YEDİTEPE UNIVERSITY
INSTITUTE OF HEALTH SCIENCES
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EFFECT OF CHILDHOOD TRAUMA ON HEALTH IN ADULTHOOD

Seda ERDOĞAN

MASTER THESIS

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ONAY

Bu tez Yeditepe Üniversitesi Lisansüstü Eğitim-Öğretim ve Sınav Yönetmeliğinin ilgili maddeleri uyarınca yukarıdaki jüri tarafından uygun görülmüş ve Enstitü Yönetim Kurulu'nun 07/02/2020.. tarih ve 02-04..... sayılı kararı ile onaylanmıştır.

Prof. Dr. Bayram YILMAZ
Sağlık Bilimleri Enstitüsü Müdürü

DECLARATION

I hereby declare that this thesis is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which has been accepted for the award of any other degree except where due acknowledgment has been made in the text.

Seda ERDOĞAN

23.01.2020

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SYMBOLS AND ABBREVATION INDEX

BDI-PC	Beck Depression Inventory for Primary Care
BMI	Body Mass Index
CTQ-SF	Childhood Trauma Questionnaire – Short Form
SPSS	Statistical Package for Social Sciences
T.R.	Turkish Republic
TSSCPI	Turkish Social Service and Children Protection Institution
UNICEF	United Nations International Children Emergency Fund
USA	United States of America
WHO	World Health Organization

ABSTRACT

Erdogan S. (2020). Effect Of Childhood Trauma On Health In Adulthood. Yeditepe University, Institute Of Health Science, Depertment Of Public Healt Msc Thesis, Istanbul

Introduction and Aim: It is thought that childhood experiences of the individual have an effect on his/her behavior and attitudes in adulthood. Although many studies have been carried out about the effects of childhood experiences on adulthood, especially in developed countries, it is seen that there is a limited number of studies in developing countries. This study aims to examine the effect of childhood traumas of the healthcare providers of Karamursel State Hospital in Kocaeli province on their health and understanding of health in adulthood.

Method: The sample of this cross-sectional analytical study consists of the healthcare providers of Karamursel State Hospital. Data collection were performed between April-May, 2019, by sealed questionnaire method. In descriptive statistics, while frequency and percentages were calculated for categorical variables, their means and standard deviations were taken for continuous variables. On the other hand, chi-square, t-test and logistic regression analysis were used for the presence of the relationship between the dependent and independent variables used in the study.

Results: When the questionnaires used for the purpose of the study are evaluated, depression was found in 68.9% of the participants. When it comes to subscales of the healthy lifestyle scale, the following results were found to be low or absent in the specified percentage of participants: moral development in 46.2% of the participants; health responsibility in 45.8%, physical activity status in 52.8%, nutritional habit in 48.6%, interpersonal relationships in 49.1%, and stress management in 51.4%. When the subscales of the Childhood Trauma Questionnaire are examined, the results are as follows: physical abuse in 26.8% of the parcipants was high, while emotional abuse in 48.8%, physical neglect in 55.5% and emotional neglect in 55.0% was high. The overall result of the Childhood Trauma Questionnaire was found to be high at a rate of 51.7%.

Conclusion: It was found that childhood trauma has a negative effect on the presence of depression and a healthy lifestyle in adulthood.

Key words: childhood, trauma, addiction, depression, healthy lifestyle

ÖZET

Erdogan S. (2020). Çocukluk Dönemi Örselenme Yaşantilarinin Erişkin Dönemde Sağlik Üzerine Etkisi. Yeditepe Üniversitesi, Halk Sağliği Anabilim Dali, Yüksek Lisans Tezi, İstanbul

Giriş ve amaç: Bireyin çocukluk dönemi yaşantısının erişkin dönemdeki davranış ve tutumları üzerinde etkisi olduğu düşünülmektedir. Bugüne kadar özellikle gelişmiş ülkelerde çocukluk dönemi yaşantılarının erişkin dönemine etkisi ile ilgili birçok çalışma yapılmış olmakla birlikte gelişmekte olan ülkelerde sınırlı sayıda araştırma bulunmaktadır. Bu araştırmanın amacı; Kocaeli iline bağlı Karamürsel Devlet Hastanesi çalışanlarının çocukluk dönemi örselenme yaşantılarının, erişkin dönemdeki sağlıkları ve sağlık anlayışları üzerine etkisinin incelenmesidir.

Yöntem: Bu çalışma kesitsel analtik tipte bir araştırmadır. Araştırma örneğini, Karamürsel Devlet Hastanesi çalışanları oluştrumaktadir. Katılımcılardan veriler 2019 Nisan-Mayıs ayları arasında kapalı zarf anket yöntemi ile toplanmıştır. Tanımlayıcı istatistiklerde, kategorik değişkenler için frekans ve yüzdeleri hesaplanırken, sürekli değişkenler için ortalamaları ve standart sapmaları alınmıştır. Çalışmada kullanılan bağımlı ve bağımsız değişkenler arasındaki ilişkinin varlığı için ise ki-kare, t-test ve lojistik regresyon analizleri kullanılmıştır.

Bulgular: Çalışmanın amacına yönelik kullanılan anketler değerlendirildiğinde katılımcıların %68.9'unda depresyon saptanmıştır. Sağlıklı yaşam biçimi ölçeğinin alt ölçekleri incelendiğinde ise %46.2'sinin manevi gelişimi, %45.8'inin sağlık sorumluluğu, %52.8'inin fiziksel aktivite durumu, %48.6'sının beslenme alışkanlığı, %49.1'inin kişiler arası ilişkileri, %51.4'ünün stres yönetimi düşük ya da yok çıkmıştır. Çocukluk Dönemi Örselenme Yaşantıları Ölçeğinin alt ölçekleri incelendiğinde ise sonuçlar, %26.8'inin fiziksel istismarı, %48.8'inin duygusal istismarı, %55.5'inin fiziksel ihmali, %55.0'ının duygusal ihmali yüksek şeklindedir. Çocukluk dönemi örselenme yaşantıları ölçeğinin genel sonucu ise %51.7 oranında yüksek çıkmıştır.

Sonuç: Çocukluk dönemi örselenme yaşantılarının erişkin dönemde depresyon varlığı ve sağlıklı yaşam biçimi üzerinde negatif yönde ilişkisi olduğu saptanmıştır.

Anahtar Sözcükler: çocukluk dönemi,örselenme,bağımlılık, depresyon, sağlıklı yaşam

1. INTRODUCTION AND AIM

It is a known fact that traces of trauma experienced by the individual in his/her childhood carry on in the future period of the person albeit at different levels. Studies to date reveal these long-term effects of childhood trauma. In these studies, it is stated that individuals who get childhood trauma show more emotional and psychotic reactions in dealing with daily stresses in adulthood (1).

It was noteworthy to observe the health problems in parallel with the increase of case reports of child abuse in the 1970s. The presence and effects of emotional abuse and verbal violence, on the other hand, started to be discussed after the 1980s (2). In studies conducted in Turkey in 1995, it was found that 43% of the families with children in the 7-14 age group experienced physical violence, while there was verbal violence in 53% of them (3). In 215 cases who applied to a child protection unit of a training in four years, physical abuse was found in 29.8% of the said cases, emotional abuse in 21.4% and sexual abuse in 9.8%. The diagnosis of neglect was made in 39.5% of the cases (4). In the studies conducted in Turkey on this issue, emotional abuse, which ranks first, comes out with a high rate of 78%. Emotional abuse can be progress alone or along with physical and sexual abuse. Emotional neglect and abuse were found in 90% of physical abuse and neglect cases. Sexual abuse was reported at rates ranging from 5-28% (5).

According to the National Incidence Study-4 of USA (United States of America), in 2005-2006, one in every 58 children was abused or neglected. While the rate of abuse of these children who were abused or neglected was 44%, the remaining children were exposed to neglect. In the report stating the total number of cases in the literature as 2.905.800, it is thought that 2.400 children died for this reason (6). The report of the USA Children's Bureau states that, in 2012, 678.810 children were victims of abuse or neglect. This result, in other words, shows that 9.2 out of every thousand children are victims (7). The results of a research carried out by Turkish Social Service and Children Protection Institution (TSSCPI) and UNICEF (United Nations International Children Emergency Fund) together show that 25% of children are neglected, 3% are sexually abused and 45% are physically abused. In addition, it was stated that one in two children in the 7-18 age group is a victim of emotional abuse (8). Both international and national data reveal that the number of abused children is a considerable amount.

Negative traces of trauma that have a great impact on all segments of society can

continue life long and these traces not only affect the health of the people but also reach the dimensions that can harm the society (9). The research of the World Health Organization (WHO) revealed that childhood abuse has serious effects on the mental and physiological health of individuals (10).

Table 1: Health-related consequences of child abuse (10)

PHYSICAL	• Abdominal/chest damages • Brain damages • Bruises and strip-shaped scars • Central nervous system damages • Injury • Fractures • Tears and abrasions • Ophthalmic damages
SEXUAL REPRODUCTIVE HEALTH	• Health problems related to the reproductive system • Sexual dysfunction • Sexually transmitted diseases, including HIV/AIDS • Unplanned pregnancy
MENTAL AND BEHAVIORAL	• Alcohol and drug abuse • Cognitive damage • Delinquency (juvenile crime), showing acts of violence and other risky-behaviors • Depression and anxiety • Developmental pauses • Eating and sleep disorders • Feelings of shame and guilt • Hyperactivity • Poor relationships • Poor school success • Lack of self-confidence • Posttraumatic Stress Disorder (PTSD) • Psychosomatic disorders • Suicidal and self-mutilative behaviour
OTHER LONG-TERM HEALTH RESULTS	• Cancer • Chronic lung diseases • Fibromyalgia syndrome • Irritable bowel syndrome • Ischemic heart diseases • Liver diseases • Reproductive system diseases such as infertility

Looking at all these physical and psychiatric consequences determined to be caused, to investigate and understand childhood traumas, and then to identify and apply protective and therapeutic factors emerge as important issues both socially and personally. Studies investigating childhood trauma have increased in recent years; both socially and clinically applicable protective, preventive and healing factors are centered on (Table 1).

1.1. Aim of the Study:

It is known that childhood traumas pose a risk for various negative behaviours on the state of complete physical, mental and social well-being that appear in the definition of health of the WHO. This study aims to identify the childhood traumas of the health care personnel of Karamursel State Hospital in Kocaeli province and to evaluate the effect childhood traumas on mental health and healthy lifestyle behaviors in adulthood. The objectives of the study determined for this purpose are;

1. To determine the prevalence of childhood traumas,
2. To determine the presence of primary level depression,
3. To evaluate the healthy lifestyle behaviours,
4. To identify the relation between the presence of childhood trauma and the presence of depression,
5. To evaluate the relation between the presence of childhood trauma and healthy lifestyle behaivours.

2. GENERAL INFORMATION

"The exposure of the child by the persons who are liable to look after or other adults in his/her childhood to the events that prevent his/her physical, emotional, mental and sexual development and that harm his/her body or mental health, which occur not accidentally is defined as child abuse" (11). We can categorize abuses as physical, emotional, and sexual abuse and neglect (12). Causing negative effects to the child also in adulthood, these maltreatments sometimes appear as physical and sexual abuse, while sometimes they can occur as emotional abuse, such as attacks or punishments that negatively affect the child's self-perception and development, and sometimes as neglect such as not meeting his/her basic physical (feeding, safety/protection, education, and health) and emotional (love, compassion, support, and interest) needs (13). As a result of these neglects and abuses, indelible traces of mental, physiological, sexual and social aspects are observed in children, moreover, their lives, their right to be healthy individuals and their safety can be imperiled (14). Many of the child neglect and abuse, which started from the existence of humanity, are still unknown even today and not being reported. Childhood neglect and abuse, the traces of which are also observed in adulthood and one of the most difficult trauma types to identify and treat due to its long-term effects, was found not to happen for one time, on the contrary, its recurrence always continues; moreover, these abuses are generally done by people around the child (15).

"Physical abuse is the physical damages of children caused by the persons who are liable to look after them, in other words, their physical integrity is impaired" (16). In its widest sense, physical abuse is defined as the injury of the child apart from an accident, this includes events that occur from a simple slap to the events resulted with harm, injury or death of the child" (15). The vast majority of physical neglect and abuse occur in infants and preschooler children. Because the fact that children of this age cannot defend themselves and cannot explain their experiences is among the most effective reasons. About two thirds of children who are physically neglected and abused are children under three years old (17). Although the story of the event in child abuse is very important, the child can rarely tell this event himself/herself. For this reason, the abuses in children are tried to be hidden mostly with the explanation of "by accident" (18).

Today, emotional abuse is considered as one of the important psychosocial problems. In Turkey, about one in two children faces emotional abuse (19). "Emotional abuse is defined as the behaviors that persist and may lead to psychological negative effects that are applied to

the child by the persons who are liable to look after him/her" (20). "Emotional abuse includes behaviors that cause disruptions in the child's development, trigger emotional and behavioral problems, affect and eliminate the well-being of the child" (21). For this reason, it is stated that children growing up with emotional neglect and abuse experience more introversion-extroversion problems than other children (22). It can be said that emotional neglect and abuse in childhood affect the individual's being in complete well-being, both psychologically and physiologically.

There is no definition of child sexual abuse accepted by everybody, nor standardized comparison methods. Therefore, there is a natural necessity to define this problem and to determine its limits as a concept (23). The definition of sexual neglect and abuse in childhood has been defined in different ways both in terms of words and meaning, besides, these sexual abuse and sexual harassment incidents have been named with different concepts in Turkish. Some used the expression of "sexual maltreatment" (24), while others preferred to use the expression of "child sexual abuse" (25). "In its first definitions, child sexual abuse was considered as the involvement of children and adolescents, who are dependent on adults and have not completed their development yet, in sexual activities that they are not fully aware of" (26). In another definition, it is defined as "any act made by an adult or an elder person with the intention of sexually arouse himself or the child" (27), while Kutchinsky states this as "abusing the child by an adult or elder person to reach sexual satisfaction" (28). Later, Jarvis, Copeland and Walton defined child sexual abuse as "an undesirable experience being lived after someone touching a person under the age of 16 in a sexual way (29).

In the past, health was associated with youth. However, chronic diseases such as diabetes, heart, blood pressure and cancer threaten the people of all ages today. Therefore, protecting and improving the health of people from all ages is of great importance for public health. Understanding the functioning and functions of social institutions plays an important role in ensuring that the efforts to protect and improve health are effective and successful (30). The concepts of health and disease are not only a medical term, but also a psychological, anthropological and sociological concept. The solution of public health problems, therefore, also requires an interdisciplinary approach (31). Health promotion is defined as "gaining the power of improving one's own health and increasing control over his own health". Taking precautions to avoid Diseases are health-promoting behaviors that play a key role in early diagnosis of health problems that may occur and maintain health. According to Pender, healthy lifestyle behaviors are inner development, health responsibility, exercise, nutrition,

interpersonal relationships, and stress management (32). Health responsibility is that one can take responsibility for his own well-being, increase the level of knowledge and get professional help when necessary. Physical activity is when exercise can be part of daily life on a regular basis. Nutrition is the ability to choose and organize meals. Inner development focuses on the improvement of internal resources. Development can occur through entering a relationship and transcendence. Transcendence provides inner peace, it creates the possibility of providing opportunities for further new experiences other than who we are and what we do. Building a relationship is to be in the relationship with the universe and to feel in harmony. Development is working for life purposes and it is the individual's maximizing his strength towards his well-being. Interpersonal relationships are relationships with others, communication is necessary to establish a meaningful relationship. Communication involves sharing thoughts and emotions through messages. Stress management is the ability of the individual to identify and mobilize physiological and psychological resources in order to reduce tension or control effectively (33).

Depression, on the other hand, is considered as one of the most discussed issues in the field of mental health in recent years and it is observed that this problem gradually threatens young individuals in terms of of their interpersonal relations. It is among the long-term negative consequences of childhood trauma affecting the adulthood. Studies reveal that there is a relationship between childhood traumas and physical disorders such as obesity, psoriasis, migraine, chronic pain, and various mental disorders such as post-traumatic stress disorder, substance-use disorders, personality disorders, eating disorders, somatization disorder, and bipolar disorder seen in adulthood. The relationship between anxiety and depression which are among mental disorders and childhood trauma history is particularly emphasized. Besides, it was reported that the age of onset was lower, the number of depression attacks was higher, and persistent depressive symptoms and psychotic symptoms were more common in depression patients with a history of childhood trauma (34). In addition, it is estimated that there is a relationship between various psychiatric disorders such as schizophrenia and drug addiction and self-destruction behavior and the presence of childhood trauma (35).

Social relationships are important for individuals from all age groups. It is one of the basic needs for people to communicate and establish relationships with other people. With the effect of many reasons, today, interpersonal communication is getting worse and the number of people who deprive of warm/intimate communication and establishing relationships is rapidly increasing. One of the factors that negatively affect relationships is loneliness. The increase in the prevalence of this situation and the negative effects we face as a result of its existence are

important problems that increase with each passing day (36). Loneliness is a hard-to-define, complicated and annoying experience (37). Loneliness is often expressed in the society as “a state of being physically alone” (38). Loneliness is not very related to age and social status, it is a situation in which people of all ages and social situations can experience even at certain periods of their lives (37). Loneliness emerges as a feeling even while being together with other people physically. Therefore, loneliness is based on the ground of inadequate social relations and the low level of satisfaction with these relationships (38). Social support is defined as the assistance provided to the individual by the people around him/her. In situations of crisis and emotional stress, individuals stand to rely on their family members and friends, who are considered natural helpers. This support network created by these informal assistants has a significant impact on the individual's adaptation period and health (39).

As clearly stated above, in national and international research, childhood traumas that have been touched on, researched and discussed from past to present have been found to have various negative effects on one's own physical and mental health. This study aims to retrospectively examine childhood traumas, to investigate the retrospective childhood of healthcare providers taking an active role in the health of other people, and to analyze the effects of these traumas on education level, mate selection, addiction, depression and their lifestyle and attitudes such as their healthy lifestyle and awareness in adulthood.

3. MATERIAL AND METHOD

3.1. Type of the Research

This study is a cross-sectional analytical research.

3.2. Research Sample

This study consists of the healthcare providers working in Karamursel State Hospital in Kocaeli province. All units and all professional groups in the hospital were included in the research. A separate sample has not been selected for the study.

3.3. Duration of the Research

The data were collected through the questionnaires filled out by the participants in person between the dates of April-May in 2019.

3.4. Data Collection Method

The questionnaires were distributed to the participants in closed envelopes with the same type and color pens at the beginning of the shift. Participants were informed about the questionnaire. Appropriate conditions were provided for everyone to answer the questionnaire on their own; following to wait for them to complete the questionnaire, the questionnaires were collected back with the closed-box technique. Before collecting data, a pretest of the questionnaire was carried out with a small group of 15 people among the hospital staff.

3.5. Variables

3.5.1. Dependent Variables

Table 2. Dependent variables

Variable	Definition	Source
Use of Cigarette	According to the World Health Organization (WHO) classification, regular use of at least one cigarette per day is defined as the presence of smoking.	Survey
Use of Alcohol	It was evaluated through the answers to the questions of 'Do you consume alcoholic beverages?' and 'How often do you consume it?'	Survey
Using Internet	To measure Internet addiction, 'Internet Addiction among University Students and the Profile of Interner Addicts Scale' was used. The answers of 'What is your daily Internet usage time?' were taken into consideration. Variable consists of four categories: 'once a week and 2-3 days a week' represents less frequent use, while '4-5 days a week, everyday regularly' means frequent use and addiction.	Internet Addiction among University Students and the Profile of Interner Addicts
Healthy Lifestyle	Healthy Lifestyle Scale-II was used to measure the healtyh lifestyle. This scale, which was adapted to Turkish and whose validity and reliability study was conducted, consists of 52 items. The analysis of the questions included in the questionnaire and the internal consistency were made with the Cronbach Alpha reliability analysis. Item total score correlations of the scale range from 0.30 to 0.59, and it was found statistically significant ($p<0.001$). The Cronbach Alpha internal reliability coefficient of the scale is 0.92. The scale has 6 sub-factors: moral development, health responsibility, physical activity, nutrition, interpersonal relationships, and stress management. These subgroups were categorized as high and low according to the median values. All of the items of the scale were positive and the total score of the scale gives the score of healthy lifestyle behaviors. For the entire scale, the minimum score was 52, while the maximum was 208.	Healthy Lifestyle Scale-II
Depression	Depression levels of the participants were determined by 'Beck Depression Inventory for Primary Care'. The scale has been adapted to Turkish and its validity and reliability have been carried out. The Cronbach Alpha reliability coefficient of the scale was found to be 0.85, while Spearman-Brown coefficient was 0.86 and Guttman Split-Half coefficient was 0.82. BDI-PC makes screening under the following seven titles: sadness, pessimism, past failure, self-dislike, self-criticalness, loss of interest, and suicidal thoughts or wishes. Each answered on scale of 0-absent to 3-severe. BDI-PC score is obtained by adding the highest scores in each title. A total of 21 points can be obtained in total. Although no cutoff score was reported, the probability of depression is above 90% in points above 4.	Beck Depression Inventory for Primary Care

3.5.2. Independent variables

Table 3. Independent variables

Variable	Definition	Source
Childhood Trauma	Childhood Trauma Questionnaire Short Form (CTQ-SF), which was developed by Bernstein et al. (2003), has been adapted in Turkish and its validity and reliability study was conducted. Both original and Turkish version of CTQ-SF consists of 28 items, it has 5 subscales: 1) Physical abuse 2) Physical neglect 3) Emotional abuse 4) Emotional neglect, and 5) Sexual abuse. However, the 5th subscale, sexual abuse, was not used in our study. The correlation measured for the entire scale and the split-half test reliability was found to be 0.73 by splitting the scale and using Spearman-Brown formula. A positive, high and significant relationship was found between the pretest and posttest scores of the CTQ-SF ($r=.78$, $p<.01$). It can be said that CTQ-SF test-retest correlation is moderate and significant.	Childhood Trauma Questionnair Short Form

3.5.3. Definitions for descriptive variables

Table 4. Descriptive Variables

Variable	Definition	Source
Gender	Genders of the participants were defined.	**Survey**
Age	Measured using the dates of birth of the participants.	**Survey**
Profession	The answers to the question of 'What is your profession?' were taken into consideration.	**Survey**
Height-Weight	The answers to the question of 'What is your height-weight?' were taken into consideration.	**Survey**
Unit worked	The answers to the question of 'In which unit do you work?' were taken into consideration.	**Survey**
Working year	The answers to the question of 'How many years have you been working?' were taken into consideration.	**Survey**
Shift working status	The answers to the question of 'Do you work shifts?' were taken into consideration.	**Survey**
Marital status	The answers to the question of 'What is your marital status?' were taken into consideration. It consists of seven categories: single, widow, divorced, married, cohabiting, I don't know, I don't want to give an answer.	**Survey**
Education status	The answers to the question of 'What is your education status?' were taken into consideration. It consists of eleven categories: not literate, literate, primary, secondary, high-school, undergraduate, graduate, post graduate, PhD, I don't know, I don't want to give an answer. Education status was categorized as high and low: below high-school was considered 'low', high-school and above was considered 'high'.	**Survey**
Parent-spouse education level	Separately, the answers given to the parents-spouse education status questions were taken into consideration. It consists of eleven categories: not literate, literate, primary, secondary, high-school, undergraduate, graduate, post graduate, PhD, I	**Survey**

	don't know, I don't want to give an answer.	
Children	The answers to the question of 'Do you have children?' were taken into consideration.	**Survey**
Socio-economic level	The answers to the question of 'How do you evaluate your socio-economic level?' were taken into consideration. It consists of seven categories: very low, low, medium, high, very high, I don't know, I don't want to give an answer.	**Survey**

Statistical Method: Descriptive statistics were used for the socio-demographic characteristics, general health characteristics, working at hospital characteristics, and social characteristics of the participants. While calculating frequencies and percentages, mean and standard deviations of continuous variables were taken. On the other hand, logistic regression was used for the presence of the relationship between the subscales of the scales used in the study. The relationship between socio-demographic characteristics and sub-scales of the trauma scale was determined by t test and chi-square test. Since there was no statistical significance in the differences between male and female, analyzes were not classified by gender. p value is taken as 0.05. SPSS Statistics 25 program was used to analyze data.

4. RESULTS

Table 5. Socio-Demographic Features of Participants

		N	Percentage	Mean	SD
Gender	Female	137	64.6		
	Male	75	35.4		
Marital Status	Married	138	66.3		
	Single	70	33.7		
Children	Yes	139	67.1		
	No	68	32.9		
Age		212		35.85	11.0
Number of Children		132		1.79	0.68

The average age of 212 participants in our study is 35.85±11.0. 64.6% of them are female, 35.4% are male, while 66.3% of them are married and 33.7% are single. The married participants cover the answers of 'married' and 'cohabiting', while single participants mean 'single', 'divorced', and 'widow'. 67.1% of the participants marked the answer of 'Yes' for the question of 'Do you have children?', while the mean of the number of children is 1.79 (Table 5).

Table 6. General Health Characteristics of Participants

		N	Percentage	Mean	SD
Body Mass Index (kg/m^2)				24.56	4.08
BMI	Normal	118	58.7		
	Underweight	60	29.9		
	Overweight	23	11.4		
Smoking	Current Smoker	67	32.4		
	Former Smoker	34	16.4		
	Non-smoker	106	51.2		
Use of Alcohol	Current Drinker	12	5.9		
	Sometimes	38	18.5		
	Former Drinker	10	4.9		
	Never	145	70.7		
Frequency of Alcohol Use (Evet – Arada Sırada İçenler)	Less than Once a Month	28	13.7		
	1-2-3 Days per month	14	6.8		
	1-2-3 per week	8	3.9		
Number of Cigarettes per day for Current Smokers		63		9.97	6.35
Age to Start Smoking for Current Smokers		61		19.74	3.71
Smoking Duration for Current Smokers (year)		60		15.42	9.14
Age to Start Smoking for Former Smokers		29		18.52	4.43
Number of Cigarettes for Former Smokers		29		14.83	7.45
PC - TV - Phone Usage Time for Weekdays (min)		157		166.41	153.96
PC - TV - Phone Usage Time for Weekend (min)		135		210.01	149.87
Usage Time of TV (min)		160		176.43	141.63
Internet Usage Time per day (min)		149		182.62	190.61

Looking at the general health status of the participants, it is seen that the mean body mass index of them is 24.56 ± 4.08 kg/m^2, while 58.7% of them was normal, 29.9% overweighted, and 11.4% of them obese. In terms of smoking habits, 32.% of the participants are current smokers, while their number of cigarette smoked per day 9.97±6.35, their age to start smoking was 19.74±3.71, and smoking duration was 15.42±9.14. The rate of former smokers was 16.4%, when their previous information are examined, their age to start smoking was 18.52±4.43, number of cigarettes per day 14.83±7.45, on the other hand, 51.2% of the participants were non-smokers. In terms of alcohol usage, 13.7% of them says less than once a month, 18.5% sometimes, 4.9% former drinker, 51.2% non-drinker. In terms of the question of

how often do you use alcohol, 19.7% of them says less than once a month, 6.8% 1-2-3 days per month, 3.9% 1-2-3 days per week. The mean of PC - TV - Phone usage time for weekdays was 166.41±153.96 minutes, it was 210.01±149.87 minutes for weekends. General TV use period was 176.43±141.63 minutes, while it was 182.62±190.61 minutes for Internet usage (Table 6).

Table 7. Working at Hospital Characteristics of the Participants

		N	Percentage	Mean	SD
Profession	Physician	16	7.7		
	Nurse+Midwife+ Health Officer	82	39.4		
	Technician +Officer	55	26.4		
	Assistant Staff	23	11.1		
	Intern	32	15.4		
Shift Work	Yes	85	41.1		
	No	122	58.9		
Unit Worked	Emergency	21	11.5		
	Operating room	13	7.1		
	Registry	2	1.1		
	Data Processing	2	1.1		
	Dialysis	4	2.2		
	Delivery room	5	2.7		
	Pharmacy	5	2.7		
	Training unit	1	0.5		
	Infection	1	0.5		
	Home Care	3	1.6		
	General Surgeon	1	0.5		
	Security	4	2.2		
	Patient Record	1	0.5		
	Administrative Unit	18	9.9		
	Lab	8	4.4		
	Kitchen	5	2.7		
	Pathology	1	0.5		
	Polyclinic	15	8.3		
	Radiology	6	3.3		
	Operator	1	0.5		
	Service	45	24.7		
	Sterilization	2	1.1		
	Technician	4	2.2		
	Diagnosis-related groups	1	0.5		
	Urology	1	0.5		
	Pay Desk	1	0.5		
	Intensive Care	11	6.0		
Working Time (years)		198		13.38	9.90

In the study conducted with the participants who were the healthcare professions in the Karamürsel State Hospital, 7.7% of them were physicians, 39.4% nurses+midwives+health officers, 26.4% technicians-officers, 11.1% assistant staff, and 15.4% interns. In terms of units worked in the hospital, 11.5% of them work in the emergency service, 7.1% in the operating room, 1.1% in the registry, 1.1% in the data processing, 2.2% in dialysis, 2.7% in the delivery room, 2.7% in the pharmacy, 0.5% in the training unit , 0.5% in infection, 1.6% in home care,

0.5% in general surgeon, 2.2% in security, 0.5% in patient record, 9.9% in administrative unit, 4.4% in lab, 2.7% 5 in the kitchen, 0.5% in pathology, 8.3% in the polyclinic, 3.3% in radiology, 0.5% in the operator, 24.7% in service, 1.1% in sterilization, 2.2% in technician, 0.5% diagnosis-related groups, 0.5% in urology, 0.5% in pay desk and 6.0% of them in intensive care units. The average working time is 13.38±9.90 years and 41.1% of the them work in shifts (Table 7).

Table 8. Socio-economic Characteristics of Participants

		N	Percentage
Education of Spouse	Literate+Primary+Secondary	20	14.4
	High School+Undergraduate	54	38.5
	Graduate	49	35.3
	Postgraduate+PhD	16	11.5
Education of Himself	Literate+Primary+Secondary	23	11.0
	High School+Undergraduate	107	51.0
	Graduate	61	29.0
	Postgraduate+PhD	19	9.0
Education of Mother	Literate+Primary+Secondary	169	80.5
	High School+Undergraduate	34	16.2
	Graduate	6	2.9
	Postgraduate+PhD	1	0.5
Education of Father	Literate+Primary+Secondary	121	57.6
	High School+Undergraduate	65	31.0
	Graduate	19	9.0
	Postgraduate+PhD	5	2.4
Socio-Economic Status Perception	Very Low	6	2.9
	Low	21	10.3
	Medium	151	74.0
	High	21	10.3
	Very High	5	2.5

In terms of educational status of the participants, 11.0% of the participants were literate+primary+secondary, while 51.0% of them high-school+undergraduate, 29.0% graduate, and 9.0% postgraduate. Looking at the education levels of their spouses, we see that 14.4% of them were literate+primary+secondary, while 38.5% high-school+undergraduate, 35.3% graduate, and 11.5% postgraduate+PhD. For the education levels of their mothers, it is found that 80.5% of them were literate+primary+secondary, while 16.2% high-school+undergraduate, 2.9% graduate, and 0.5% postgraduate+PhD; in terms od the education level of their fathers, 57.6% of them were literate+primary+secondary, while 31.0% high-school+undergraduate, 9.0% graduate, and 2.4% postgraduate+PhD. When the socio-economic characteristics of the participants are examined, 2.9% of them stated that it is very low, 10.3% low, 74.0% medium, 10.3% high, 2.5% very high (Table 8).

Table 9. Depression Status and the Distribution of Social Support, Healthy Lifestyle and Trauma Status in Participants

Variables		N	Percentage
DEPRESSION			
	Yes	142	68.9
	No	64	31.1
SOCIAL SUPPORT			
Social Support at Home	Yes	101	48.6
	No	107	51.4
Social Support at Work	Yes	85	41.5
	No	120	58.5
HEALTHY LIFESTYLE			
Moral Development	Low	98	46.2
	High	114	53.8
Health Responsibility	Low	97	45.8
	High	115	54.2
Physical Activity	Low	112	52.8
	High	100	47.2
Nutritional Habit	Low	103	48.6
	High	109	51.4
Interpersonal Relationships	Low	104	49.1
	High	108	50.9
Stress Management	Low	109	51.4
	High	103	48.6
TRAUMA			
Physical Abuse	Low	153	73.2
	High	56	26.8
Emotional Abuse	Low	107	51.2
	High	102	48.8
Physical Neglect	Low	93	44.5
	High	116	55.5
Emotional Neglect	Low	94	45.0
	High	115	55.0
Trauma total	Low	101	48.3
	High	108	51.7

Evaluating the questionnaires used for the purpose of the study, it was found that 68.9% of the participants answered ‘Yes’ for depression, 48.6% of them ‘Yes’ for support at home, while 41.5% of them say ‘Yes’ for support at work. Examining the subscales of healthy lifestyle scale, moral development was found ‘low or none’ in the 46.2% of the participants, while health responsibility in 45.8%, physical activity in 52.8%, nutrition habits in 48.6%, interpersonal relationships in 49.1%, stress management in 51.4% was found similarly, as ‘low or none’. When it comes to the subscales of the Childhood Trauma Scale, physical abuse was high in 26.8% of the participants, while emotional abuse in 48.8%, physical neglect in 55.5%, emotional neglect was high in 55.0% of the participants. The overall result of the childhood trauma scale was found high with a rate of 51.7% (Table 9).

Table 10. Distribution of Answers of Participants to Childhood Trauma Questionnaire

Variables		N	Percentage
1.I believe that I was fed enough in my childhood.			
	Never	34	16.3
	Rarely	39	18.7
	Sometimes	58	27.8
	Often	52	24.9
	Very Often	26	12.4
2.In my childhood, there was one or more than one person caring or protecting me.			
	Never	101	48.3
	Rarely	64	30.6
	Sometimes	28	13.4
	Often	11	5.3
	Very Often	5	2.4
3.In my childhood, people in my family used to call me with words such as 'Stupid', 'Lazy' or 'Ugly'.			
	Never	131	62.7
	Rarely	36	17.2
	Sometimes	30	14.4
	Often	9	4.3
	Very Often	3	1.4
4.My mother and father were too drunk or high on drugs to care our family.			
	Never	183	87.6
	Rarely	6	2.9
	Sometimes	10	4.8
	Often	7	3.3
	Very Often	3	1.4
5.There was one or more than one members of my family who made me feel special.			
	Never	81	38.8
	Rarely	62	29.7
	Sometimes	34	16.3
	Often	21	10.0
	Very Often	11	5.3
6.In my childhood, I had to wear dirty clothes.			
	Never	151	72.2
	Rarely	31	14.8
	Sometimes	22	10.5
	Often	2	1.0
	Very Often	3	1.4
7.In my childhood, I felt I was loved.			
	Never	95	45.5
	Rarely	75	35.9
	Sometimes	26	12.4
	Often	10	4.8
	Very Often	3	1.4
8. In my childhoold, I thought that my parents wished I had never been born.			
	Never	156	74.6
	Rarely	21	10.0
	Sometimes	23	11.0
	Often	6	2.9

	Very Often	3	1.4
9. In my childhood, I had beaten by the members of my family such an extent that I had to apply to a hospital or visit a doctor.			
	Never	186	89.0
	Rarely	11	5.2
	Sometimes	10	4.8
	Often	1	0.5
	Very Often	1	0.5
10. In terms of my childhood, there is nothing I want to change related to my family.			
	Never	72	34.4
	Rarely	42	20.1
	Sometimes	52	24.9
	Often	13	6.2
	Very Often	30	14.4
11.In my childhood, the members of my family beat me black and blue.			
	Never	187	89.5
	Rarely	12	5.7
	Sometimes	6	2.9
	Often	3	1.4
	Very Often	1	0.5
12. In my childhood, I was punished beaten with a strap, stick, cable or similar hard objects.			
	Never	182	87.1
	Rarely	13	6.2
	Sometimes	12	5.7
	Often	1	0.5
	Very Often	1	0.5
13. In my childhood, the members of my family protected each other.			
	Never	105	50.2
	Rarely	66	31.6
	Sometimes	17	8.1
	Often	14	6.7
	Very Often	7	3.3
14. In my childhood, the members of my family used to say hurtful or offensive words to me.			
	Never	131	62.7
	Rarely	46	22.0
	Sometimes	24	11.5
	Often	7	3.3
	Very Often	1	0.5
15. I believe that I was physically abused in my childhood.			
	Never	182	87.1
	Rarely	11	5.3
	Sometimes	9	4.3
	Often	4	1.9
	Very Often	3	1.4
16. I had a perfect childhood.			
	Never	11	5.3
	Rarely	15	7.2
	Sometimes	56	26.8

	Often	76	36.4
	Very Often	51	24.4
17. In my childhood, I was beaten by people such as teachers, neighbors, or doctors badly enough to be noticed.			
	Never	188	89.1
	Rarely	11	5.2
	Sometimes	9	4.3
	Often	2	0.9
	Very Often	1	0.5
18. In my childhood, I felt that there was one or more than one member of my family hating me.			
	Never	166	78.7
	Rarely	21	10.0
	Sometimes	13	6.2
	Often	8	3.8
	Very Often	3	1.4
19. In my childhood, members of my family were close to each other.			
	Never	11	5.2
	Rarely	9	4.3
	Sometimes	29	13.7
	Often	65	30.8
	Very Often	97	46.0
20. In my childhood, I had the best family in the world.			
	Never	11	5.2
	Rarely	19	9.0
	Sometimes	32	15.2
	Often	69	32.7
	Very Often	80	37.9
21. I believe that I was emotionally abused in my childhood.			
	Never	156	73.9
	Rarely	22	10.4
	Sometimes	21	10.0
	Often	9	4.3
	Very Often	3	1.4
22. In my childhood, there was always one or more than one person in my family to take me to the doctor when I needed it.			
	Never	127	60.2
	Rarely	50	23.7
	Sometimes	17	8.1
	Often	8	3.8
	Very Often	9	4.3
23.In my childhood, my family was a source of strength and support for me.			
	Never	131	62.1
	Rarely	48	22.7
	Sometimes	20	9.5
	Often	4	1.9
	Very Often	8	3.8

Examining the answers given to the question of '*I believe that I was fed enough in my childhood*', it was observed that 16.3% of the participants said 'never', 18.7% 'rarely', 27.8% 'sometimes', 24.9% 'often', 12.4% 'very often'.

In terms of the question of '*in my childhood, there was one or more than one person caring or protecting me*', it was found that 48.3% of them said 'never', 30.6% 'rarely', 13.4% 'sometimes', 5.3% 'often', and 2.4% of them said 'very often'.

Evaluating the answers of the question of '*in my childhood, people in my family used to call me with words such as 'Stupid', 'Lazy' or 'Ugly''*, it was seen that 62.7% of them responded as 'never', 17.2% 'rarely', 14.4% 'sometimes', 4.3% 'often', and 1.4% 'very often'.

For the question of '*my mother and father were too drunk or high on drugs to care our family*', it was observed that 87.6% of them prefered to say 'never', 2.9% 'rarely', 4.8% 'sometimes', 3.3% 'often', and 1.4% very often.

Examining the answers of the '*there was one or more than one members of my family who made me feel special*', it was found that 38.8% of them said 'never', 29.7% 'rarely', 16.3% 'sometimes', 10.0% 'often', 5.3% 'very often'.

For the answers of '*in my childhood, I had to wear dirty clothes*', it was seen that 72.2% of them said 'never', 14.8% 'rarely', 10.5% 'sometimes', 1.0% 'often', 1.4% 'very often'.

Evaluating the question of '*in my childhood, I felt I was loved*', it was observed that 45.5% of them said 'never', 35.9% 'rarely', 12.4% 'sometimes', 4.8% 'frequently', and 1.4% 'very often'.

When the answers of the question of 'in my childhoold, I thought that my parents wished I had never been born' are examined, it was observed that 74.6% said 'never', 10.0% 'rarely', 11.0% 'sometimes', 2.9% 'often', and 1.4% 'very often'.

In terms of the question of '*in my childhood, I had beaten by the members of my family such an extent that I had to apply to a hospital or visit a doctor'*, it was observed that 89.9% of them said 'never', 5.2% 'rarely', 4.8% 'sometimes', 0.5% 'often', and 0.5% 'very often'.

For the question of '*in terms of my childhood, there is nothing I want to change related to my family*', it was observed that 34.4% of them said 'never', 20.1% 'rarely', 24.9% 'sometimes', 6.2% 'often', and 14.4% 'very often'.

When it comes to the question of '*in my childhood, the members of my family beat me black and blue*', it was observed that 89.5% of them said 'never', 5.7% 'rarely', 2.9% 'sometimes', 1.4% 'often', 0.5% 'very often'.

For the question of '*in my childhood, I was punished beaten with a strap, stick, cable or similar hard objects*', it was found that 87.1% of them said 'never', 6.2% 'rarely', 5.7% 'sometimes',

0.5% ‘often’, 0.5% ‘very often’.

For the question of ‘*in my childhood, the members of my family protected each other*’, it was observed that 50.2% of them said ‘never’, 31.6% ‘rarely’, 8.1% ‘sometimes’, 6.7% ‘often’, and 3.3% ‘very often’.

In terms of the question of ‘*in my childhood, the members of my family used to say hurtful or offensive words to me*’, it was observed that 62.7% of them said ‘never’, 22.0% ‘rarely’, 11.5% ‘sometimes’, 3.3% ‘often’, and 0.5% ‘very often’.

For the question of ‘*I believe that I was physically abused in my childhood*’, it was observed that 87.12% of them said ‘never’, 5.3% ‘rarely’, 4.3% ‘sometimes’, 1.9% ‘often’, and 1.4% ‘very often’.

Examining the answers of the ‘*I had a perfect childhood*’, it was found that 5.3% of them said ‘never’, 7.2% ‘rarely’, 26.8% ‘sometimes’, 36.4% ‘often’, 24.4% ‘very often’.

For the question of ‘*in my childhood, I was beaten by people such as teachers, neighbors, or doctors badly enough to be noticed*’, it was observed that 89.1% of them said ‘never’, 5.2% ‘rarely’, 4.3% ‘sometimes’, 0.9% ‘often’, and 0.5% ‘very often’.

For the question of ‘*in my childhood, I felt that there was one or more than one member of my family hating me*’, it was observed that 78.7% of them said ‘never’, 10.0% ‘rarely’, 6.2% ‘sometimes’, 3.8% ‘often’, and 1.4% ‘very often’.

Evaluating the question of ‘*in my childhood, members of my family were close to each other*’, it was observed that 5.2% of them said ‘never’, 4.3% ‘rarely’, 13.7% ‘sometimes’, 30.8% ‘often’, 46.0% ‘very often’.

For the question of ‘*in my childhood, I had the best family in the world*’, it was observed that 5.2% of them said ‘never’, 9.0% ‘rarely’, 15.2% ‘sometimes’, 32.7% ‘frequently’, 37.9% ‘very often’.

For the question of ‘*I believe that I was emotionally abused in my childhood*’, it was observed that 73.9% of them said ‘never’, 10.4% ‘rarely’, 10.02% ‘sometimes’, 4.3% ‘often’, and 1.4% ‘very often’.

For the question of ‘*in my childhood, there was always one or more than one person in my family to take me to the doctor when I needed it*’, it was observed that 60.2% of them said ‘never’, 23.7% ‘rarely’, 8.1% ‘sometimes’, 3.8% ‘often’, 4.32% ‘very often’.

And finally, when the answers of the question of ‘*in my childhood, my family was a source of strength and support for me*’, it was observed that 62.1% said ‘never’, 22.7% ‘rarely’, 9.5% ‘sometimes’, 1.9% ‘often’, and 3.82% ‘very often’ (Table 10).

Table 11. The effect of social support at home and at work on the presence of depression in the participants

	Presence of Depression		
	OR	**%95 GA**	**p value**
Social support at home (n=208)			
Yes	2.79	1.50-5.18	**0.001**
No	1.00		
Social support at work (n=205)			
Yes	2.18	1.18-4.01	**0.012**
No	1.00		

Those who did not receive social support at home experienced 2.79 (%95 GA:1.50-5.18) times more depression than those who received it, while this result was also parallel to the social support at work, those who did not receive social support at work experienced 2.18 (%95 GA:1.18-4.01) times more depression than those who received it (Table 11).

Table 12. The Effect of Subscales of Healthy Lifestyle Scale on the Presence of Depression in Participants

	Presence of Depression		
	OR	**%95 GA**	**p value**
Moral Development			
Low	9.34	4.54-19.19	< **0.001**
High	1.00		
Heath Responsibility (n:212)			
Low	3.54	1.90-6.61	< **0.001**
High	1.00		
Physical Activity (n:212)			
Low	1.56	0.85-2.84	0.14
High	1.00		
Nutrition Habit(n:212)			
Low	1.67	0.92-3.03	0.09
High	1.00		
Interpersonal Relationships(n:212)			
Low	2.53	1.37-4.68	**0.003**
High	1.00		
Stress Management (n:212)			
Low	3.49	1.84-6.61	< **0.001**
High	1.00		

Depression was 9.34 (%95 GA:4.54-19.19) times higher in those with low moral development than those with high levels, while depression was 3.54 (%95 GA:1.90-6.61) times more in those with low awareness of health responsibility than those with high awareness level. Whereas, no statistical significance was found between depression and physical activity (p:0.14 OR:1.56 %95 GA:0.85-2.84) and nutrition habits (p:0.09 OR:1.67 %95 GA:0.92-3.03). In those with

low interpersonal relationships, the rate of depression was 2.53 (%95 GA: 1.37-4.68) times higher than those with high level interpersonal relationships. In those with low stress management, depression was 3.49 (%95 GA: 1.84-6.61) times higher than in those with high level stress management (Table 12).

Table 13. The Effect of the Subscales of Childhood Trauma Scale on the Presence of Depression in Participants

	Presence of Depression		
	OR	**%95 GA**	**p value**
Physical abuse (n:209)			
High	1.45	0.75-2.79	0.26
Low	1.00		
Emotional abuse (n:209)			
High	1.73	0.95-3.17	0.07
Low	1.00		
Physical neglect (n:210)			
High	0.99	0.54-1.80	0.99
Low	1.00		
Emotional neglect (n:209)			
High	2.72	1.43-5.16	**0.002**
Low	1.00		
Trauma total (n:209)			
High	2.00	1.08-3.69	**0.02**
Low	1.00		

Examining the relationship between physical abuse (p:0.26 %95 OR:1.45 GA:0.75-2.79), emotional abuse (p:0.07 OR:1.73 %95 GA:0.95-3.17), and physical neglect (p:0.99 OR:0.99 %95 GA:0.54-1.80) in childhood and depression in adulthood, no statistical significance was found. Compared to those with low emotional neglect, depression was 2.72 (%95 GA: 1.43-5.16) times higher in those with high emotional neglect. Looking at the overall childhood trauma scale, on the other hand, depression was 2.00 (%95 GA:1.08-3.69) times higher in those with high trauma levels than those with low levels (Table 13).

Table 14. The Relationship Between Physical Abuse and Parent's and Participant's Own Education Level

	High Exposure of Physical Abuse		
	OR	**%95 GA**	**p value**
Education of Mother			
Low	1.49	0.66-3.34	0.33
High	1.00		
Education of Father			
Low	1.92	1.01-3.66	**0.04**
High	1.00		

While no statistical significance was found between the education level of the participant's mother and his/her physical abuse in childhood (p:0.33 OR:1.49 %95 GA:0.66-3.34); in terms of the level of father's education, on the other hand, it was observed that those whose father's education levels were low were 1.92 (%95 GA:1.01-3.66) times more likely to be exposed to physical abuse in childhood, compared to the higher ones (Table 14).

Table 15. The Relationship between the Emotional Abuse and Parent's and Participant's Own Education Level

	High Exposure of Emotional Abuse		
	OR	**%95 GA**	**p value**
Education of Mother			
Low	0.99	0.51-1.95	0.99
High	1.00		
Education of Father			
Low	1.11	0.64-1.93	0.69
High	1.00		

No statistical significance was found between emotional abuse and education level of mother (p:0.99 OR:0.99 %95 GA:0.51-1.95) and father (p:1.69 OR:1.11 %95 GA:0.64-1.93) (Table 15).

Table 16. The Relationship between the Physical Neglect and Parent's and Participant's Own Education Level

	High Exposure of Physical Neglect		
	OR	**%95 GA**	**p value**
Education of Mother			
Low	1.10	0.56-2.17	0.76
High	1.00		
Education of Father			
Low	1.21	0.70-2.11	0.48
High	1.00		

No statistical significance was found between physical neglect and education level of mother (p:0.76 OR:1.10 %95 GA:0.56-2.17) and father (p:0.48 OR:1.21 %95 GA:0.70-2.11) (Table 16).

Table 17. The Relationship between the Emotional Neglect and Parent's and Participant's Own Education Level

	High Exposure of Emotional Neglect		
	OR	**%95 GA**	**p value**
Education of Mother			
Low	0.75	0.38-1.49	0.42
High	1.00		
Education of Father			
Low	1.00	0.58-1.74	0.98
High	1.00		

No statistical significance was found between emotional neglect and education level of mother (p:0.42 OR:0.75 %95 GA:0.38-1.49) and father (p:0.98 OR:1.00 %95 GA:0.58-1.74) (Table 17).

Table 18. The Relationship between the Trauma Total and Parent's and Participant's Own Education Level

	High Exposure of Trauma		
	OR	**%95 GA**	**p value**
Education of Mother			
Low	1.02	0.52-2.00	0.94
High	1.00		
Education of Father			
Low	1.26	0.73-2.19	0.39
High	1.00		

Looking at the overall childhood trauma scale, no statistical significance was found between education level of mother (p:0.94 OR:1.02 %95 GA:0.52-2.00) and father (p:0.39 OR:1.26 %95 GA:0.73-2.19) (Table 18).

Table 19. The Effect of Moral Development on the Subscales of Childhood Trauma Scale

	High Moral Development		
	OR	**%95 GA**	**p value**
Physical abuse			
Low	1.52	0.82-2.81	0.18
High	1.00		
Emotional abuse			
Low	2.20	1.26-3.84	**0.005**
High	1.00		
Physical neglect			
Low	1.33	0.77-2.31	0.30
High	1.00		
Emotional neglect			
Low	3.12	1.76-5.55	**< 0.001**
High	1.00		
Trauma total			
Low	0.25	1.29-3.93	**0.004**
High	1.00		

No statistical significance was found between physical abuse (p:0.18 OR:1.52 %95 GA:0.82-2.81) and physical neglect (p:0.30 OR:1.33 %95 GA:0.77-2.31) experienced during childhood and moral development. It was determined that those with low emotional abuse had 2.20 (%95 GA:1.26-3.84) times more moral development than those with high emotional abuse, while moral development of those with low emotional neglect was 3.12 (%95 GA:1.76-5.55) times higher than those with high emotional neglect. Examining the overall childhood trauma scale, it was seen that those with low trauma had 0.25 (%95 GA: 1.29-3.93) times more moral development than those with high trauma (Table 19).

Table 20. The Effect of Health Responsibility on the Subscales of Childhood Trauma Scale

	High Health Responsibility		
	OR	**%95 GA**	**p value**
Physical abuse			
Low	1.37	0.74-2.54	0.30
High	1.00		
Emotional abuse			
Low	1.61	0.93-2.78	0.08
High	1.00		
Physical neglect			
Low	0.97	0.56-1.69	0.93
High	1.00		
Emotional neglect			
Low	2.24	1.27-3.92	**0.005**
High	1.00		
Trauma total			
Low	1.51	0.87-2.62	0.13
High	1.00		

No statistical significance was found between physical abuse (p:0.30 OR:1.37 %95 GA:0.74-2.54), emotional abuse (p:0.08 OR:1.61 %95 GA:0.93-2.78), and physical neglect

(p:0.93 OR:0.97 %95 GA:0.56-1.69) experienced during childhood and overall childhood trauma (p:0.13 OR:1.51 %95 GA:0.87-2.62). It was observed that those with low emotional neglect developed 2.24 (%95 GA: 1.27-3.92) times more health responsibility than those with high emotional neglect (Table 20).

Table 21. The Effect of Physical Activity on the Subscales of Childhood Trauma Scale

	High Physical Activity		
	OR	**%95 GA**	**p value**
Physical abuse			
Low	0.93	0.50-1.71	0.81
High	1.00		
Emotional abuse			
Low	1.06	0.61-1.83	0.81
High	1.00		
Physical neglect			
Low	0.81	0.47-1.41	0.46
High	1.00		
Emotional neglect			
Low	1.46	0.84-2.53	0.17
High	1.00		
Trauma total			
Low	1.22	0.71-2.11	0.46
High	1.00		

No statistical significance was found between physical activity and physical abuse (p:0.81 OR:0.93 %95 GA:0.50-1.71), emotional abuse (p:0.81%95 OR:1.06 GA:0.61-1.83), physical neglect (p:0.46 OR:0.81 %95 GA:0.47-1.41), emotional neglect (p:0.17 %95 OR:1.46 GA:0.84-2.53) experienced during childhood and total trauma (P:0.46 OR:1.22 %95 GA:0.71-2.11) (Table 21).

Table 22. The Effect of Nutrition Habit on the Subscales of Childhood Trauma Scale

	High Nutrition Habit		
	OR	**%95 GA**	**p value**
Physical abuse			
Low	1.09	0.59-2.02	0.76
High	1.00		
Emotional abuse			
Low	1.43	0.83-2.47	1.19
High	1.00		
Physical neglect			
Low	1.07	0.62-1.85	0.79
High	1.00		
Emotional neglect			
Low	2.46	1.40-4.31	**0.002**
High	1.00		
Trauma total			
Low	1.97	1.14-3.43	**0.01**
High	1.00		

No statistical significance was found between nutrition habit and physical abuse (p:0.76 OR:1.09 %95 GA:0.59-2.02), emotional abuse (p:1.19 OR:1.43 %95 GA:0.83-2.47), and physical neglect (p:0.79 OR:1.07 %95 GA:0.62-1.85) experienced during childhood. It was observed that those who have low emotional neglect have 2.46 (%95 GA:1.40-4.31) times more nutrition habits than those who do not. Looking at the overall childhood trauma scale, it was observed that those with low trauma develop 1.97 (%95 GA:1.14-3.43) times more health responsibility than those with high trauma (Table 22).

Table 23. The Effect of Interpersonal Relationships on the Subscales of Childhood Trauma Scale

	High Interpersonal Relationships		
	OR	**%95 GA**	**p value**
Physical abuse			
Low	1.93	1.03-3.60	**0.03**
High	1.00		
Emotional abuse			
Low	3.05	1.78-5.37	**<0.001**
High	1.00		
Physical neglect			
Low	1.11	0.64-1.92	0.69
High	1.00		
Emotional neglect			
Low	2.55	1.45-4.47	**0.001**
High	1.00		
Trauma total			
Low	2.22	1.27-2.87	**0.005**
High	1.00		

No statistical significance was found between interpersonal relationships and physical neglect in childhood (p:0.69 OR:1.11 %95 GA:0.64-1.92). It was seen that in those with low physical abuse, 1.93 (%95 GA:1.03-3.60) times more interpersonal relationships developed than those with high ones; those with low emotional abuse develop 3.05 (%95 GA:1.78-5.37) times more interpersonal relationships than those with high emotional abuse; and in those with low emotional neglect, it was observed that interpersonal relationships developed 2.55 (%95 GA:1.45-4.47) times more than those with high. Looking at the overall childhood trauma scale, it was observed that interpersonal relationships developed 2.22 (%95 GA:1.27-2.87) times more in those with low trauma than those with high trauma (Table 23).

Table 24. The Effect of Stress Management on the Subscales of Childhood Trauma Scale

	High Stress Management		
	OR	**%95 GA**	**p value**
Physical abuse			
Low	1.03	0.56-1.90	0.91
High	1.00		
Emotional abuse			
Low	1.97	1.13-3.42	**0.01**
High	1.00		
Physical neglect			
Low	1.32	0.76-2.28	0.31
High	1.00		
Emotional neglect			
Low	2.04	1.17-3.55	**0.01**
High	1.00		
Trauma total			
Low	2.13	1.22-3.68	**0.008**
High	1.00		

No statistical significance was identified between physical abuse (p:0.91 OR:1.03 %95 GA:0.56-1.90) and physical neglect (p:0.31 OR:1.32 %95 GA:0.76-2.28) experienced during childhood and stress management. It was observed that those with low emotional abuse developed 1.97 (%95 GA:1.13-3.42) times more stress management than those with high emotional abuse, while those with low emotional neglect developed 2.04 (%95 GA:1.17-3.55) times more stress management than those with high emotional neglect. Looking at the overall childhood trauma scale, it was observed that stress management developed 2.13 (%95 GA:1.22-3.68) times more in those with low trauma than those with high trauma (Table 24).

Table 25. The Effect of Participant's Own Education Level on the Subscales of Childhood Trauma Scale

	Participant's Own Education Level		
	OR	**%95 GA**	**P value**
Physical abuse			
Low	2.55	1.03-6.30	0.48
High	1.00		
Emotional abuse			
Low	0.86	0.35-2.08	0.84
High	1.00		
Physical neglect			
Low	3.02	1.07-8.53	**0.03**
High	1.00		
Emotional neglect			
Low	1.86	0.72-4.78	0.19
High	1.00		
Trauma total			
Low	1.39	0.57-3.43	0.46
High	1.00		

Considering the relationship between the participants' own education levels and

childhood trauma, no statistical significance was found between physical abuse (p:0.48 OR:2.55 %95 GA:1.03-6.30), emotional abuse (p:0.84 OR:0.86 %95 GA:0.35-2.08), emotional neglect (p:0.19 OR:1.86 %95 GA:0.72-4.78) experienced during childhood and overall childhood trauma (p:0.46 OR:1.39 %95 GA:0.57-3.43). It was seen that those with low physical neglect had 3.02 (%95 GA:1.07-8.53) times higher education levels than those with high levels (Table 25).

Table 26. The Effect of Participant's Age on the Presence of Subscales of the Questionnaires used in the Study

AGE			
	OR	**%95 GA**	**p value**
Depression	0.97	0.94-0.99	**0.03**
Social Support at Home	1.04	1.01-1.07	**0.002**
Social Support at Work	0.99	0.97-1.02	0.83
Moral Development	1.01	0.99-1.04	0.24
Health Responsibility	1.02	0.99-1.05	0.06
Physical Activity	0.98	0.96-1.01	0.32
Nutrition Habits	1.00	0.98-1.03	0.59
Interpersonal Relationships	0.99	0.97-1.01	0.65
Stress Management	1.02	0.99-1.04	0.07
Physical Abuse	1.01	0.98-1.04	0.28
Emotional Abuse	0.97	0.94-0.99	**0.01**
Physical Neglect	1.04	1.01-1.07	**0.002**
Emotional Neglect	0.98	0.96-1.01	0.36
Trauma Total	1.01	0.98-1.03	0.39

It was observed that, in each unit age increase, depression was 0.97 (% 95 GA: 0.94-0.99), social support at home was 1.04 (% 95 GA: 1.01-1.07), emotional abuse was 0.97 (%95 GA: 0.94-0.99), and physical neglect in childhood was 1.04 (%95 GA:1.01-1.07) times higher. No statistical significance was observed between age and moral development (p:0.24 OR:1.01 %95 GA:0.99-1.04), health responsibility (p:0.06 OR:1.02 %95 GA: 0.99-1.05), physical activity (p:0.32 OR:0.98 %95 GA: 0.96-1.01), nutritional habits (p:0.59 OR:1.00 %95 GA: 0.98-1.03), interpersonal relationships (p:0.65 OR:0.99 %95 GA: 0.97-1.01), stress management (p:0.07 OR:1.02 %95 GA:0.99-1.04), physical abuse (p:0.28 OR:1.01 %95 GA:0.98-1.04), emotional neglect (p:0.36 OR:0.98 %95 GA:0.96-1.01), and overall childhood trauma scale (p:0.39 OR:1.01 %95 GA:0.98-1.03) (Table 26).

Table 27. The Relationship Between Sociodemographic and Lifestyle Characteristics and Physical Abuse

	Physical Abuse				
	High		Low		
	n	%	n	%	p value
Gender					
Female	31	22.8	105	77.2	0.101
Male	25	34.2	48	65.8	
Profession					
Physician	3	18.8	13	81.3	
Nurse+midwife+health officer+other	21	25.6	61	74.4	0.91
Technician+Officer	15	28.3	38	71.7	
Assistant Personnel	22	31.8	15	68.2	
Intern	32	28.1	23	71.19	
Shift Work					
Yes	23	27.4	61	72.6	0.74
No	30	25.0	90	75	
Marital Status					
Married	36	26.5	100	73.5	1.00
Single	18	26.1	51	73.9	
Education of Spouse					
Below High-School	36	26.5	100	73.5	
High-School and above	18	26.1	51	73.9	1.00
Children					
Yes	38	27.9	98	72.1	0.73
No	17	25	51	75.0	
Socio-Economic Status					
Very Low	1	16,7%	5	83,3%	
Low	5	23,8%	16	76,2%	
Medium	41	27,7%	107	72,3%	0.41
High	4	19,0%	17	81,0%	
Very High	3	60,0%	2	40,0%	
Smoking					
Current Smoker	15	25.0	48	75	0.23
Former Smoker	13	38.2	21	61.8	
Non-smoker	25	23.6	81	76.4	
Alcohol use					
Current Drinker	2	18.2	9	81.8	
Sometimes	8	21.1	30	78.9	0.27
Former Drinker	5	50.0	5	50.0	
Non-drinker	37	25.9	150	74.3	
Frequency of Alcohol					
Less than Once a Month	4	14.3	24	85.7	
1-2-3 Days per month	5	35.7	9	64.3	0.33
1-2-3 Days per week	1	14.3	6	85.7	
Non-drinker	42	27.5	111	72.5	

	High			Low			
	N	Mean	SD	N	Mean	SD	p value
Body Mass Index	53	24.94	4.18	146	24.39	0.33	0.40
Working Year	51	14.79	11.16	144	12.81	0.78	0.26
Number of Children	35	1.97	0.78	94	1.73	0.66	0.08
TV Time	40	172.56	94.36	118	177.77	155.29	0.84
Internet per day	41	189.52	172.38	106	181.13	199.37	0.81

Table 28. The Relationship Between Sociodemographic and Lifestyle Characteristics and Emotional Abuse

	Emotional Abuse				
	High		Low		
	n	%	n	%	p value
Gender					
Female	64	47.1	72	52.9	0.56
Male	38	52.1	35	47.9	
Profession					
Physician	7	43.8	9	56.3	
Nurse+midwife+health officer+other	41	50.0	41	50.0	**0.01**
Technician+Officer	20	37.7	33	62.3	
Assistant Personnel	9	40.9	13	59.1	
Intern	24	75.0	8	25.0	
Shift Work					
Yes	40	47.6	44	52.4	0.88
No	59	49.2	61	50.8	
Marital Status					**0.04**
Married	58	42.6	78	57.4	
Single	40	58.0	28	42.0	
Education of Spouse					**0.04**
Below High-School	58	42.6	78	57.4	
High-School and above	40	58.0	29	42.0	
Children					0.13
Yes	60	44.1	75	55.9	
No	38	55.9	30	44.1	
Socio-Economic Status					0.14
Very Low	1	16,7%	5	83,3%	
Low	13	61.9	8	38.1	
Medium	73	49.3	75	50.7	
High	8	38.1	13	61.9	
Very High	4	80.0	1	20.0	
Smoking					0.91
Current Smoker	31	48.4	33	51.6	
Former Smoker	17	50.0	17	50.0	
Non-smoker	49	46.2	57	53.8	
Alcohol use					0.42
Current Drinker	7	63.6	4	36.4	
Sometimes	15	39.5	23	60.5	
Former Drinker	6	60.0	4	40.0	
Non-drinker	97	48.0	105	52.0	
Frequency of Alcohol					
Less than Once a Month	11	39.3	17	60.7	0.76
1-2-3 Days per month	7	50.0	7	50.0	
1-2-3 Days per week	4	57.1	3	42.9	
Non-drinker	97	48.0	105	52.0	

	High			Low			
	N	Mean	SD	N	Mean	SD	p value
Body Mass Index	98	24.37	4.11	101	24.71	4.09	0.55
Working Year	94	12.33	10.19	101	14.26	9.61	0.17
Number of Children	60	1.83	0.78	69	1.77	0.59	0.60
TV Time	75	179.30	132.97	83	173.88	150.61	0.81
Internet per day	76	188.16	186.24	71	178.45	198.73	0.76

Table 29. The Relationship Between Sociodemographic and Lifestyle Characteristics and Physical Neglect

	Physical Neglect				
	High		Low		
	n	%	n	%	p value
Gender					
Female	71	52.2	65	47.8	0.24
Male	45	61.6	28	38.4	
Profession					
Physician	8	50.0	8	50.0	
Nurse+midwife+health officer+other	51	62.2	61	37.8	**0.03**
Technician+Officer	25	47.2	28	52.8	
Assistant Personnel	17	77.3	5	22.7	
Intern	13	40.6	13	59.4	
Shift Work					
Yes	53	63.1	31	36.9	0.08
No	60	50.0	60	50.0	
Marital Status					**0.008**
Married	84	61.8	52	38.2	
Single	29	42.0	40	58.0	
Education of Spouse					**0.008**
Below High-School	84	61.8	52	38.2	
High-School and above	29	42.0	40	58.0	
Children					0.01
Yes	85	62.5	51	37.5	
No	29	42.6	39	57.4	
Socio-Economic Status					0.95
Very Low	4	66.7	2	33.3	
Low	13	61.9	8	38.1	
Medium	67	45.3	81	54.7	
High	12	57.1	9	42.9	
Very High	3	60.0	2	40.0	
Smoking					0.91
Current Smoker	34	53.1	30	46.9	
Former Smoker	24	70.6	10	29.4	
Non-smoker	54	50.9	52	49.1	
Alcohol use					0.18
Current Drinker	5	45.5	6	54.5	
Sometimes	17	44.7	21	55.3	
Former Drinker	8	80.0	2	20.0	
Non-drinker	82	57.3	61	42.7	
Frequency of Alcohol					
Less than Once a Month	13	46.4	15	53.6	
1-2-3 Days per month	6	42.9	8	57.1	0.39
1-2-3 Days per week	3	42.9	4	57.1	
Non-drinker	90	58.8	63	41.2	

	High			Low			
	N	Mean	SD	N	Mean	SD	p value
Body Mass Index	106	25.02	4.04	93	23.99	4.11	0.07
Working Year	109	15.14	9.94	86	11.03	9.45	**0.004**
Number of Children	82	1.83	0.73	47	1.74	0.62	0.50
TV Time	86	168.10	128.58	72	186.42	157.05	0.42
Internet per day	78	176.15	177.52	69	191.75	207.72	062

Table 30. The Relationship Between Sociodemographic and Lifestyle Characteristics and Emotional Neglect

	Emotional Neglect				
	High		Low		
	n	%	n	%	p value
Gender					
Female	70	51.5	66	48.5	0.19
Male	45	61.6	28	38.4	
Profession					
Physician	6	37.5	10	62.5	
Nurse+midwife+health officer+other	52	63.4	30	36.6	0.07
Technician+Officer	22	41.5	31	58.5	
Assistant Personnel	13	59.1	9	40.9	
Intern	19	59.4	13	40.6	
Shift Work					**0.04**
Yes	53	63.1	31	36.9	
No	58	48.3	62	51.7	
Marital Status					0.65
Married	72	52.9	64	47.1	
Single	39	56.5	30	43.5	
Education of Spouse					0.65
Below High-School	72	52.9	64	47.1	
High-School and above	39	56.5	30	43.5	
Children					1.00
Yes	73	53.7	63	46.3	
No	37	54.4	31	45.6	
Socio-Economic Status					0.25
Very Low	3	50.0	3	50.0	
Low	16	76.2	5	23.8	
Medium	79	53.4	69	46.6	
High	9	42.9	12	57.1	
Very High	3	60.0	2	40.0	
Smoking					0.82
Current Smoker	35	54.7	29	45.3	
Former Smoker	20	58.8	14	41.2	
Non-smoker	56	52.8	50	47.2	
Alcohol use					0.40
Current Drinker	5	54.5	5	45.5	
Sometimes	20	52.6	18	47.4	
Former Drinker	8	80.0	2	20.0	
Non-drinker	68	47.6	75	52.4	
Frequency of Alcohol					
Less than Once a Month	14	50.0	14	50.0	
1-2-3 Days per month	8	57.1	6	42.9	0.96
1-2-3 Days per week	4	57.1	3	42.9	
Non-drinker	83	54.2	70	45.8	

	High			Low			
	N	Mean	SD	N	Mean	SD	p value
Body Mass Index	107	24.69	4.14	92	24.36	4.05	0.56
Working Year	106	12.44	9.89	89	14.39	9.89	0.17
Number of Children	71	1.82	0.76	58	1.78	0.59	0.73
TV Time	85	195.60	169.17	73	154.15	98.47	0.06
Internet per day	83	213.98	231.51	64	143.91	112.48	**0.01**

Table 31. The Relationship Between Sociodemographic and Lifestyle Characteristics and Overall Childhood Trauma Scale

	Trauma Total				
	High		Low		
	n	%	n	%	p value
Gender					
Female	67	49.3	69	50.7	0.19
Male	41	56.2	32	43.8	
Profession					
Physician	7	43.8	8	56.3	
Nurse+midwife+health officer+other	45	54.9	37	45.1	0.84
Technician+Officer	26	49.1	27	50.9	
Assistant Personnel	13	59.1	9	40.9	
Intern	16	50.0	16	50.0	
Shift Work					**0.04**
Yes	53	63.1	31	36.9	
No	58	48.3	62	51.7	
Marital Status					1.00
Married	70	51.5	66	48.5	
Single	35	50.7	34	49.3	
Education of Spouse					1.00
Below High-School	70	51.5	66	48.5	
High-School and above	35	50.70	34	49.3	
Children					0.55
Yes	73	53.7	63	46.3	
No	33	48.5	35	51.5	
Socio-Economic Status					0.48
Very Low	2	33.3	4	66.7	
Low	14	66.7	7	33.3	
Medium	77	52.0	71	48.0	
High	9	42.9	12	57.1	
Very High	3	60.0	2	40.0	
Smoking					0.84
Current Smoker	34	53.1	30	46.9	
Former Smoker	18	52.9	16	47.1	
Non-smoker	52	49.1	54	50.9	
Alcohol use					0.35
Current Drinker	4	36.4	7	63.6	
Sometimes	17	44.7	21	55.3	
Former Drinker	7	70.0	3	30.0	
Non-drinker	76	53.1	67	46.9	
Frequency of Alcohol					
Less than Once a Month	13	46.4	15	53.6	
1-2-3 Days per month	5	35.7	9	64.3	0.50
1-2-3 Days per week	3	42.9	4	57.1	
Non-drinker	83	54.2	70	45.8	

	High			Low			
	N	Mean	SD	N	Mean	SD	p value
Body Mass Index	101	24.76	4.22	98	24.31	3.97	043
Working Year	101	13.53	10.07	94	13.12	9.80	0.77
Number of Children	71	1.85	0.78	58	1.74	0.54	0.38
TV Time	81	182.26	133.21	77	170.34	151.51	0.60
Internet per day	78	207.95	233.30	69	155.80	125.97	0.08

Considering the relationship between sociodemographic characteristics and subscales of childhood traumas, statistical significance was found between emotional abuse and profession (p:0.01), marital status (p:0.04) and spouse education (p:0.04); between physical neglect and profession (p:0.03), marital status (p:0.008), spouse education (p:0.008) and working year (p:0.004); between emotional neglect and shift work (p:0.04) and daily internet use (p:0.01); when looking at the overall childhood trauma scale, on the other hand, statistical significance was observed between the shift work (p:0.04). When other socio-demographic characteristics were examined, no statistical significance was found (Table 27-28-29-30-31).

5.DISCUSSION

This study was carried out with a total of 212 healthcare providers (137 female (64.6%), 75 male (35%)) worked in Karamürsel State Hospital in Kocaeli Province. The average age of healthcare providers in the study group was determined as 35.85±11.0. The findings of the research conducted with 212 healthcare providers were discussed in the light of the literature.

In our study, which investigates the childhood traumas and their effects on the health in adulthood, among the childhood traumas, the prevalence of physical neglect was 55.5%, the prevalence of emotional neglect 55.0%, and the overall of the trauma scale was 51.7%. While it was identified that among the trauma variables, emotional neglect was more important, statistical significance was found between emotional neglect and depression, moral development, health responsibility, nutritional habits, interpersonal relationships, stress management, and father's education level. Examining the literature, it is seen that there are many studies pointing out that childhood traumas have symptoms related to various health problems and psychological disorders (40).

Evaluating the questionnaires, it was found that 68.9% of the participants have depression, 48.6% have social support at home, and 41.5% have social support at work. Considering the subscales of healthy lifestyle scale, the moral development of 46.2% of the participants was low, while health responsibility of 45.8%, physical activity of 52.8%, nutrition habit of 48.6%, interpersonal relationships of 49.1%, and stress management of 51.4% was low. In the relevant literature, there are many studies pointing out that childhood traumas have symptoms related to various health problems and psychological disorders (40). Bostancı et al. (2006) stated that individuals with childhood traumas were more likely to become depressed (41).

Findings showing that emotional abuse and neglect significantly undermines the development of the child and that this damage continues also in adulthood increase gradually. Examining the subscales of Childhood Trauma Scale in this study, the results show that 55.5% have high physical neglect and 55.0% have emotional neglect. In the study conducted by Linehan (1993), it was reported that especially the emotions of children who were exposed to emotional abuse were ignored by their families and punished for their emotional expressions, and this situation causes deterioration in the skills of children to notice, name and explain their reasons (42). Burns et al. (2010) stated that traumas caused intense emotions in the children and

that children had difficulties in emotion regulation due to insufficient ability of the child to cope with these emotions (43).

Depression was more common in those with low moral development than those with high moral development, while it was observed that those with low health responsibility awareness had higher rates of depression than those with high awareness of health responsibility. However, no statistical significance was found between depression and physical activity and nutritional habits. The presence of depression was more common in those with low interpersonal relationships than those with higher interpersonal relationships. Depression was more common in those with low stress management than those with high.

In the academic research findings conducted in Turkey related to children who have been the victims of abuse and neglect, it is noteworthy that "girls were at higher rates than boys", when examined in terms of abuse types, it was found that the rate of girls was higher than that of boys in cases of sexual abuse (44).

Considering the relationship between physical abuse, emotional abuse and physical neglect in childhood with depression in adulthood, no statistical significance was observed. Depression was more common in those with higher emotional neglect than those with low emotional neglect. Looking at overall childhood trauma scale, depression was observed more in individuals with higher trauma than those with low trauma. In the literature, it was identified that people who were emotionally abused in childhood were shown to have depression, over-anxiety, low self-perception, and inadequate social relationships in the following years (45). According to the findings obtained in the research conducted by EyigünKantürk (2014), it was found that "there was emotional abuse in the 21.8% of children, physical abuse in 14.9%, sexual abuse in 5%, neglect in 20.8%, and economic exploitation in 5%", while there was childhood emotional abuse in the 18.8% of the mothers, physical abuse in 17.8%, and sexual abuse in 6.9% (46). On the other hand, it was found that the childhood emotional abuse and self-disclosure of the mother contributed significantly to the prediction of depression level of the mother. The level of depression decreases as self-disclosure level increases, and as the level of emotional abuse increases, the level of depression increases.

While there was no statistical significance between the education level of the mother of the participant and physical abuse in childhood, considering the education level of the father, it was observed that the participants' father's education level was 1.92 times more likely to be

exposed to physical abuse in childhood than those who had higher education. Özdemir et al. (2014) made a review on 60 children who applied to the forensic units. "It was determined that 90% of these children were female, 10% were male, 74.2% of their mothers and 62.7% of their fathers were primary school graduates". It was found that 28.3% of the children were also exposed to physical abuse and 18.6% to emotional abuse. While the average age of abuse was 13.42±2.54 in girls, this figure was found to be 9.5±3.14 in boys. The rate of recognizing the abuser was found to be 100% in boys (47).

No statistical significance was observed between emotional abuse and education level of mother and father. There was no statistical significance between physical neglect and education level of mother and father. Bayramoğlu (2009) stated that when studies conducted in Turkey on child abuse are examined, it would be seen that emotional abuse was more common with a rate of 78%, while physical abuse with 24%, and sexual abuse with 9% compared to the present study (48).

No statistical significance was found between emotional neglect and the education level of the mother and the education level of the father. EyigünKantürk (2014) stated that "mothers with low level of education may not be able to fully respond to emotional needs of children due to not having sufficient information about their emotional and physical development and emotional needs" (46).

Considering the overall childhood trauma scale, on the other hand, there was no statistical significance between this overall and the education level of the mother and the education level of the father. In their study examining the effect of multiple abuse life on adult mental health, Edwards et al. (2003) reported that *"34.6% of people who reported childhood abuse experience multiple exposure to more than one type of abuse"* (49).

In this study, no statistical significance was found between moral development with physical abuse and physical neglect experienced during childhood. Aral (1997) determined that 65.72% of children were physically abused by their parents (50). In the studies carried out by Kozcu (1991) and Jones and McCurdy (1992), it was identified that sexual harassment is at the most between 3-5 years of age (51) (52). Physical or emotional abuse in children can be first identified by their classroom teachers. These teachers can organize home visits or informative seminars to students under their responsibility. The fact that informing is effective in preventing abuse was determined in the research carried out with children in the 8-10 age group by Akgiray

(2007) and with children and their parents in the 10-12 age group by Adalı (2007) (53).

In this study, it was observed that those with low emotional abuse had more moral development than those with high emotional abuse, while those with low emotional neglect have been found to have more more development than those with high emotional neglect. Considering these findings in the study, it can be stated that physical abuse experienced in childhood increased psychological problems and psychiatric diseases in people's following lives. The fact that people tend to use alcohol, cigarettes or any substance in order to reduce psychological problems is a fact to be kept in mind.

No statistical significance was found between health responsibility and physical abuse, emotional abuse, and physical neglect in childhood and the overall of childhood trauma scale. The study conducted by Vranceanu, Hobfoll and Johnson (2007) revealed that as the perceptions of those who have been exposed to abuse during childhood may change, they may be more distrustful and shy in their social relationships and social support perceived by these people may be weak. However, when open to social support perceived from the environment, social support has a healing effect on a person's mental health (54). In a study carried out by Al-Mahroos and Al-Amer (2012), as the signs of health problems in physically abused children, it was determined that there was skin problems with a rate of 58%, fractures 10.5%, and head injuries 9.7%. 89% of the people who abuse these children were adults and 64% were male. For 48% of these cases, an application was made to the legal procedure, and children who were exposed to physical abuse were removed from the environment in which they were abused at the level of 10% (55).

No statistical significance was found between physical activity with physical abuse, emotional abuse, physical neglect, and emotional neglect in childhood and total trauma. Güler, Uzun, Boztaş and Aydoğan (2002) reported that 93% of mothers emotionally abused/neglected their children (56). The fact that "mothers in Turkey do not show their love to their children is described as a means of discipline not to lead demoralization and get spoiled them". For this reason, mothers usually do not show that they love their children, and the mothers' attitudes of shouting and scolding can be considered as necessary behaviors for the education of the child (57).

No statistical significance was found between physical abuse, emotional abuse, and physical neglect in childhood with nutrition habits. Mladenova and Andreenko (2005)

determined that most adolescents consume three main meals per day (58). In a study conducted by Siega-Riz, Popkin and Carson (1998), it was found that high school students in the United States do not usually make breakfast, which are of great importance for optimal health and school success. It was stated that "25% of high school students do not have breakfast at all and this rate increases day by day" (59). It was observed that those with low emotional neglect had more eating habits than those who did not. Looking at the overall of childhood trauma scale, it was observed that those with low trauma develop more health responsibilities than those with high trauma.

In this study, no statistical significance was observed between interpersonal relationships and physical neglect in childhood. It was determined that people with low physical abuse develop more interpersonal relationships than those who do not; those with low emotional abuse develop more interpersonal relationships than those with high emotional abuse; and in those with low emotional neglect, it was observed that they developed more interpersonal relationships than those with high emotional neglect. Looking at the overall of childhood trauma scale, it was observed that those with low trauma develop more interpersonal relationships than those with high trauma. According to a study carried out in 2010, it was determined that the group with high level of abuse had more early disordering schemes than the group with low level of abuse and these people exhibited negative interpersonal styles more. In addition, it was found that interpersonal relationships are predicted by childhood abuse and early disordering schemes mediate this relationship (60). On the other hand, based on the results of the study conducted by Batıgün (2008), it was determined that "male mostly use the frustrative interpersonal style whereas female mostly use the substantial interpersonal style" (61).

No statistical significance was observed between physical abuse and physical neglect experienced during childhood and stress management. It was found that those with low emotional abuse developed more stress management than those with high emotional abuse, while those with low emotional neglect developed more stress management than those with higher emotional neglect. Looking at the overall of childhood trauma scale, it was observed that those with low trauma develop more stress management than those with high trauma. Several studies in the literature reveal that some parents do not provide their children with the support they need in terms of children's interests and needs, so they lead their children to be harmed in many areas such as self-confidence development and academic success (63).

Considering the relationship between the participants' own education levels and their childhood traumas, no statistical significance was observed between this factor and physical abuse, emotional abuse, and emotional neglect in childhood and the overall of the childhood trauma scale. It was observed that those with low physical neglect had higher education levels than those with high physical neglect. Other studies in the literature reveal that "the level of education has a significant effect on childhood trauma". According to the findings obtained in these studies, "primary school graduates stated more abuse than high school and university graduates, while high school graduates state more than university graduates" (64).

It was observed that, in each unit age increase, depression was 0.97, social support at home was 1.04, emotional abuse was 0.97, and physical neglect in childhood was 1.04 times higher. No statistical significance was observed between age and moral development, health responsibility, physical activity, nutritional habits, interpersonal relationships, stress management, physical abuse, emotional neglect, and overall childhood trauma scale.

Considering the relationship between sociodemographic characteristics and subscales of childhood traumas, statistical significance was found between emotional abuse and profession, marital status and spouse education; between physical neglect and profession, marital status, spouse education and working year; between emotional neglect and shift work and daily internet use; when looking at the overall childhood trauma scale, on the other hand, statistical significance was observed between the shift work. In a research conducted by EyigünKantürk (2014), "depression levels of children and their relationship between socio-demographic variables" were examined, and no significant relationship was found between "depression levels and mother's age, family's economic level, number of children, history of trauma event, and the presence of someone with a psychological problem in the family" (46). In a study conducted by Al-Mahroos and Al-Amer (2012), a total of 237 child physical abuse cases applying to a hospital in Bahrain between 2000-2009 was examined to evaluate the physical abuse in children and the magnitude of the event and the characteristics of victims of abuse. The average age of children who were physically abused was 7 and 58% of these children were boys (55).

When a general evaluation of the study and the findings obtained in the relevant literature was made, it was observed that children who had trauma history and physically and emotionally abused in their childhood experience nutritional disorders and psychological disorders in their adulthood, besides, their school life and education lives were negatively

affected in this direction; moreover, in abused children, girls were observed to be predominant, and in adults who abused the children, the male was found to be predominant.

In terms of the participants of this study who were the healthcare professions in the Karamürsel State Hospital, 7.7% of them were physicians, 39.4% nurses+midwives+health officers, 26.4% technicians-officers, 11.1% assistant staff, and 15.4% interns. Considering the general state of health of the participants, the average of the body mass index of the participants was 24.56±4.08 kg/m2 and 58.7% of the participants were normal, 29.9% were overweight and 11.4% were obese. According to the body mass indexes of participants of the research conducted by Akdevelioğlu (2012), 7.2% of female was obese, while 2.2% of male was obese (66). On the other hand, in their study conducted by Süzek and Azkaya (2012) with a total of 250 officers worked in "Turkish Eximbank" located in Ankara affiliated to "Prime Ministry Undersecretariat of Treasury" using screening model, it was identified that 33.6% of male and 1.14% of female was obese (67). As a result of the "Obesity and Hypertension Screening" study conducted by scanning 23888 people in Turkey in 2002, Hatemi (2003) reports that obesity rate in female was found to be 36.17% (68).

In terms of smoking status of the participants, it was found that 32.4% of them are current smokers and the average of their number of cigarettes per day is 9.97±6.35, the average age to start smoking was 19.74±3.71 and the average period of smoking was 15.42±9.14 years. The rate of former smokers was 16.4%, when their previous information are examined, their age to start smoking was 18.52±4.43, number of cigarettes per day 14.83±7.45, on the other hand, 51.2% of the participants were non-smokers. In their study investigating the "male high school students aged 14-18 studying in Amasya in 2014-2015 academic year" with screening model, Özlü et al (2017) reported that 21.72% of the participants were current smokers, while 78.28% of them non-smokers; 43.10% of the current smokers smoke an average of 1-5 cigarettes per day, 18.97% of them smoke more than 20 cigarettes per day (69). In the study conducted by Gölbaşı et al. (2011) named "Smoking prevalence among high school students in Turkey", it was determined that 20.4% of high school students are current smokers (70). Again, in a similar study named "Smoking, Alcohol and Substance Use among High School Students in Samsun City Center", Arslan et al. (2012) found that 24.79% of high school students in Samsun province are current smokers (71). Güler et al. (2009) found that 34.1% of the students smoked 1-5 cigarettes per day and 9.3% of them smoked more than 20 cigarettes (72).

Considering the alcohol use of the participants who participated in the research, it was found that 13.7% of them says less than once a month, 18.5% sometimes, 4.9% former drinker, 51.2% non-drinker. In terms of the question of how often do you use alcohol, 19.7% of them says less than once a month, 6.8% 1-2-3 days per month, 3.9% 1-2-3 days per week. In a study conducted in 2003, it was reported that dissociation may not be associated with childhood or life-long trauma, especially in male alcohol addicts. The relationship between dissociative symptoms and childhood traumas in alcohol or substance addicts in our country is thought to be most evident with emotional abuse and physical neglect (73). Wu et al. (2015) reported that every childhood trauma increased lifetime risk of alcohol addiction by 16% (74).

The mean of PC - TV - Phone usage time for weekdays was 166.41±153.96 minutes, it was 210.01±149.87 minutes for weekends. In the research, this high rate of computer use levels is due to the participants whose normal job is on computer use. General TV use period was 176.43±141.63 minutes, while it was 182.62±190.61 minutes for Internet usage (Table 6). Steffen et al. (2009) determined that in addition to watching TV or every 1 hour in addition to the total watch time per day increased the status of being overweight by 20-30% (75). According to the "Health Behavior Report in School Age Children" carried out by WHO (World Health Organization) investigating the adolescents in countries in North America and Europe in 2005 and 2006, 61-70% of the children participating in the research stated that they spend two or more hours a day watching TV (76). In the "National School Health Survey" conducted by Camelo et al. (2012) with the participation of Brazilian students, it was determined that 79.2% of adolescents watch TV for 2 hours or more daily (77). The screen types used by young people change rapidly in time.

When the socio-economic characteristics of the participants are examined, 2.9% of them stated that it is very low, 10.3% low, 74.0% medium, 10.3% high, 2.5% very high. In a study carried out by Bilim (2012), in the comparison of depression levels in terms of socio-demographic variables, there was no significant difference between mothers' employment status and education levels. In terms of family income level variable, it was stated that the emotional abuse, emotional neglect and physical abuse experiences of mothers are changing (60).

6.CONCLUSION

The results of this study which we conducted to identify the effect of childhood trauma on the health in adulthood are summarized below:

1. Considering the general health status of the participants of this study, 41.3% of them was found to have abnormal (underweight, overweight) body index masses. A similar result applies to smoking. Smoking rates of hospital health providers were determined to be 32.4%. Considering both of these results, it was determined that a significant number of healthcare providers in the hospital did not pay attention to their own health. Therefore, general health education should be provided in the hospital, and awareness about nutrition and smoking and alcohol use should be increased.
2. The average number of daily computer and TV usage times of the participants in the study was high. It has been determined that the reason for this value to be high is the fact that the people whose main job in the hospital is using computers, telephones, and the internet affects the general average.
3. Examining the subscales of the healthy lifestyle scale, health responsibility, physical activity, interpersonal relationships, and nutritional habits of the participants were low. It was determined that the hospital staff did not pay attention to their own health and did not have the necessary awareness in this regard.
4. Looking at the subscales of the Childhood Trauma Scale, the presence of trauma in childhood was significantly high. It was found that childhood trauma was statistically significant with depression in adulthood. For this, clinical psychologist interviews should be added to routine health checks planned and carried out by the ministry of health and carried out within the scope of employee health and safety, and it is necessary to determine the presence of childhood traumas as well as to determine the existing depression and to plan the related interventions.
5. It was found that depression was higher in those with low moral development, stress management, health responsibility awareness, physical activity, and nutritional habits compared to those with high levels in these mentioned categories. In this context, it was found that the state of being healthy in daily life has an effect on depression, at the same time, it was observed that personal health, personal care and personal attention were effective in struggling with depression.

6. A statistically significant difference was found between the education level of the father of the participants and childhood trauma. In parallel, there was no statistically significant difference between the education level of the mother. It was observed that a father plays a more active role in the family and therefore, the education level of a father is important in the family life.
7. It was found that the rate of depression decreases in each unit age increase. Age was found to be a protective factor on depression.

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T.R. YEDİTEPE UNIVERSITY

Appendix 1.

Item : 37068608-6100-15- 1585 **17/01/2019**
Subject: Ethics Committe Approval

TO WHOM IT MAY CONCERN (SEDA ERDOGAN)

The application of Clinical Research Ethics Committee (KAEK) (KAEK Application File, registry number:**1555**) for the Ethics Committee Approval regarding the research project named **"The Effect of Childhood Trauma on the Health in Adulthood"** (Advisor: Asts. Prof. Hale TAŞYIKAN, Yeditepe University Faculty of Medicine Public Health Department) has been reviewed by Yeditepe University Clinical Research Ethics Committee at the meeting held on the date of **January 16, 2019**.

As a result of the review made by the Committee, the abovementioned study has been deemed to be ethically and scientifically appropriate (**KAEK Decision no: 938**)

(Signed)
Prof. Dr. Turgay ÇELİK
Yeditepe University
Chair of Ethics Committee

KOCAELİ İL SAĞLIK MÜDÜRLÜĞÜ - KOCAELİ EĞİTİM HİZMETLERİ BİRİMİ
09/12/2019 23:31 - 65530689 - 799 - E.158
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Appendix 2.

REPUBLIC OF TURKEY
KOCAELİ GOVERNORATE
Provincial Directorate Of Health

Item : 65530689-799
Subject: Master's Thesis-Seda ERDOĞAN

TO THE HEAD PHYSICIAN OF KARAMÜRSEL STATE HOSPITAL

Based on the application (dated 15.11.2019 and numbered 10242) of Seda ERDOĞAN, a master's degree student at Yeditepe University, Department of Public Health, Master's Thesis of the aforementioned student on "The Effect of Childhood Trauma on the Health in Adulthood" was reviewed by the commission of our Directorate and performing the study in your hospital was approved.

Please take necessary action.

e-signed.
Asts. Prof. Onursal VARLIKLI
On behalf of Provincial Health Director
Head of Health Services

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App. 3

KARAMÜRSEL STATE HOSPITAL
QUESTIONNAIRE OF THE STUDY NAMED
"THE EFFECT OF CHILDHOOD TRAUMA ON THE HEALTH IN ADULTHOOD"

This study investigates the effect of childhood trauma on the health in adulthood. Please answer the questions as accurately and completely as possible. In demographic questions, make a marking by filling the circle at the head of your answer.

S1. What is your gender?	❍ Female	❍ Male	
S2. What is your date of birth?	……/……/…….		
S3. How old are you?	…….		
S4. What is your height-weight?	…….		
S5. What is your profession?	…….		
S6. How many years have you been working?	…….		
S7. In which unit do you work? …….			
S8. Do you work shifts?	❍ Yes	❍ No	
S9. What is your Marital Status?			
❍ Married ❍ Single	❍ Widow ❍ Divorced	❍ Cohabiting ❍ I don't know	❍ I don't want to give an answer
S10. If you are married, what is your spouse's educational status?			
❍ Not literate ❍ Literate ❍ Primary ❍ Secondary	❍ High School ❍ Undergraduate ❍ Graduate ❍ Postgraduate	❍ PhD ❍ I don't know ❍ I don't want to give an answer	
S11. What is your educational status?			
❍ Not literate ❍ Literate ❍ Primary ❍ Secondary	❍ High School ❍ Undergraduate ❍ Graduate ❍ Postgraduate	❍ PhD ❍ I don't know ❍ I don't want to give an answer	
S12. What is your mother's educational status?			
❍ Not literate ❍ Literate ❍ Primary ❍ Secondary	❍ High School ❍ Undergraduate ❍ Graduate ❍ Postgraduate	❍ PhD ❍ I don't know ❍ I don't want to give an answer	
S13. What is your father's educational status?			
❍ Not literate ❍ Literate ❍ Primary ❍ Secondary	❍ High School ❍ Undergraduate ❍ Graduate ❍ Postgraduate	❍ Phd ❍ I don't know ❍ I don't want to give an answer	
S14. Do you have children?			
❍ Yes	❍No	❍ I don't know	❍ I don't want to give an answer
S15. If yes, how many?	.....		
S16. How do you find your socioeconomic level?			
❍ Very Low ❍ Low	❍ Medium ❍ High	❍ Very High ❍ I don't know	❍ I don't want to give an answer
S17. Dou you smoke?			
❍ Yes (At least 1 regular per day –*see Table 1)*	❍ Never smoked *(18. Soruya git)*		

❍ Sometimes *(see Table 1)* ❍ I quit *(see Table 2)*	❍ I don't know ❍ I don't want to give an answer

Table 1 → How many cigarettes do you smoke per day? ……
What is your age to start smoking? ……
How long have you been smoking? ……

Table 2 → How many cigarettes did you smoke per day? ……
What was your age to start smoking? ……
How long did you smoke? ……

S18. Do you consume alcoholic beverages?

❍ Yes *(See Table 3)* ❍ Sometimes *(See Table 3)* ❍ Former drinker *(See Table 4)*	❍ Non-drinker *(See Question 19)* ❍ I don't know ❍ I don't want to give an answer

Table 3 → How often do you consume alcoholic beverages?

❍ Everyday ❍ 5-6 days a week	❍ 3-4 days a week ❍ 2-3 days a week	❍ 1 day a week ❍ Less than once a week	❍ 1-3 days a month ❍ Less than once a month

Table 4 → Before you quit, how often did you drink alcoholic beverages?

❍ Everyday ❍ 5-6 days a week	❍ 3-4 days a week ❍ 2-3 days a week	❍ 1 day a week ❍ Less than once a week	❍ 1-3 days a month ❍ Less than once a month

S19. On average, how much time do you spend a day on sitting activities such as watching TV, spending time on the computer and/or on the phone, wasting time on social media, etc.?

❍ Weekdays …….. hour/ ……. minutes ❍ Weekend …….. hour / …… minutes	❍ I don't know ❍ I don't want to give an answer

S20. What is your daily internet usage time? …….hour(s)

❍ I don't know
❍ I don't want to give an answer

Beck Depression Inventory for Primary Care

Below are some sentences in groups. Read the sentences in each group carefully. Choose the sentence that best describes how you felt during the last week, including today. Make a marking by filling the circle at the beginning of the sentences you choose. Before making your choice, carefully read all the sentences in each group.

S21. Sadness

❍ **0** I do not feel sad.	❍ **2** I am sad all the time.
❍ **1** I feel sad much of the time.	❍ **3** I'm so sad or unhappy I can't stand it.

S22. Pessimism

❍ **0** I'm not discouraged about my future.	❍ **2** I do not expect things to work out for me.
❍ **1** I am more discouraged about my future than I used to be	❍ **3** I feel that my future is hopeless and will only get worse.

S23. Past Failure

❍ **0** I do not feel like a failure.	❍ **2** As I look back, I see a lot of failure.
❍ **1** I have failed more than I should have.	❍ **3** I feel that I am total failure as a person.

S24. Self-dislike

❍ **0** I feel the same about myself as I always have.	❍ **2** I am disappointed in myself.
❍ **1** I have lost confidence in myself.	❍ **3** I dislike myself.

S25. Self-criticalness

❍ **0** I don't criticize or blame myself more than usual.	❍ **2** I criticize myself for all of my faults.
❍ **1** I am more critical of myself than I used to be.	❍ **3** I blame myself for everything bad that happens.

S26. Loss of interest

❍ **0** I have not lost interest in other people or activities.	❍ **2** I have lost most of my interest in other people or things.
❍ **1** I am less interested in other people or things than before.	❍ **3** It's hard to get interested in anything.

S27. Suicidal thoughts or wishes

❍ **0** I don't have any thoughts of harming myself.	❍ **2** I feel I would be better off dead.
❍ **1** I have thoughts of harming myself but I would not carry them out.	❍ **3** I would kill myself if I could.

In the questions given in the table below, social support at home and at work research is conducted. Check the box that corresponds to your opinion.

	Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**
S28. There is a calm and pleasant environment at home	4	3	2	1
S29. We get on well with each other at home.	4	3	2	1
S30. Other people living at home support me.	4	3	2	1
S31. If I'm on a bad day, the people at home understand my situation.	4	3	2	1
S32. I have no problems with my spouse regarding housework.	4	3	2	1
S33. I like working at home.	4	3	2	1
S34. There is a calm and pleasant environment where I work.	4	3	2	1
S35. We get on well with each other where I work.	4	3	2	1
S36. Employees in the workplace support me.	4	3	2	1
S37. If I'm on a bad day, those at work will understand me.	4	3	2	1
S38. I have a good relation with my superiors.	4	3	2	1

S39. I like working with my colleagues.	4	3	2	1

HEALTHY LIFESTYLE BEHAVIOUR SCALE-II

This questionnaire contains questions about your current lifestyle and habits. Please answer the questions as accurately and completely as possible. Indicate the frequency of each habit by checking the appropriate option (Never 1, sometimes 2, often 3, routinely 4 points)

		Never	Sometimes	Often	Routinely
1	Discuss my problems and concerns with people close to me.				
2	Choose a diet low in fat, saturate fat, and cholesterol				
3	Report any unusual signs or symptoms to a physician or other health professional				
4	Follow a planned exercise program				
5	Get enough sleep				
6	Feel I am growing and changing in positive ways				
7	Praise other people easily for their achievements.				
8	Limit use of sugars and food containing sugar (sweets)				
9	Read or watch TV programs about improving health				
10	Exercise vigorously for 20 or more minutes at least three times a week (such as brisk walking, bicycling, aerobic dancing, using a stair climber)				
11	Take some time for relaxation each day				
12	Believe that my life has purpose.				
13	Maintain meaningful and fulfilling relationships with others.				
14	Eat 6-11 servings of bread, cereal, rice and pasta each day.				
15	Question health professionals in order to understand their instructions.				
16	Take part in light to moderate physical activity (such as sustained walking 30-40 minutes 5 or more times a week).				
17	Accept those things in my life which I cannot change				
18	Look forward to the future				
		Never	Sometimes	Often	Routinely
19	Spend time with close friends				

20	Eat 2-4 servings of fruit each day				
21	Get a second opinion when I question my health care provider's advice.				
22	Take part in leisure-time (recreational) physical activities (such as swimming, dancing, bicycling).				
23	Concentrate on pleasant thoughts at bedtime.				
24	Feel content and at peace with myself.				
25	Find it easy to show concern, love and warmth to others				
26	Eat 3-5 servings of vegetables each day.				
27	Discuss my health concerns with health professionals.				
28	Do stretching exercises at least 3 times per week				
29	Use specific methods to control my stress				
30	Work toward long-term goals in my life				
31	Touch and am touched by people I care about				
32	Eat 2-3 servings of milk, yogurt or cheese each day				
33	Inspect my body at least monthly for physical changes/danger signs				
34	Get exercise during usual daily activities (such as walking during lunch, using stairs instead of elevators, parting car away from destination and walking).				
35	Balance time between work and play.				
36	Find each day interesting and challenging				
37	Find ways to meet my needs for intimacy.				
38	Eat only 2-3 servings from the meat, poultry, fish, dried beans, eggs, and nuts group each day.				
39	Ask for information from health professionals about how to take good care of myself				
40	Check my pulse rate when exercising.				
41	Practice relaxation or mediation for 15-20 minutes daily.				
42	Am aware of what is important to me in life				
43	Get support from a network of caring people				
44	Read labels to identify nutrients, fats, sodium content in packaged food				
45	Attend educational programs on personal health care				
46	Reach my target heart rate when exercising.				
47	Pace myself to prevent tiredness				
48	Feel connected with some force greater than myself				
49	Settle conflicts with other through discussion and compromise.				
50	Eat breakfast				

51	Seek guidance or counseling when necessary				
52	Expose myself to new experiences and challenges.				

Childhood Trauma Scale

Below are questions about your childhood. Make a marking on the box corresponding to the answer option that you think is appropriate for you.

	Never	Rarely	Sometimes	Often	Very Often
1. I believe that I was fed enough in my childhood.	**0**	**1**	**2**	**3**	**4**
2. In my childhood, there was one or more than one person caring or protecting me.	**0**	**1**	**2**	**3**	**4**
3. In my childhood, people in my family used to call me with words such as 'Stupid', 'Lazy' or 'Ugly'.	**0**	**1**	**2**	**3**	**4**
4. My mother and father were too drunk or high on drugs to care our family.	**0**	**1**	**2**	**3**	**4**
5. There was one or more than one members of my family who made me feel special.	**0**	**1**	**2**	**3**	**4**
6. In my childhood, I had to wear dirty clothes.	**0**	**1**	**2**	**3**	**4**
7. In my childhood, I felt I was loved.	**0**	**1**	**2**	**3**	**4**
8. In my childhoold, I thought that my parents wished I had never been born.	**0**	**1**	**2**	**3**	**4**
9. In my childhood, I had beaten by the members of my family such an extent that I had to apply to a hospital or visit a doctor.	**0**	**1**	**2**	**3**	**4**
10. In terms of my childhood, there is nothing I want to change related to my family.	**0**	**1**	**2**	**3**	**4**
11. In my childhood, the members of my family beat me black and blue.	**0**	**1**	**2**	**3**	**4**
12. In my childhood, I was punished beaten with a strap, stick, cable or similar hard objects.	**0**	**1**	**2**	**3**	**4**
13. In my childhood, the members of my family protected each other.	**0**	**1**	**2**	**3**	**4**
14. In my childhood, the members of my family used to say hurtful or offensive words to me.	**0**	**1**	**2**	**3**	**4**
15. I believe that I was physically abused in my childhood.	**0**	**1**	**2**	**3**	**4**
16. I had a perfect childhood.	**0**	**1**	**2**	**3**	**4**
17. In my childhood, I was beaten by people such as teachers, neighbors, or doctors badly enough to be noticed.	**0**	**1**	**2**	**3**	**4**
18. In my childhood, I felt that there was one or more than one member of my family hating me.	**0**	**1**	**2**	**3**	**4**

19. In my childhood, members of my family were close to each other.	**0**	**1**	**2**	**3**	**4**
22. In my childhood, I had the best family in the world.	**0**	**1**	**2**	**3**	**4**
25. I believe that I was emotionally abused in my childhood.	**0**	**1**	**2**	**3**	**4**
26. In my childhood, there was always one or more than one person in my family to take me to the doctor when I needed it.	**0**	**1**	**2**	**3**	**4**
28. In my childhood, my family was a source of strength and support for me.	**0**	**1**	**2**	**3**	**4**

Thank you for participating in our research by filling out the questionnaire.

11. CURRICULUM VITAE

Personal Details

Name	Seda	**Surname**	ERDOĞAN
Place of Birth	İzmit	**Date of Birth**	09.11.1991
Nationality	Republic of Turkey	**T.R. ID No**	47374467282
E-mail	s_erdogan@windowvslive.com	**Mobile**	+905307342064

Educational Background

Degree	Field	Name of the Institution Graduated	Year of Graduation
PhD			
Master's Degree			
Bachelor's Degree	Nursing	**Sakarya University**	2014
High School			

Work Experience (Sort from last to past)

Position	Institution	Duration (Year - Year)
Nurse	Karamürsel State Hospital	2018-
Nurse	Dr. Lürfi Kırdar Kartal Train. and Res. Hosp.	2014-2018
Nurse	Acıbadem Kocaeli Hospital	2014-2015