understand the reliability of each scale in current study sample.

Related analysis result of each statistical method is shown in their corresponding tables throughout the text. Level of significance was accepted to be 0.05 for the whole study.

CHAPTER IV

RESULTS

Table 1. Descriptive statistics of the participants regarding their sociodemographic characteristics

	Female		Male		Total	
	n	%	n	%	n	%
Age Groups						
29 and Younger	35	50.0	17	24.3	52	37.1
30 – 34	21	30.0	22	31.4	43	30.7
35 and Older	14	20.0	31	44.3	45	32.1
Education						
Primary and Secondary School	9	12.9	12	17.1	21	15.0
High School	30	42.9	21	30.0	51	36.4
University or Higher Degree	31	44.3	37	52.9	68	48.6
Employment						
Employed	36	51.4	64	91.4	100	71.4
Unemployed	34	48.6	6	8.6	40	28.6
Monthly Income						
2,500 TL or Less	48	68.6	36	51.4	84	60.0
More than 2,500 TL	22	31.4	34	48.6	56	40.0

Table 1 shows the distribution of sociodemographic characteristics of the participants in both genders.

Accordingly, female participants were most frequently aged 29 years old or younger (50.0%). However, male participants were most frequently aged 35 years old or older (44.3%).

For the distribution of education level of female participants, 9 of them (12.9%) were primary or secondary school graduates, 30 of them (42.9%) were high school graduates while 31 of them (44.3%) had university or higher degree. For male participants; 12 of them (17.1%) were primary or secondary school graduates, 21 of

them (30.0%) were high school graduates while 37 of them (52.9%) had university or higher degree.

In total, 36 of the female participants (51.4%) and 64 of the male participants (91.4%) were employed at the time of the study.

Monthly income distribution of the female participants showed that 22 of them (31.4%) had an income more than 2,500 TL. Amongst male participants, 34 (48.6%) had an income level higher than 2,500 TL.

Table 2. Descriptive statistics of the participants regarding their birth and pregnancy expectations

	Female		Male		Total	
	N	%	n	%	n	%
Gender of the Baby						
Girl	35	50.0	35	50.0	70	50.0
Boy	35	50.0	35	50.0	70	50.0
Planned/Wanted Pregnancy						
Planned	47	67.1	46	65.7	93	66.4
Unplanned / Wanted	19	27.1	22	31.4	41	29.3
Unplanned / Unwanted	4	5.7	2	2.9	6	4.3
Satisfied with Gender of the Baby						
Yes	70	100.0	70	100.0	100	100.0
No	0	0.0	0	0.0	0	0.0
Time Passed Since the Delivery						
0-6 Months	41	58.6	41	58.6	82	58.6
7-12 Months	29	41.4	29	41.4	58	41.4
Favoured Gender for the Baby						
Girl	10	14.3	8	11.4	18	12.9
Boy	4	5.7	5	7.1	9	6.4
No Preference	56	80.0	57	81.4	113	80.7

Table 2 represents the expectations of the female and male participants regarding their child's birth.

Since the sample constitutes married couples, percentage of female babies was equal (50.5%) for both parent pairs.

On the other hand, majority of the female participants (67.1%) stated that the pregnancy was planned. Similarly, male participants also mostly declared that the child was planned (65.7%).

Amongst the 70 couples, 41 of them (58.6%) stated that it had been 0 to 6 months since the delivery.

Although all participants 140 (100.0%) reported that they were satisfied with the gender of their babies, 14 female participants (20.0%) and 13 male participants (18.5%) declared that before the delivery they favoured specific gender for their babies. Amongst the mothers, 10 (14.3%) favoured baby girls and 4 (5.7%) favoured baby boys. On the other hand, 8 of the fathers (11.4%) favoured girls and 5 of them (7.1%) favoured boys before the birth of the baby.

Table 3. Descriptive statistics of the mothers regarding their pregnancy history

	Frequency (n)	Percentage (%)
How Many Deliveries in Total		
1	33	47.1
2	28	40.0
3	9	12.9
History of Curettage / Miscarriage		
Curettage	6	8.6
Miscarriage	9	12.9
Curettage and Miscarriage	4	5.7
No	51	72.9

In Table 3, female participants' distribution regarding their total number of deliveries and history of curettage and/or miscarriage were displayed.

Mostly (47.1%), female participants reported that this was their very first delivery. Number of females who reported history of curettage was 6 (8.6%), history of miscarriage was 9 (12.9%), history of both curettage and miscarriage was 4 (5.7%). In total, 51 female participants (72.9%) stated that they had no history of curettage and/or miscarriage.

Table 4. Descriptive statistics of the participants regarding their pregnancy related treatment and other health conditions

	Female		Male		Total	
	n	%	n	%	n	%
Treatment for Pregnancy						
Yes	11	15.7	11	15.7	22	15.7
No	59	84.3	59	84.3	118	84.3
Chronic Diseases						
Yes	9	12.9	2	2.9	11	7.9
No	61	87.1	68	97.1	129	92.1
Psychiatric Diseases						
Yes	2	2.9	2	2.9	4	2.9
No	68	97.1	68	97.1	136	97.1
Psychiatric Diseases in Family						
Yes	5	7.1	6	8.6	11	7.9
No	65	92.9	64	91.4	129	92.1

In Table 4, descriptive statistics with respect to the pregnancy treatment and other health conditions in both genders were shown.

As reported in the table, 11 couples (15.7%) received treatment for pregnancy while 59 of them (84.3%) did not receive any treatment.

For the female participants; the percentage of chronic diseases was 12.9, percentage of psychiatric diseases was 2.9 and the percentage of psychiatric diseases in the family was 7.1.

For the male participants; the percentage of chronic diseases was 2.9, percentage of psychiatric diseases was 2.9 and the percentage of psychiatric diseases in the family was 8.6.

Table 5. Descriptive statistics and statistical comparison of the female and male participants regarding their MLS, MSPSS and EPDS scores

	Female					Male					Z	p
	\bar{x}	s	Median	Min	Max	\bar{x}	s	Median	Min	Max		
MLS	40,21	7,63	41,00	11,00	50,00	40,64	7,81	42,00	11,00	50,00	-0,51	0,61
MSPSS												
Family	24,64	4,33	26,50	8,00	28,00	23,83	4,30	25,00	13,00	28,00	-1,29	0,20
Friends	19,93	8,09	23,00	4,00	28,00	19,10	7,02	19,50	4,00	28,00	-1,16	0,25
Sig. other	17,74	8,93	21,00	4,00	28,00	15,51	8,52	16,00	4,00	28,00	-1,67	0,10
Total	62,31	16,98	65,00	24,00	84,00	58,44	15,95	59,50	24,00	84,00	-1,50	0,14
EPDS	7,54	4,81	6,00	0,00	20,00	6,91	5,12	5,50	0,00	22,00	-1,00	0,32

Table 5 shows the descriptive statistics as well as the statistical comparisons of MLS, MPSS and EPDS scores between the gender groups.

As seen in the table, none of the scale scores showed statistically significant difference between female and male participants ($p>0.05$).

MLS scale score of the female participants was 41.00 (11.00-50.00) and for males it was 42.00 (11.00-50.00) ($p=0.61$).

MSPSS Family subscale level of females was 26.50 (8.00-28.00) while it was 25.00 (13.00-28.00) for males ($p=0.20$). MSPSS Friends subscale level of females was 23.00 (4.00-28.00) while it was 19.50 (4.00-28.00) for males ($p=0.25$). MSPSS Significant other subscale subscale level of females was 21.00 (4.00-28.00) while it was 16.00 (4.00-28.00) for males ($p=0.10$). As a result, MSPSS Total scale score of females was 65.00 (24.00-84.00) and males was 59.50 (24.00-84.00) and the difference was insignificant ($p=0.14$).

For the EPDS scale; the level of mothers was 6.00 (0.00-20.00) and for fathers it was 5.50 (0.00-22.00). The difference between the married couples was not statistically significant ($p=0.32$).

Table 6.1. Descriptive statistics and statistical comparison of the female participants of different education categories regarding their MLS, MSPSS and EPDS scores

		Female					χ^2	p
	Education	\bar{x}	s	Median	Min	Max		
MLS	Pri & Sec. School	36,33	8,20	36,00	22,00	50,00	3.68	0.16
	High School	40,87	8,86	44,00	11,00	50,00		
	University or Higher	40,71	5,91	41,00	25,00	50,00		
MSPSS								
Family	Pri & Sec. School	21,22	7,01	24,00	8,00	28,00	4.15	0.13
	High School	25,70	3,58	27,00	11,00	28,00		
	University or Higher	24,61	3,60	26,00	17,00	28,00		
Friends	Pri & Sec. School	19,44	8,69	21,00	5,00	28,00	0.37	0.83
	High School	20,40	8,11	23,50	4,00	28,00		
	University or Higher	19,61	8,15	22,00	4,00	28,00		
Sig. other	Pri & Sec. School	13,44	9,45	8,00	4,00	28,00	2.06	0.36
	High School	17,83	8,70	21,00	4,00	28,00		
	University or Higher	18,90	8,92	22,00	4,00	28,00		
Total	Pri & Sec. School	54,11	21,36	53,00	24,00	84,00	2.04	0.36
	High School	63,93	15,82	67,00	30,00	84,00		
	University or Higher	63,13	16,62	65,00	26,00	84,00		
EPDS	Pri & Sec. School	10,67	6,10	9,00	3,00	19,00	3.58	0.17
	High School	6,60	3,92	6,00	1,00	15,00		
	University or Higher	7,55	4,97	6,00	0,00	20,00		

On Table 6.1, females with different levels of education were compared with respect to their scale scores.

As shown in the table, for none of the applied scales, education level of women showed statistical significance ($p>0.05$).

Level of MLS score for primary or secondary school graduated women was 36.00 (22.00-50.00), for high school graduated women it was 44.00 (11.00-50.00) and for university or higher degree women it was 41.00 (25.00-50.00) ($p=0.16$).

Level of MSPSS Family subscale score for primary or secondary school graduated women was 24.00 (8.00-28.00), for high school graduated women it was 27.00 (11.00-28.00) and for university or higher degree women it was 26.00 (17.00-28.00) ($p=0.13$).

Level of MSPSS Friends subscale score for primary or secondary school graduated women was 21.00 (5.00-28.00), for high school graduated women it was 23.50 (4.00-28.00) and for university or higher degree women it was 22.00 (4.00-28.00) ($p=0.83$).

Level of MSPSS Significant other subscale score for primary or secondary school graduated women was 8.00 (4.00-28.00), for high school graduated women it was 21.00 (4.00-28.00) and for university or higher degree women it was 22.00 (4.00-28.00) ($p=0.36$).

Level of MSPSS total scale score for primary or secondary school graduated women was 53.00 (24.00-84.00), for high school graduated women it was 67.00 (30.00-84.00) and for university or higher degree women it was 65.00 (26.00-84.00) ($p=0.36$).

Level of EPDS scale score for primary or secondary school graduated women was 9.00 (3.00-19.00), for high school graduated women it was 6.00 (1.00-15.00) and for university or higher degree women it was 6.00 (0.00-20.00) ($p=0.17$).

Table 6.2. Descriptive statistics and statistical comparison of the male participants of different education categories regarding their MLS, MSPSS and EPDS scores

		Male						
	Education	\bar{x}	s	Median	Min	Max	χ^2	p
MLS	Pri & Sec. School	35,83	11,19	37,50	11,00	48,00	5.25	0.07
	High School	39,48	7,98	40,00	17,00	49,00		
	University or Higher	42,86	5,46	44,00	29,00	50,00		
MSPSS								
Family	Pri & Sec. School	23,25	5,79	25,50	13,00	28,00	1.70	0.43
	High School	24,76	3,94	27,00	15,00	28,00		
	University or Higher	23,49	3,98	24,00	15,00	28,00		
Friends	Pri & Sec. School	18,25	7,85	16,00	5,00	28,00	2.04	0.36
	High School	20,86	6,67	22,00	4,00	28,00		
	University or Higher	18,38	6,95	19,00	4,00	28,00		
Sig. other	Pri & Sec. School	14,42	10,46	14,00	4,00	28,00	0.29	0.87
	High School	15,43	7,87	16,00	4,00	28,00		
	University or Higher	15,92	8,41	17,00	4,00	28,00		
Total	Pri & Sec. School	55,92	18,97	50,00	33,00	84,00	0.84	0.66
	High School	61,05	12,33	61,00	36,00	84,00		
	University or Higher	57,78	16,93	58,00	24,00	84,00		
EPDS	Pri & Sec. School	6,25	5,07	4,00	0,00	17,00	0.61	0.74
	High School	7,76	5,55	7,00	1,00	22,00		
	University or Higher	6,65	4,96	5,00	0,00	18,00		

On Table 6.2, males with different levels of education were compared with respect to their scale scores.

As shown in the table, for none of the applied scales, education level of fathers showed statistical significance ($p>0.05$).

Level of MLS score for primary or secondary school graduated fathers was 37.50 (11.00-48.00), for high school graduated fathers it was 40.00 (17.00-49.00) and for university or higher degree fathers it was 44.00 (29.00-50.00) ($p=0.07$).

Level of MSPSS Family subscale score for primary or secondary school graduated fathers was 25.50 (13.00-28.00), for high school graduated fathers it was 27.00 (15.00-28.00) and for university or higher degree fathers it was 24.00 (15.00-28.00) ($p=0.43$).

Level of MSPSS Friends subscale score for primary or secondary school graduated fathers was 16.00 (5.00-28.00), for high school graduated fathers it was 22.00 (4.00-28.00) and for university or higher degree fathers it was 19.00 (4.00-28.00) ($p=0.36$).

Level of MSPSS Significant other subscale score for primary or secondary school graduated fathers was 14.00 (4.00-28.00), for high school graduated fathers it was 16.00 (4.00-28.00) and for university or higher degree fathers it was 17.00 (4.00-28.00) ($p=0.87$).

Level of MSPSS total scale score for primary or secondary school graduated fathers was 50.00 (33.00-84.00), for high school graduated fathers it was 61.00 (36.00-84.00) and for university or higher degree fathers it was 58.00 (24.00-84.00) ($p=0.66$).

Level of EPDS scale score for primary or secondary school graduated fathers was 4.00 (0.00-17.00), for high school graduated fathers it was 7.00 (1.00-22.00) and for university or higher degree fathers it was 5.00 (0.00-18.00) ($p=0.74$).

Table 7.1. Descriptive statistics and statistical comparison of the female participants of different age categories regarding their MLS, MSPSS and EPDS scores

	Age	Female							p	Diff.
		\bar{x}	s	Median	Min	Max	χ^2			
MLS	29 and Younger	42,37	5,72	42,00	29,00	50,00	4.07	0.13		
	30 - 34	37,38	9,50	38,00	11,00	49,00				
	35 and Older	39,07	7,59	40,00	25,00	50,00				
MSPSS										
Family	29 and Younger	25,63	2,96	27,00	18,00	28,00	1.83	0.40		
	30 - 34	23,90	4,31	24,00	11,00	28,00				
	35 and Older	23,29	6,52	27,00	8,00	28,00				
Friends	29 and Younger	20,49	7,13	22,00	4,00	28,00	0.55	0.76		
	30 - 34	20,57	8,08	23,00	4,00	28,00				
	35 and Older	17,57	10,31	22,00	4,00	28,00				
Sig. other	29 and Younger	17,97	8,19	21,00	4,00	28,00	0.35	0.84		
	30 - 34	17,00	9,26	15,00	4,00	28,00				
	35 and Older	18,29	10,71	25,50	4,00	28,00				
Total	29 and Younger	64,09	14,88	67,00	26,00	84,00	0.53	0.77		
	30 - 34	61,48	15,27	63,00	30,00	84,00				
	35 and Older	59,14	23,93	62,00	24,00	84,00				
EPDS	29 and Younger	5,71	3,23	6,00	0,00	12,00	7.77	0.02*	1-2	
	30 - 34	9,05	5,13	9,00	1,00	17,00			1-3	
	35 and Older	9,86	6,05	10,00	2,00	20,00				

On Table 7.1, females in different age categories were compared with respect to their scale scores.

As shown in the table, for MLS and MSPSS scales, women in different age categories did not show any statistical significance ($p > 0.05$), while for EPDS scale, statistical significance amongst age groups was observed ($p < 0.05$)

Level of MLS score for 29 years and younger women was 42.00 (29.00-50.00), for 30-34 years old women it was 38.00 (11.00-49.00) and for 35 years and older women it was 40.00 (25.00-50.00) ($p = 0.13$).

Level of MSPSS Family subscale score for 29 years and younger women was 27.00 (18.00-28.00), for 30-34 years old women it was 24.00 (11.00-28.00) and for 35 years and older women it was 27.00 (8.00-28.00) ($p=0.40$).

Level of MSPSS Friends subscale score for 29 years and younger women was 22.00 (4.00-28.00), for 30-34 years old women it was 23.00 (4.00-28.00) and for 35 years and older women it was 22.00 (4.00-28.00) ($p=0.76$).

Level of MSPSS Significant other subscale score for 29 years and younger women was 21.00 (4.00-28.00), for 30-34 years old women it was 15.00 (4.00-28.00) and for 35 years and older women it was 25.50 (4.00-28.00) ($p=0.84$).

Level of MSPSS total scale score for 29 years and younger women was 67.00 (26.00-84.00), for 30-34 years old women it was 63.00 (30.00-84.00) and for 35 years and older women it was 62.00 (24.00-84.00) ($p=0.77$).

Level of EPDS scale score for 29 years and younger women was 6.00 (0.00-12.00), for 30-34 years old women it was 9.00 (1.00-17.00) and for 35 years and older women it was 10.00 (2.00-20.00) ($p=0.02$). Further pairwise analysis between the groups showed that 29 years and younger group women had significantly lower EPDS scale scores from both 30-34 years old group women and 35 years and older group women.

Table 7.2. Descriptive statistics and statistical comparison of the male participants of different age categories regarding their MLS, MSPSS and EPDS scores

	Age	Male						
		\bar{x}	s	Median	Min	Max	χ^2	p
MLS	29 and Younger	42,47	7,18	46,00	27,00	49,00	2.47	0.29
	30 - 34	40,05	9,85	42,50	11,00	50,00		
	35 and Older	40,06	6,52	41,00	17,00	49,00		
MSPSS								
Family	29 and Younger	25,29	4,13	27,00	15,00	28,00	3.40	0.18
	30 – 34	22,91	4,60	24,00	14,00	28,00		
	35 and Older	23,68	4,09	25,00	13,00	28,00		
Friends	29 and Younger	19,94	7,51	22,00	5,00	28,00	2.06	0.36
	30 – 34	17,73	6,32	19,00	4,00	28,00		
	35 and Older	19,61	7,30	21,00	4,00	28,00		
Sig. other	29 and Younger	16,65	7,98	17,00	4,00	28,00	0.95	0.62
	30 – 34	15,68	7,86	16,00	4,00	28,00		
	35 and Older	14,77	9,40	14,00	4,00	28,00		
Total	29 and Younger	61,88	16,24	59,00	24,00	84,00	0.81	0.67
	30 – 34	56,32	14,14	59,50	26,00	74,00		
	35 and Older	58,06	17,16	60,00	27,00	84,00		
EPDS	29 and Younger	5,76	4,01	5,00	1,00	14,00	1.18	0.55
	30 – 34	6,55	4,85	4,50	1,00	18,00		
	35 and Older	7,81	5,79	8,00	0,00	22,00		

On Table 7.2, males in different age categories were compared with respect to their scale scores.

As shown in the table, for none of the scale scores, males in different age categories did show any statistical significance ($p > 0.05$).

Level of MLS score for 29 years and younger males was 46.00 (27.00-49.00), for 30-34 years old males it was 42.50 (11.00-50.00) and for 35 years and older males it was 41.00 (17.00-49.00) ($p = 0.29$).

Level of MSPSS Family subscale score for 29 years and younger males was 27.00 (15.00-28.00), for 30-34 years old males it was 24.00 (14.00-28.00) and for 35 years and older males it was 25.00 (13.00-28.00) ($p=0.18$).

Level of MSPSS Friends subscale score for 29 years and younger males was 22.00 (5.00-28.00), for 30-34 years old males it was 19.00 (4.00-28.00) and for 35 years and older males it was 21.00 (4.00-28.00) ($p=0.36$).

Level of MSPSS Significant other subscale score for 29 years and younger males was 17.00 (4.00-28.00), for 30-34 years old males it was 16.00 (4.00-28.00) and for 35 years and older males it was 14.00 (4.00-28.00) ($p=0.62$).

Level of MSPSS total scale score for 29 years and younger males was 59.00 (24.00-84.00), for 30-34 years old males it was 59.50 (26.00-74.00) and for 35 years and older males it was 60.00 (27.00-84.00) ($p=0.67$).

Level of EPDS scale score for 29 years and younger males was 5.00 (1.00-14.00), for 30-34 years old males it was 4.50 (1.00-18.00) and for 35 years and older males it was 8.00 (0.00-22.00) ($p=0.55$).

Table 8.1. Descriptive statistics and statistical comparison of the female participants of different monthly income categories regarding their MLS, MSPSS and EPDS scores

	Monthly Income	Female		Median	Min	Max	Z	p
		\bar{x}	s					
MLS	2,500 TL or Less	40,00	8,27	41,50	11,00	50,00	0.00	1.00
	More than 2,500 TL	40,68	6,15	40,50	25,00	50,00		
MSPSS								
Family	2,500 TL or Less	24,46	4,72	27,00	8,00	28,00	-0.08	0.93
	More than 2,500 TL	25,05	3,39	26,00	17,00	28,00		
Friends	2,500 TL or Less	19,77	8,17	20,50	4,00	28,00	-0.13	0.89
	More than 2,500 TL	20,27	8,09	23,50	4,00	28,00		
Sig. other	2,500 TL or Less	17,15	8,94	19,00	4,00	28,00	-0.72	0.47
	More than 2,500 TL	19,05	8,97	22,50	4,00	28,00		
Total	2,500 TL or Less	61,38	17,96	64,00	24,00	84,00	-0.44	0.66
	More than 2,500 TL	64,36	14,80	65,50	35,00	84,00		
EPDS	2,500 TL or Less	7,65	4,70	7,00	0,00	19,00	-0.43	0.66
	More than 2,500 TL	7,32	5,16	6,00	1,00	20,00		

On Table 8.1, females with different levels of monthly income were compared with respect to their scale scores.

As shown in the table, for none of the applied scales, monthly income groups of women showed statistical significance ($p > 0.05$).

Level of MLS score for 2,500 TL or less income group women was 41.50 (11.00-50.00), while for more than 2,500 TL income group women it was 40.50 (25.00-50.00) ($p = 1.00$).

Level of MSPSS Family subscale score for 2,500 TL or less income group women was 27.00 (8.00-28.00), while for more than 2,500 TL income group women it was 26.00 (17.00-28.00) ($p = 0.93$).

Level of MSPSS Friends subscale score for 2,500 TL or less income group women was 20.50 (4.00-28.00), while for more than 2,500 TL income group women it was 23.50 (4.00-28.00) ($p=0.89$).

Level of MSPSS Significant other subscale score for 2,500 TL or less income group women was 19.00 (4.00-28.00), while for more than 2,500 TL income group women it was 22.50 (4.00-28.00) ($p=0.47$).

Level of MSPSS total scale score for 2,500 TL or less income group women was 64.00 (24.00-84.00), while for more than 2,500 TL income group women it was 65.50 (35.00-84.00) ($p=0.66$).

Level of EPDS scale score for 2,500 TL or less income group women was 7.00 (0.00-19.00), while for more than 2,500 TL income group women it was 6.00 (1.00-20.00) ($p=0.66$).

Table 8.2. Descriptive statistics and statistical comparison of the male participants of different monthly income categories regarding their MLS, MSPSS and EPDS scores

	Monthly Income	Male		Median	Min	Max	Z	p
		\bar{x}	s					
MLS	2,500 TL or Less	39,03	9,13	42,00	11,00	50,00	-1.28	0.20
	More than 2,500 TL	42,35	5,77	42,50	22,00	50,00		
MSPSS								
Family	2,500 TL or Less	23,97	4,77	25,50	13,00	28,00	-0.70	0.48
	More than 2,500 TL	23,68	3,80	24,00	16,00	28,00		
Friends	2,500 TL or Less	18,61	7,26	19,50	4,00	28,00	-0.58	0.56
	More than 2,500 TL	19,62	6,83	19,50	4,00	28,00		
Sig. other	2,500 TL or Less	14,25	8,22	16,00	4,00	28,00	-1.45	0.15
	More than 2,500 TL	16,85	8,75	17,00	4,00	28,00		
Total	2,500 TL or Less	56,83	15,58	60,00	24,00	84,00	-0.69	0.49
	More than 2,500 TL	60,15	16,39	59,00	27,00	84,00		
EPDS	2,500 TL or Less	7,67	5,47	6,50	0,00	22,00	-1.11	0.27
	More than 2,500 TL	6,12	4,66	4,50	0,00	16,00		

On Table 8.2, males with different levels of monthly income were compared with respect to their scale scores.

As shown in the table, for none of the applied scales, monthly income groups of males showed statistical significance ($p>0.05$).

Level of MLS score for 2,500 TL or less income group males was 42.00 (11.00-50.00), while for more than 2,500 TL income group males it was 42.50 (22.00-50.00) ($p=0.20$).

Level of MSPSS Family subscale score for 2,500 TL or less income group males was 25.50 (13.00-28.00), while for more than 2,500 TL income group males it was 24.00 (16.00-28.00) ($p=0.48$).

Level of MSPSS Friends subscale score for 2,500 TL or less income group males was 19.50 (4.00-28.00), while for more than 2,500 TL income group males it was 19.50 (4.00-28.00) ($p=0.56$).

Level of MSPSS Significant other subscale score for 2,500 TL or less income group males was 16.00 (4.00-28.00), while for more than 2,500 TL income group males it was 17.00 (4.00-28.00) ($p=0.15$).

Level of MSPSS total scale score for 2,500 TL or less income group males was 60.00 (24.00-84.00), while for more than 2,500 TL income group males it was 59.00 (27.00-84.00) ($p=0.49$).

Level of EPDS scale score for 2,500 TL or less income group males was 6.50 (0.00-22.00), while for more than 2,500 TL income group males it was 4.50 (0.00-16.00) ($p=0.27$).

Table 9.1. Descriptive statistics and statistical comparison of the female participants of different deliverance time categories regarding their MLS, MSPSS and EPDS scores

	Time Passed Since the Delivery	Female						
		\bar{x}	s	Median	Min	Max	Z	p
MLS	0-6 Months	40,07	8,47	40,00	11,00	50,00	-0.11	0.91
	7-12 Months	40,41	6,40	42,00	25,00	50,00		
MSPSS								
Family	0-6 Months	24,56	4,45	27,00	8,00	28,00	-0.52	0.60
	7-12 Months	24,76	4,23	26,00	11,00	28,00		
Friends	0-6 Months	20,41	7,72	23,00	4,00	28,00	-0.30	0.76
	7-12 Months	19,24	8,68	21,00	4,00	28,00		
Sig. other	0-6 Months	18,85	8,81	22,00	4,00	28,00	-1.16	0.24
	7-12 Months	16,17	9,01	15,00	4,00	28,00		
Total	0-6 Months	63,83	16,04	67,00	24,00	84,00	-0.71	0.48
	7-12 Months	60,17	18,30	63,00	26,00	84,00		
EPDS	0-6 Months	7,71	5,00	6,00	2,00	20,00	-0.08	0.93
	7-12 Months	7,31	4,61	7,00	0,00	17,00		

On Table 9.1, groups of females with different times passed since their delivery were compared with respect to their scale scores.

As shown in the table, for none of the scales, time passed since the delivery groups of women showed statistical significance ($p > 0.05$).

Level of MLS score for 0-6 months from the delivery group women was 40.00 (11.00-50.00), while for 7-12 months from the delivery group women it was 42.00 (25.00-50.00) ($p = 0.91$).

Level of MSPSS Family subscale score for 0-6 months from the delivery group women was 27.00 (8.00-28.00), while for 7-12 months from the delivery group women it was 26.00 (11.00-28.00) ($p = 0.60$).

Level of MSPSS Friends subscale score for 0-6 months from the delivery group women was 23.00 (4.00-28.00), while for 7-12 months from the delivery group women it was 21.00 (4.00-28.00) ($p=0.76$).

Level of MSPSS Significant other subscale score for 0-6 months from the delivery group women was 22.00 (4.00-28.00), while for 7-12 months from the delivery group women it was 15.00 (4.00-28.00) ($p=0.24$).

Level of MSPSS total scale score for 0-6 months from the delivery group women was 67.00 (24.00-84.00), while for 7-12 months from the delivery group women it was 63.00 (26.00-84.00) ($p=0.48$).

Level of EPDS scale score for 0-6 months from the delivery group women was 6.00 (2.00-20.00), while for 7-12 months from the delivery group women it was 7.00 (0.00-17.00) ($p=0.93$).

Table 9.2. Descriptive statistics and statistical comparison of the male participants of different deliverance time categories regarding their MLS, MSPSS and EPDS scores

		Male						
	Time Passed Since the Delivery	\bar{x}	s	Median	Min	Max	Z	p
MLS	0-6 Months	41,22	8,31	42,00	11,00	50,00	-1.27	0.20
	7-12 Months	39,83	7,11	41,00	17,00	49,00		
MSPSS								
Family	0-6 Months	23,56	4,64	25,00	13,00	28,00	-0.46	0.65
	7-12 Months	24,21	3,81	25,00	16,00	28,00		
Friends	0-6 Months	18,71	7,02	19,00	4,00	28,00	-0.69	0.49
	7-12 Months	19,66	7,10	20,00	4,00	28,00		
Sig. other	0-6 Months	15,37	8,58	16,00	4,00	28,00	-0.25	0.81
	7-12 Months	15,72	8,58	16,00	4,00	28,00		
Total	0-6 Months	57,63	15,61	55,00	24,00	84,00	-0.78	0.44
	7-12 Months	59,59	16,63	61,00	26,00	84,00		
EPDS	0-6 Months	6,37	4,84	5,00	0,00	18,00	-0.99	0.32
	7-12 Months	7,69	5,48	7,00	1,00	22,00		

On Table 9.2, groups of males with different times passed since the delivery were compared with respect to their scale scores.

As shown in the table, for none of the applied scales, time passed since the delivery groups of males showed statistical significance ($p > 0.05$).

Level of MLS score for 0-6 months from the delivery group males was 42.00 (11.00-50.00), while for 7-12 months from the delivery group males it was 41.00 (17.00-49.00) ($p = 0.20$).

Level of MSPSS Family subscale score for 0-6 months from the delivery group males was 25.00 (13.00-28.00), while for 7-12 months from the delivery group males it was 25.00 (16.00-28.00) ($p = 0.65$).

Level of MSPSS Friends subscale score for 0-6 months from the delivery group males was 19.00 (4.00-28.00), while for 7-12 months from the delivery group males it was 20.00 (4.00-28.00) ($p=0.49$).

Level of MSPSS Significant other subscale score for 0-6 months from the delivery group males was 16.00 (4.00-28.00), while for 7-12 months from the delivery group males it was 16.00 (4.00-28.00) ($p=0.81$).

Level of MSPSS total scale score for 0-6 months from the delivery group males was 55.00 (24.00-84.00), while for 7-12 months from the delivery group males it was 61.00 (26.00-84.00) ($p=0.44$).

Level of EPDS scale score for 0-6 months from the delivery group males was 5.00 (0.00-18.00), while for 7-12 months from the delivery group males it was 7.00 (1.00-22.00) ($p=0.32$).

Table 10. Correlation analysis between age and each MLS, MSPSS and EPDS scores for each gender groups

		Age	
		Female (n=70)	Male (n=70)
MLS	r	-0.21	-0.16
	p	0.08	0.20
MSPSS			
Family	r	-0.22	-0.16
	p	0.07	0.20
Friends	r	-0.13	0.00
	p	0.29	1.00
Significant other	r	0.01	-0.02
	p	0.91	0.88
Total	r	-0.11	-0.05
	p	0.36	0.67
EPDS	r	0.33	0.17
	p	0.01*	0.15

* $p < 0.05$

Table 10 displays the correlation analysis findings between age and scale scores for each gender groups.

For females, age did not have any statistically significant association with MLS, MSPSS Family, MSPSS Friends, MSPSS Significant other or MSPSS total scores ($p > 0.05$). However, it has a statistically significant positive correlation with EPDS score ($r = 0.33$; $p = 0.01$). Although it is a moderate level association, it is statistically significant and it indicates that older mothers tend to have higher EPDS scores while younger ones tend to have lower.

For males, age did not have any statistically significant association with MLS, MSPSS Family, MSPSS Friends, MSPSS Significant other, MSPSS total or EPDS scores ($p > 0.05$).

Table 11. Correlation analysis between age at marriage and each MLS, MSPSS and EPDS scores for each gender groups

		Age at Marriage	
		Female (n=70)	Male (n=70)
MLS	r	-0.38	-0.22
	p	0.01*	0.07
MSPSS			
Family	r	-0.15	-0.15
	p	0.23	0.23
Friends	r	-0.15	-0.11
	p	0.21	0.35
Significant other	r	0.02	-0.18
	p	0.88	0.13
Total	r	-0.10	-0.19
	p	0.41	0.12
EPDS	r	0.15	0.31
	p	0.23	0.01*

* $p < 0.05$

Table 11 displays the correlation analysis findings between age at marriage and scale scores for each gender groups.

For females, age at marriage did not have any statistically significant association with MSPSS Family, MSPSS Friends, MSPSS Significant other, MSPSS total or EPDS scores ($p > 0.05$). However, it has a statistically significant negative correlation with MLS score ($r = -0.38$; $p = 0.01$). Although it is a moderate level association, it is statistically significant and it indicates that women who got married in older ages tend to have lower MLS scores while the women who got married in younger ages tend to have higher.

For males, age at marriage did not have any statistically significant association with MLS, MSPSS Family, MSPSS Friends, MSPSS Significant other or MSPSS

total scores ($p>0.05$). However, it has a statistically significant positive correlation with EPDS score ($r= 0.31$; $p=0.01$). Although it is a moderate level association, it is statistically significant and it indicates that males who got married in older ages tend to have higher EPDS scores while the males who got married in younger ages tend to have lower.

Table 12. Correlation analysis between years of marriage and each MLS, MSPSS and EPDS scores for each gender groups

		Years of Marriage	
		Female (n=70)	Male (n=70)
MLS	r	0,05	0,02
	p	0,69	0,86
MSPSS			
Family	r	-0,14	-0,04
	p	0,26	0,75
Friends	r	-0,01	0,12
	p	0,94	0,32
Significant other	r	-0,01	0,14
	p	0,94	0,27
Total	r	-0,04	0,11
	p	0,72	0,35
EPDS	r	0,26	-0,07
	p	0,03*	0,59

* $p < 0.05$

Table 12 displays the correlation analysis findings between years of marriage and scale scores for each gender groups.

For females, years of marriage did not have any statistically significant association with MLS, MSPSS Family, MSPSS Friends, MSPSS Significant other or MSPSS total scores ($p > 0.05$). However, it has a statistically significant positive correlation with EPDS score ($r = 0.26$; $p = 0.03$). Although it is a weak level association, it is statistically significant and it indicates that for the women, as years of marriage increases EPDS score also tends to increase, while as years of marriage decreases, EPDS score tends to decrease.

For males, years of marriage did not have any statistically significant association with MLS, MSPSS Family, MSPSS Friends, MSPSS Significant other, MSPSS total or EPDS scores ($p>0.05$).

Table 13. Correlation analysis between number of people living in the house and each MLS, MSPSS and EPDS scores for each gender groups

		Number of People Living in the House	
		Female (n=70)	Male (n=70)
MLS	r	-0.31	-0,17
	p	0,01*	0,17
MSPSS			
Family	r	-0,30	-0,13
	p	0,01*	0,27
Friends	r	0,05	-0,10
	p	0,97	0,43
Significant other	r	-0,05	-0,01
	p	0,71	0,92
Total	r	-0,10	-0,09
	p	0,42	0,48
EPDS	r	0,22	0,25
	p	0,07	0,04*

* $p < 0.05$

Table 13 displays the correlation analysis findings between number of people living in the house and scale scores for each gender groups.

For females, number of people living in the house did not have any statistically significant association with MSPSS Friends, MSPSS Significant other, MSPSS total or EPDS scores ($p > 0.05$). However, it has a statistically significant negative correlation with MLS score ($r = -0.31$; $p = 0.01$). Although it is a moderate level association, it is statistically significant and it indicates that women who are living in crowded houses tend to have lower MLS scores while the women who are living with less people tend to have higher.

Similarly, for the females, number of people living in the house has a statistically significant negative correlation with MSPSS Family score ($r = -0.30$; $p = 0.01$). Although it is a moderate level association, it is statistically significant and it indicates that women who are living in crowded houses tend to have lower MSPSS Family scores while the women who are living with less people tend to have higher.

For males, number of people living in the house did not have any statistically significant association with MLS, MSPSS Family, MSPSS Friends, MSPSS Significant other or MSPSS total scores ($p > 0.05$). However, it has a statistically significant positive correlation with EPDS score ($r = 0.25$; $p = 0.04$). Although it is a weak level association, it is statistically significant and it indicates that males who are living in crowded houses tend to have higher EPDS scores while the males who are living with less people tend to have lower.

Table 14. Correlation analysis between number of dependants and each MLS, MSPSS and EPDS scores for male participants

		Number of Dependants Male (n=70)	
MLS	r	-0,07	
	p	0,58	
MSPSS	Family	r	-0,17
		p	0,16
	Friends	r	-0,11
		p	0,36
	Significant other	r	-0,11
		p	0,37
Total	r	-0,15	
	p	0,21	
EPDS	r	0,32	
	p	0,01*	

* $p < 0.05$

Table 14 displays the correlation analysis findings between number of dependants and scale scores in each male group.

For males, number of dependants did not have any statistically significant association with MLS, MSPSS Family, MSPSS Friends, MSPSS Significant other or MSPSS total scores ($p > 0.05$). However, it has a statistically significant positive correlation with EPDS score ($r = 0.32$; $p = 0.01$). Although it is a moderate level association, it is statistically significant and it indicates that males who are looking after higher number of people tend to have higher EPDS scores while the males who are looking after less people tend to have lower.

Table 15. Correlation analysis between MLS, MSPSS and EPDS scores for all participants

		MSPSS Family	MSPSS Friends	MSPSS Sig. other	MSPSS Total	EPDS
MLS	r	0,17	0,06	-0,03	0,06	-0,35
	p	0,04*	0,49	0,73	0,52	0,01*
MSPSS	r		0,43	0,31	0,63	-0,20
Family	p		0,01*	0,01*	0,01*	0,02*
MSPSS	r			0,52	0,85	-0,01
Friends	p			0,01*	0,01*	0,93
MSPSS	r				0,85	-0,04
Sig. other	p				0,01*	0,66
MSPSS	r					-0,08
Total	p					0,37

* $p < 0.05$

Table 15 displays all pairwise correlation findings between the scale scores.

Accordingly, MLS score has a significantly positive correlation with MSPSS Family subscale score ($r = 0.17$; $p = 0.04$). Both scale scores tend to move in the same direction in this weak but significant association. In addition, MLS scale score has a significantly negative correlation with EPDS scale score ($r = -0.35$; $p = 0.01$). This indicates that as MLS score gets higher, EPDS score tends to decrease, and vice versa.

MSPSS Family subscale score has positive and significant correlations with MSPSS Friends subscale score ($r = 0.43$; $p = 0.01$), MSPSS Significant other subscale score ($r = 0.31$; $p = 0.01$), and MSPSS total scale score ($r = 0.63$; $p = 0.01$). These findings indicate that as MSPSS Family score increases, participants tend to get higher MSPSS Friends, MSPSS Significant other and MSPSS total scores.

However, MSPSS Family subscale score has negative and significant correlation with EPDS scale score ($r = -0.20$; $p = 0.02$). This shows that as participants get higher scores for MSPSS Family subscale, their EPDS scale scores tend to decrease, and vice versa.

MSPSS Friends subscale score has positive and significant correlations with MSPSS Significant other subscale score ($r = 0.52$; $p = 0.01$), and MSPSS total scale score ($r = 0.85$; $p = 0.01$). These findings indicate that as MSPSS Friends score increases, participants tend to get higher MSPSS Significant other and MSPSS total scores.

MSPSS Significant other subscale score has a positive and significant correlation with MSPSS total scale score ($r = 0.85$; $p = 0.01$). This strong association indicates that as MSPSS Significant other score increases, participants tend to get higher MSPSS total scores.

Table 16. Linear regression analysis with EPDS Score as dependent while age and other scale scores as independent variables for female participants

	Unstandardized Coefficients		Standardized Coefficients		p
	B	Std. Error	Beta	t	
Model Constant	9.998	5.818		1.719	.091
Age	.274	.117	.262	2.340	.022*
MLS	-.185	.072	-.293	-2.579	.012*
MSPSS					
Family	-.164	.079	-.157	-1.086	.281
Friends	.218	.128	.275	1.806	.076
Sig. other	-.054	.069	-.191	-.781	.438

*($p < 0,05$), R^2 : 0.265

Table 16 shows the results of the linear regression analysis where the EPDS score is dependent variable and all remaining scale scores and age are independent variables for female participants.

As the table indicates, coefficient of determination of the linear model is 26.5%. Amongst all independent variables, Age and MLS score were significantly contributing to the model. Age has a regression coefficient of 0.274 ($p=0.022$) and this shows that every 1 year increase in age of the female participant corresponds to a 0.274 units increase in her EPDS score.

In addition, MLS score has a regression coefficient of -0.185 ($p=0.012$). This indicates that as the MLS score of the female participant increases for 1 unit, her EPDS score will decrease for 0.185 units.

MSPSS Family, MSPSS Friends and MSPSS Significant other scores did not significantly contribute to the model ($p > 0.05$).

Table 17. Linear regression analysis with EPDS Score as dependent while age, number of dependants and other scale scores as independent variables for male participants

	Unstandardized Coefficients		Standardized Coefficients		p
	B	Std. Error	Beta	t	
Model					
Constant	11.510	6.530		1.763	.083
Age	.073	.119	.071	.611	.543
MLS	-.198	.074	-.303	-2.675	.010*
MSPSS					
Family	-.071	.155	-.060	-.458	.649
Friends	-.021	.102	-.029	-.204	.839
Sig. other	-.018	.078	-.030	-.232	.817
Number of Dependants	1.181	.492	.275	2.401	.019*

*($p < 0,05$), $R^2: 0.220$

Table 17 shows the results of the linear regression analysis where the EPDS score is dependent variable and all remaining scale scores age and number of dependants are independent variables for male participants.

As the table indicates, coefficient of determination of the linear model is 22.0%. Amongst all independent variables, MLS score, and number of dependants were significantly contributing to the model. MLS score has a regression coefficient of -0.198 ($p=0.010$). This indicates that as the MLS score of the male participant increases for 1 unit, his EPDS score will decrease for 0.198 units.

Also, number of dependants has a regression coefficient of 1.181 ($p=0.019$). This indicates that as number of people the male participant is responsible for increases for 1 individual, his EPDS score will increase for 1.181 units.

Age, MSPSS Family, MSPSS Friends and MSPSS total scores did not contribute

Table 18. Correlation analysis between EPDS Scores of female and male participants

		EPDS Score of Males
EPDS Score of Females	r	0.44
	p	0.01*

* $p < 0.05$

Table 18 displays the correlation analysis of EPDS score between female and male participants.

As shown in the table, EPDS scale score shows a positive and significant association between the paired couples ($r = 0.44$; $p = 0.01$). This indicates that if the female parent has high EPDS score, male parent also tends to have higher EPDS score, and vice versa.

CHAPTER V

DISCUSSION

The birth and postpartum period which women experience great changes in is also a risky period in terms of depression. This challenging process affects men as well as women, and leaves them with the risk of depression. It is known that depression, especially in the early postpartum period, can cause cognitive and emotional development problems in children. In terms of paternal PPD, physicians, especially those working in primary care, should be careful and remember to scan. This research was conducted to collect information about correlation between paternal and maternal PPD levels, their relationship with marital satisfaction, perceived social support, and other sociodemographic variables.

When the EPDS scores of women and men were compared, there was no significant difference between gender groups, but a positive and significant association between the paired couples. PPD levels of the male and female participants for paired couples are found to have positive and significant correlation. This suggests that if one of the couple experiences PPD, his partner also has increased risk for experiencing PPD. Meta-analysis studies by Paulson and Bazemore (2010) and Cameron et al. (2016) also support the finding that maternal and paternal PPD are related. In Goodman's 2004 compilation; maternal depression is the most important risk factor for prenatal and postnatal depression in the father. In the same study, it was stated that the rates of paternal PPD were between 1.2% and 25.5%, and these rates were increased to 24-50% in which men their wives were depressed. Rhamchandani also argues that depression rates are higher in men with depressed wives. Almost all studies in the literature support this hypothesis and Nishimura and Ohashi (2010) did not find any relationship between maternal and paternal PPD in

the measurements made at 4 weeks postpartum. In Turkey, Cömert Okutucu's (2013) study with fathers whose wives gave birth; there was no relationship between depression in wife and paternal PPD. As a reason for this, in the study of Cömert Okutucu, the information about presence of maternal depression is obtained by asking men. The association of PPD levels of spouses may be related with the risk factors of PPD affecting both of the partners as a family like marital satisfaction, perceived social support from family. Also, the experience of PPD by one partner may have some negative effect on the other.

PPD level was found not to have a significant relationship with education level and income level. Most studies show that maternal PPD is not related to family income (Okanlı, 2003; Sevil et al., 2004; Keleş, 2007). Similarly, in Aydemir's (2007) study, maternal PPD, in Serhan et al.'s (2010) study found that maternal and paternal PPD did not have a statistically significant relationship with income and education level. In Eren's (2007) study, maternal PPD was found to be negatively related to education level, not related to economic level. In the study of the Cömert Okutucu (2013), it was determined that as these levels increase, the risk of depression decreases in men. Wee et al. (2011) reported that low levels of education increase PPD risk in their work. In a cohort study of 570 women in Geneva, it has been shown that women who develop PPD receive professional training at a lower level (Righetti-Veltema et al., 1998). Chung et al. (2004) conducted another study on 774 women in Pennsylvania, which showed that PPD was quite widespread among women with lower level of education. In the study on 2514 women in 5 provinces in the eastern and south-eastern regions of Turkey in 2001, there was a significant tendency to decrease in depression with education was observed. According to the same study, the risk of PPD in uneducated women is 2 times higher than university

graduates (İnandı et al., 2002). In another study with 85 newborn mothers at Van Yüzüncü Yıl University, low-level education was found to be an important risk factor for PPD and was accused of creating a vicious cycle in terms of depression by causing side effects such as short delivery intervals, many children and child care quality decline (Gürel and Gürel, 2000). The diversity of findings in the literature suggests that income level and education level may not to be associated with PPD directly, but indirectly when evaluated with other factors.

In the current study, a significant positive correlation was found between PPD level and the age and the length of marriage in women, but not in men. Findings show that 29 years old and younger women have lower PPD levels than older women. Similarly, in Aydemir's study (2007), there was no correlation between the age of women and PPD levels. In many studies in the literature, there is no significant relationship between depression level of women and age and marriage duration (Eren, 2007, Okanlı, 2003, Sevil et al., 2004, Keleş, 2007). Cömert Okutucu (2013) and Serhan et al. (2013) also stated that age and marriage duration were not significant variables on EPDS point averages in men. In Rhamchandani's 2011 publication, there was no age-related prevalence on paternal PPD.

When the age of marriage is compared with PPD level, while it was found no significant relationship in women, a significant positive correlation was found in men. Similarly, in Aydemir's study (2007), there was no relationship between age of marriage and PPD levels of women. Green et al. (2006) conducted a study in the United Arab Emirates that late marriage was found to be an effective risk factor for maternal PPD. In Danacı's (2002) and İnandı's (2002) studies, low marriage age was determined as a risk factor for PPD: In early age, before the age of 18, the rate of depression in married women was found to be high. It has been reported in various

literature that giving birth in adolescence period is a risk factor for PPD in women (Warner et al., 1996; Georgiopoulos et al., 1999; O'Neill et al., 1990; Reid and Meadows-Oliver, 2007). Cultural and religious differences are thought to be the reason for while the low age of marriage is considered as a risk factor for maternal PPD in some studies, as a protective factor in some other studies.

In the current study, there was no significant relationship between the time passed since the delivery and PPD level. A meta-analysis study of Cameron et al. (2016) involving 74 studies reported that PPD rates in men were relatively stable throughout the transition to parenting and not depend on the timing of the evaluation. As a result of Paulson and Bazemore's (2010) study of 43 articles, maternal and paternal PPD levels were found to be relatively low in the period of from birth to 3 months postpartum, and relatively high in the 3- to 6 month postpartum period. Paulson and Bazemore (2010) reported that the measurement method used could also lead to different outcomes, in studies using questionnaire methods participants indicated a higher level of PPD than in studies using interview methods.

In the current study, PPD level was found to have a significant positive relationship with the number of people living in the house and the number of dependants in men, but was not related to these factors in women. In the study of the Cömert Okutucu (2013), a positive increase was detected between the average number of people living in the home and the number of dependants and the average EPDS scores of the fathers. The number of dependants is considered to be a more significant factor for fathers. The indirect and negative effect of this factor is mainly due to the increase in economic expenses. This is thought to increase the father's burden and the risk of depression.

There was a significant negative correlation between PPD level and marital satisfaction in this study. The findings of Alkar and Gençöz (2007), Feeney et al. (2003), Kargar et al. (2014) and Pollock et al. (2009) show that low marital satisfaction increases PPD risk and these findings support the current study. This can be interpreted as the fact that couples with a happy marriage experience have a lower risk of depression because they share tasks at home, share responsibility for child care, prepare for their new roles together and reduce each other's burden and overcome these difficult processes easier by supporting each other.

In the current study, PPD level was found to be significantly negatively correlated with perceived social support from family. It was also determined that the family subscale had a positive significant relationship with the friends subscale, the significant other subscale, and the total MSPSS score. However, PPD level was not significantly associated with perceived social support from the friends, from the significant other, and with the MSPSS total score. According to these findings, as the perceived social support from the family increases, PPD level decreases, but perceived social support from friends, from significant other and generally perceived social support are not correlated with PPD level. Similarly, Aydemir (2007) found that maternal PPD was not associated with social support. In a study examining the relationship between perceived social support and PPD level, Büyükkoca (2001) found a significant relationship between the PPD level and the perceived social support from family, friends, and significant other. Many other studies also found that PPD level is negatively correlated with social support, suggesting that social support prevents depression and that lack of social support increases the risk of depression (Beck, 2001; Robertson et al., 2004; Aydemir, 2007; Ceyhun Peker et al., 2016; Cutrano, 1986). Serhan et al. (2013) noted that the lack of social support

known to constitute a risk factor for maternal PPD also plays an important role in the development of paternal PPD. In the current study, only the perceived social support from the family is associated to the PPD may be attributed to the fact that the sample size is not large enough.

CHAPTER VI

CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

In conclusion, findings of the current study indicate that;

- PPD levels of mothers and fathers are not significantly different.
- When one of the couple experiences PPD, the other one also has increased risk for experiencing PPD.
- Education level, income level, and the time passed since the delivery do not effect the level of PPD.
- The higher the age and the length of marriage, the higher the PPD level in women, but not in men.
- When marriage age, number of people living in the house, and the number of dependants increases, PPD level also increases in men, but not in women.
- If the mothers and fathers are satisfied with their marriage, their PPD risk are lower.
- If the mothers and fathers are supported by their family, their PPD risk are lower.
- Individuals who perceive more social support from their family, friends, and significant other, they are more satisfied with their marriage.

6.2. Recommendations

6.2.1. Recommendations for clinical practice

Especially in primary care, the fathers should also be called to pregnant and healthy children follow-up, and it should be kept in mind that PPD may also occur in fathers. Mothers and fathers should be followed together for the risk of prenatal and

postpartum depression due to pregnancy, and these risks should be determined by screening tools if necessary.

It is recommended that those who have a high risk of depression or those who are diagnosed with depression should be followed up with the secondary care with a multidisciplinary approach. The effects of a depression on family members are another issue that is recommended to be followed.

6.2.2. Recommendations for the future research

In order for the results to be generalized to the Turkish society; it is recommended that similar studies should be carried out with wider groups and multi-centers, including different sociocultural and economic groups.

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APPENDICES

APPENDIX-A. ETİK KURUL ONAY YAZISI



YAKIN DOĞU ÜNİVERSİTESİ

BİLİMSEL ARAŞTIRMALAR ETİK KURULU

18.04.2017

Sayın Doç. Dr. Ebru Çakıcı

Bilimsel Araştırmalar Etik Kurulu'na yapmış olduğunuz YDÜ/SB/2017/26 proje numaralı ve **“Babalarda Doğum Sonrası Depresyon: Evlilik Doyumu ve Sosyal Destek ile İlişkisi”** başlıklı proje önerisi kurulumuzca değerlendirilmiş olup, etik olarak uygun bulunmuştur. Bu yazı ile birlikte, başvuru formunuzda belirttiğiniz bilgilerin dışına çıkmamak suretiyle araştırmaya başlayabilirsiniz.

Yardımcı Doçent Doktor Direnç Kanol

Bilimsel Araştırmalar Etik Kurulu Raportörü

Direnç Kanol

APPENDIX-B. ARAŞTIRMA İZİNİ



GİRESUN İLİ KAMU HASTANELERİ BİRLİĞİ GENEL
SEKRETERLİĞİ - GİRESUN İLİ KHBGS İDARİ
HİZMETLER BAŞKANLIĞI
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SAĞLIK BAKANLIĞI
Türkiye Kamu Hastaneleri Kurumu Başkanlığı
Giresun İli Kamu Hastaneleri Birliği Genel Sekreterliği

Sayı : 42991614-663.08
Konu : Araştırma İzni
Psk. İrem Bengü ŞENSOY

GENEL SEKRETERLİK MAKAMINA

Yakın Doğu Üniversitesi Klinik Psikoloji Yüksek Lisans öğrencisi İrem Bengü ŞENSOY'un "Babalarda Doğum Sonrası Depresyon: Evlilik Doyumu ve Sosyal Destek ile İlişkisi" konulu anket çalışmasını Birliğimize bağlı GRÜ Kadın Doğum ve Çocuk Hastalıkları Eğitim ve Araştırma Hastanesi polikliniğine başvuran hastalar üzerinde 01.04.2017 - 01.06.2017 tarihleri arasında hizmeti aksatmayacak şekilde gönüllük esasına göre uygulaması ve söz konusu çalışmanın sonucunun Genel Sekreterliğimiz ve Bakanlığımız bilgisi dışında ilan edilmemesi kaydıyla yapması Başkanlığımızca uygun değerlendirilmekte olup Makamlarımızca da uygun görüldüğü takdirde Olur'larınıza arz ederim.

Dr. Muhammet AKSU
İdari Hizmetler Başkanı

OLUR
.../.../2017

Opr.Dr. Hasan H. ARSLANTÜRK
Genel Sekreter

EKLER:
-Araştırma (32 Sayfa)

Eğitim Birimi / İdari Hizmetler Başkanlığı
Faks No:04542701004
e-Posta:pembe.yildiz@saglik.gov.tr İnt.Adresi: www.giresunkhb.gov.tr

Bilgi için:PEMBE YILDIZ
Unvan:HEMŞİRE
Telefon No:0(454) 270 10 00 - 1165

Evrakın elektronik imzalı suretine <http://e-belge.saglik.gov.tr> adresinden 372c946f-909e-4e61-9b17-47f5e723acc5 kodu ile erişebilirsiniz.
Bu belge 5070 sayılı elektronik imza kanuna göre güvenli elektronik imza ile imzalanmıştır.

APPENDIX-C. AYDINLATILMIŐ ONAM

Bu alıŐma, Yakın DoĐu niversitesi Fen Edebiyat Fakltesi Psikoloji Blm tarafından gerekleŐtirilen bir alıŐmadır.

Bu alıŐmanın amacı yakın zamanda ocuk sahibi olmuŐ iftlerin depresyon dzeylerini ve bununla iliŐkili olabilecek bazı faktrleri incelemektir.

Anket tamamen bilimsel amalarla dzenlenmiŐtir. Anket formunda kimlik bilgileriniz yer almayacaktır. Size ait bilgiler kesinlikle gizli tutulacaktır. alıŐmadan elde edilen veriler yalnızca istatistik veri olarak kullanılacaktır. Yanıtlarınızı iten ve doĐru olarak vermeniz bu anket sonularının toplum iin yararlı bir bilgi olarak kullanılmasını saĐlayacaktır.

Telefon numaranız anketrn denetlemesi ve anketin uygulandıĐının belirlenmesi amacıyla istenmektedir.

Yardımanız iin ok teŐekkr ederim.

Psikolog
İrem Beng Őensoy

Yukarıdaki bilgilerin tmn ayrıntılı biimde okudum ve anketin uygulanmasını onayladım.

İsim:

İmza:

Telefon:

APPENDIX-D. BİLGİLENDİRME FORMU**Babalarda Doğum Sonrası Depresyon: Evlilik Doyumu ve Sosyal Destek ile İlişkisi**

Bu çalışmanın amacı yakın zamanda çocuk sahibi olmuş çiftlerin depresyon düzeylerini ve bununla ilişkili olabilecek bazı faktörleri belirlemektir.

Bu çalışmada size bir demografik bilgi formu ve bir dizi ölçek sunduk. Demografik bilgi formu sizin yaş cinsiyet gibi demografik özellikleriniz hakkındaki soruları içermektedir. Ölçekler ise doğum sonrası depresyon düzeyinizi ve depresyon düzeyinizin evlilik yaşantınız ve aldığınız sosyal destek ile ilişkisini ölçmektedir.

Daha önce de belirtildiği gibi, ölçeklerde ve görüşmelerde verdiğiniz cevaplar kesinlikle gizli kalacaktır. Eğer çalışmayla ilgili herhangi bir şikayet, görüş veya sorunuz varsa bu çalışmanın araştırmacılarından biri olan Psk. İrem Bengü Şensoy ile iletişime geçmekten lütfen çekinmeyiniz ([email: bengusensoy@gmail.com](mailto:bengusensoy@gmail.com)).

Eğer araştırmanın sonuçlarıyla ilgileniyorsanız, 01.07.2017 tarihinden itibaren araştırmacıyla iletişime geçebilirsiniz.

Katıldığınız için tekrar teşekkür ederim.

Psikolog
İrem Bengü Şensoy
Psikoloji Bölümü,
Yakın Doğu Üniversitesi,
Lefkoşa.

APPENDIX-E. Demografik Bilgi Formu

Cinsiyetiniz:

Kadın Erkek

Yaşınız:

Eğitim düzeyiniz:

Okur-yazar İlkokul Ortaokul Lise Üniversite Yüksek
Lisans ve üstü

Çalışma durumunuz:

Çalışıyor Çalışmıyor

Aylık geliriniz:

Evlilik yaşınız:

Evlilik süresi:

Doğum sonrası dönem (ay):

Kaçıncı doğumunuz?:

Bebğinizin cinsiyeti:

Kız Erkek

Bebğinizin cinsiyetinden memnun musunuz?

Evet Hayır

Gebeliğiniz planlı mıydı?

Planlı Plansız/istenen Plansız/istenmeyen

Tedavi ile gerçekleşen bir gebelik miydi?

Evet Hayır

Cinsiyet beklentiniz var mıydı?

Kız Erkek Fark etmez

Kürtaj/düşük geçmişiniz var mı?

Kürtaj Düşük Kürtaj ve düşük Yok

Kronik bir hastalığınız var mı?

Yok Var (Belirtiniz:

Psikiyatrik bir hastalığınız var mı?

Yok Var (Belirtiniz:

Ailenizde psikiyatrik hastalığı olan biri var mı?

Yok Var (Belirtiniz:

Evde yaşayan kişi sayısı:

Bakmakla yükümlü olunan kişi sayısı:

APPENDIX-F. EYÖ

Aşağıda evlilik yaşamına ilişkin 10 cümle bulunmaktadır. Bu cümlelerden her birinin altında da “kesinlikle katılmıyorum”, “katılmıyorum”, “kararsızım”, “katılıyorum” ve “kesinlikle katılıyorum” seçenekleri yer almaktadır. Her cümleyi dikkatle okuyunuz ve sizin evlilik yaşamınıza uyan seçeneği çarpı (X) koyarak işaretleyiniz.

1. Evlilikten beklediklerimin çoğu gerçekleşti.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kesinlikle Katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle Katılıyorum

2. Evliliğimizdeki engellerin aşılamaz olduğunu düşünüyorum.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kesinlikle Katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle Katılıyorum

3. Evliliğimizi çok anlamlı buluyorum.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kesinlikle Katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle Katılıyorum

4. Evliliğimizde giderek eksilen heyecan beni rahatsız ediyor.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kesinlikle Katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle Katılıyorum

5. Evliliğimiz zaman zaman bana bir yük gibi geliyor.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kesinlikle Katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle Katılıyorum

6. Huzurlu bir ev yaşamım var.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kesinlikle Katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle Katılıyorum

7. Evliliğimiz her geçen gün daha iyiye doğru gitti.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kesinlikle Katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle Katılıyorum

8. Bizim ilişkimiz ideal bir karı-koca ilişkisidir.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kesinlikle Katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle Katılıyorum

9. Eşim benim için aynı zamanda iyi bir arkadaştır.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kesinlikle Katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle Katılıyorum

10. Başbaşa kaldığımız zaman benim canım hiç sıkılmaz.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kesinlikle Katılmıyorum	Katılmıyorum	Kararsızım	Katılıyorum	Kesinlikle Katılıyorum

APPENDIX-G. ÇBASDÖ Gözden Geçirilmiş Formu

Aşağıda 12 cümle ve her bir cümle altında da cevaplarınızı işaretlemeniz için 1'den 7'ye kadar rakamlar verilmiştir.

Her cümlede söylenenin sizin için ne kadar çok doğru olduğunu veya olmadığını belirtmek için o cümle altındaki rakamlardan yalnız bir tanesini daire içine alarak işaretleyiniz. Bu şekilde 12 cümlenin her birine bir işaret koyarak cevaplarınızı veriniz.

Lütfen hiçbir cümleyi cevapsız bırakmayınız. Sizce doğruya en yakın olan rakamı işaretleyiniz.

- 1.** Ailem ve arkadaşlarım dışında olan ve ihtiyacım olduğunda yanımda olan bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) var.
Kesinlikle hayır 1, 2, 3, 4, 5, 6, 7 kesinlikle evet.
- 2.** Ailem ve arkadaşlarım dışında olan ve sevinç ve kederlerimi paylaşabileceğim bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) var.
Kesinlikle hayır 1,2,3,4,5,6,7 kesinlikle evet
- 3.** Ailem (örneğin, annem, babam, eşim, çocuklarım, kardeşlerim) bana gerçekten yardımcı olmaya çalışır.
Kesinlikle hayır 1,2,3,4,5,6,7 kesinlikle evet
- 4.** İhtiyacım olan duygusal yardımı ve desteği ailemden (örneğin, annemden, babamdan, eşimden, çocuklarımdan, kardeşlerimden) alırım.
Kesinlikle hayır 1,2,3,4,5,6,7 kesinlikle evet
- 5.** Ailem ve arkadaşlarım dışında olan ve beni gerçekten rahatlatan bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) var.
Kesinlikle hayır 1,2,3,4,5,6,7 kesinlikle evet
- 6.** Arkadaşlarım bana gerçekten yardımcı olmaya çalışırlar.
Kesinlikle hayır 1,2,3,4,5,6,7 kesinlikle evet
- 7.** İşler kötü gittiğinde arkadaşlarıma güvenebilirim.
Kesinlikle hayır 1,2,3,4,5,6,7 kesinlikle evet
- 8.** Sorunlarımı ailemle (örneğin, annemle, babamla, eşimle, çocuklarımla, kardeşlerimle) konuşabilirim.
Kesinlikle hayır 1,2,3,4,5,6,7 kesinlikle evet
- 9.** Sevinç ve kederlerimi paylaşabileceğim arkadaşlarım var.
Kesinlikle hayır 1,2,3,4,5,6,7 kesinlikle evet
- 10.** Ailem ve arkadaşlarım dışında olan ve duygularıma önem veren bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) var.
Kesinlikle hayır 1,2,3,4,5,6,7 kesinlikle evet
- 11.** Kararlarımı vermede ailem (örneğin, annem, babam, eşim, çocuklarım, kardeşlerim) bana yardımcı olmaya isteklidir.
Kesinlikle hayır 1,2,3,4,5,6,7 kesinlikle evet
- 12.** Sorunlarımı arkadaşlarımla konuşabilirim.
Kesinlikle hayır 1,2,3,4,5,6,7 kesinlikle evet

APPENDIX-H. EDSÖ

Yakın zamanlarda bebeğiniz oldu. Sizin son hafta içindeki duygularınızı öğrenmek istiyoruz. Böylelikle size daha iyi yardımcı olabileceğimize inanıyoruz. Lütfen, yalnızca bugün değil son 7 gün içinde, kendinizi nasıl hissettiğinizi en iyi tanımlayan ifadeyi işaretleyiniz.

Son 7 gündür;

1) Gülebiliyorum ve olayların komik tarafını görebiliyorum.

- Her zaman olduğu kadar
- Artık pek o kadar değil
- Artık kesinlikle o kadar değil
- Artık hiç değil

Son 7 gündür;

2) Geleceğe hevesle bakıyorum.

- Her zaman olduğu kadar
- Her zamankinden biraz daha az
- Her zamankinden kesinlikle daha az
- Hemen hemen hiç

Son 7 gündür;

3) Bir şeyler kötü gittiğinde gereksiz yere kendimi suçluyorum.

- Evet, çoğu zaman
- Evet, bazen
- Çok sık değil
- Hayır, hiçbir zaman

Son 7 gündür;

4) Nedensiz yere kendimi sıkıntılı ya da endişeli hissediyorum.

- Hayır, hiçbir zaman
- Çok seyrek
- Evet, bazen
- Evet, çoğu zaman

Son 7 gündür;

5) İyi bir nedeni olmadığı halde, korkuyor ya da panikliyorum.

- Evet, çoğu zaman
- Evet, bazen
- Hayır, çok sık değil
- Hayır, hiçbir zaman

Son 7 gündür;

- 6) Her şey giderek sırtıma yükleniyor.
- Evet, çoğu zaman hiç başa çıkamıyorum
 - Evet, bazen eskisi gibi başa çıkamıyorum
 - Hayır, çoğu zaman oldukça iyi başa çıkamıyorum
 - Hayır, her zamanki gibi başa çıkabiliyorum

Son 7 gündür;

- 7) Öylesine mutsuzum ki uyumakta zorlanıyorum.
- Evet, çoğu zaman
 - Evet, bazen
 - Çok sık değil
 - Hayır, hiçbir zaman

Son 7 gündür;

- 8) Kendimi üzüntülü ya da çökkün hissediyorum.
- Evet, çoğu zaman
 - Evet, oldukça sık
 - Çok sık değil
 - Hayır, hiçbir zaman

Son 7 gündür;

- 9) Öylesine mutsuzum ki ağlıyorum.
- Evet, çoğu zaman
 - Evet, oldukça sık
 - Çok seyrek
 - Hayır, asla

Son 7 gündür;

- 10) Kendime zarar verme düşüncesinin aklıma geldiği oldu.
- Evet, oldukça sık
 - Bazen
 - Hemen hemen hiç
 - Asla

APPENDIX-I. CURRICULUM VITAE

İrem Bengü Şensoy was born in 1993 in Giresun. She completed elementary school education at Gazipaşa Elementary School between the years 1999-2007, and high school education at Hamdi Bozbağ Anatolian High School between the years 2007-2011. Then she graduated from Psychology Undergraduate Programme from Cyprus International University between the years 2011-2015. Lastly, she graduated from Clinical Psychology Master's Programme from Near East University between the years 2015-2017.

She made intership at Prof. Dr. A. İlhan Özdemir Public Hospital in February, 2015, Ankara Atatürk Training and Research Hospital in January, 2016, and at Gazi University Medical Faculty Hospital in June, 2016.

APPENDIX-J. ORIGINALITY REPORT

7/4/2017

Turnitin Originality Report

 **Turnitin Originality Report**

tez by İrem Bengü Şensoy

From clinical psychology (clinical psychology)

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