


Marital adjustment in risky and healthy pregnant

Riskli ve sağlıklı gebelerde evlilik uyumu

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ABSTRACT

Aim: This study was conducted to evaluate the relationship between the health risk experienced by women during pregnancy and marital satisfaction and marital adjustment.

Materials and Methods: This descriptive and comparative study was conducted with 202 pregnant women in a gynecology and obstetrics hospital between 01/12/2021-01/06/2022. Data were collected using questions on socio-demographic and obstetric characteristics, The Satisfaction with Marriage Scale and The Revised Dyadic Adjustment Scale. The results were evaluated at the level of significance $p<0.05$ at the 95% confidence interval.

Results: The mean age of healthy pregnant women was 27.18 ± 5.55 and risky pregnant women was 29.61 ± 6.72 . "The Satisfaction with Marriage Scale " and "The Revised Dyadic Adjustment Scale" scores medians were statistically significantly higher in the risky pregnant group ($p<0.001$). The marital satisfaction and dyadic adjustment of those with primiparous and primigravid were statistically significantly higher ($p<0.05$).

Conclusion: Marital satisfaction and dyadic adjustment of the risky pregnancy group and pregnant women without children are at a better level than healthy pregnant women.

Keywords: Pregnancy, high-risk pregnancy, marital satisfaction, marital adjustment.

ÖZ

Amaç: Bu araştırma, kadınların gebelikte yaşadıkları sağlık riski ile evlilik doyumu ve evlilik uyumu arasındaki ilişkiyi değerlendirmek amacıyla yapılmıştır.

Gereç ve Yöntem: Karşılaştırmalı ve tanımlayıcı bu çalışma, 01/12/2021-01/06/2022 tarihleri arasında bir kadın doğum hastanesinde yatan 202 gebe ile yapılmıştır. Veriler, sosyo-demografik ve obstetrik özellikler ile ilgili sorular, Evlilik Doyumu Ölçeği ve Revize Edilmiş Çift Uyumu Ölçeği kullanılarak toplanmıştır. Sonuçlar %95 güven aralığında anlamlılık $p<0,05$ düzeyinde değerlendirilmiştir.

Bulgular: Sağlıklı gebelerin yaş ortalaması $27,18\pm5,55$, riskli gebelerin yaş ortalaması $29,61\pm6,72$ 'dir. "Evlilik Doyumu Ölçeği" ve "Revize Edilmiş Çift Uyumu Ölçeği" puan medyanları riskli gebe grubunda istatistiksel olarak anlamlı düzeyde yüksektir ($p<0,001$). Primipar ve primigravid olanların evlilik doyumu ve çift uyumu istatistiksel olarak anlamlı derecede yüksektir ($p<0,05$).

Sonuç: Riskli gebelik grubu ve çocuğu olmayan gebelerin evlilik doyumları ve evlilik uyumları sağlıklı gebelere göre daha iyi düzeydedir.

Anahtar Sözcükler: Gebelik, yüksek riskli gebelik, evlilik doyumu, evlilik uyumu.

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INTRODUCTION

The term "marriage adjustment" is used to evaluate marital and family relationships (1). Marital adjustment is an important component of the family system. Marriage adjustment is a process that includes more than just a trait or behavior. It is an indicator of compliance rates in mutual relations (2). Marital adjustment is conceptualized as a multidimensional construct based on each partner's subjective perception of satisfaction, consensus, harmony, and love (3).

Marriage is a form of relationship that provides mutual sexual satisfaction, continuity of family lineage, coexistence, and cooperation. Marriage, which is a part of social life, is an integrity in which individuals are in harmony (4).

The quality of the togetherness of a married couple can be defined as marital satisfaction (5). Marital satisfaction is thought to be a key predictor of both individual and relational well-being (6).

Marital adjustment is affected by many factors, including social status, education, age of marriage, recognition before marriage, good relations with parents in childhood, happiness in parents' marriage, gender roles, marriage approval by friends and family, ethnic and religious history of the couple (7, 8).

Another factor that can affect marital adjustment is pregnancy, in which individuals experience different emotions (9). Pregnancy is a natural process in which changes are experienced in biological, physiological and psychosocial areas. Pregnancy is one of the important life periods for women. It is important to have adjustment between couples for a healthy pregnancy (10). Although pregnancy is not the basis for the marriage union, it is complementary (11). In addition, pregnancy may be affected by marital adjustment. Close relatives of pregnant women are among the important sources of support (9).

Pregnant women may encounter various sources of stress during their pregnancy. The high marital adjustment of pregnant women supports them to spend this period more easily and positively (12). However, if the pregnancy is risky, pregnant women may be exposed to unstable emotions more often and for longer periods of time. Such feelings experienced by high-risk pregnant women may also affect family relationships (13, 14).

Duties of the nurse during pregnancy; It includes the evaluation of the pregnant woman both

physically and psychosocially, determining and meeting her care needs, training and consultancy services. While providing these services, the nurse should evaluate not only the pregnant but also all family members, and the family and spouse should definitely participate in the care plan to be prepared for the expectant mother (15). It is very important for the nurse to determine the problems related to marital adjustment while determining the problems experienced by the pregnant, both for the pregnancy and the postpartum period. In order for both the woman and her family to be in complete well-being, she should be aware of the importance of marital adjustment in the pregnancy and postpartum period and recognize the problems that affect marital adjustment. In this way, increasing marital adjustment will ensure a positive development of spousal adjustment and reduce the usual pregnancy complaints (16).

The most important sources of support for pregnant women are their close family members, especially their spouses. It is thought that supportive relationships in people's lives play an important role in promoting health, preventing health problems, protecting from the effects of stress and strengthening coping efforts (4).

Due to the fact that pregnancy can affect marital adjustment, it was aimed to guide midwives and obstetric nurses who care for pregnant women in their caregiving that includes family relations.

MATERIALS and METHODS

Aim: This study was conducted to evaluate the relationship between the health risk experienced by women during pregnancy and marital satisfaction and marital adjustment.

Design: The study was in the type of descriptive and comparative research. Research data were collected between 01/12/2021-01/06/2022.

Sample/Participants: The study population consisted of pregnant women (control group) who applied to the pregnancy outpatient clinic and pregnant women who were hospitalized for at least 48 hours with the diagnosis of risky pregnancy in the Perinatology clinic (case group) in a gynecology hospital. The research sample (0.95 confidence interval, 0.05 margin of error, 0.05 effect size) should consist of at least 176 (88 healthy, 88 risky pregnant) pregnant women. The study was completed with 202 (101 healthy, 101 risky pregnant) pregnant women.

Criteria for inclusion in the case group: Hospitalized in the perinatology clinic for at least 48 hours, diagnosed with clinical and related high risk factors (hemorrhagic pregnancy conditions, preterm labor, placental location anomalies, amniotic fluid disorders, preeclampsia and gestational diabetes mellitus, infections, fetal anomaly) and systemic disease (Hypertension, Heart Disease, Diabetes Mellitus,...), who did not have any diagnosed psychiatric problems and who were married were included.

Criteria for inclusion in the control group: Pregnant women who did not have any diagnosed risk factors related to pregnancy, any systemic disease, any diagnosed psychiatric problem and who were married were included.

Pregnant women who did not meet the conditions for participation in the study and did not accept participation were excluded from the study.

Data collection: The data collection form used in the research consists of 4 parts. In the first part, there are questions about the data on socio-demographic characteristics, and in the second part there are questions about the data on obstetric characteristics. The third section includes the Marriage Satisfaction Scale and the fourth section includes The Revised Dyadic Adjustment Scale.

The Satisfaction With Life Scale (SWLS) was developed by Diener et al., (1985) to measure life satisfaction in a short form (17). In a study conducted by Gündoğdu (2007), the word "marriage" was used instead of the word "life" in the items in the original version of the scale to measure marital satisfaction and named the scale as "The Satisfaction with Marriage Scale". A total of 5 questions were rated on a 5-point Likert-type scale (1 = strongly disagree, 5 = completely agree).¹⁸ The Cronbach's alpha coefficient of the original version of the scale was 0.87.¹³ Reliability analysis results also indicated a high Cronbach's alpha value of 0.92 for married couples in Gündoğdu's study (18). In this study, the Cronbach's alpha value was determined as 0.88. In the factor analysis, it was determined that there was only one factor.

The original version of the 32-item Dyadic Adjustment Scale was developed by Spanier

(1976). Total scale reliability analysis revealed a Cronbach's alpha coefficient of 0.96 for the entire scale, and 0.90, 0.94, 0.86, and 0.73 for dyadic satisfaction, dyadic agreement, dyadic consensus, and emotional expression, respectively (19). Busby et al. (1995) restructured the scale, reducing the number of items to 14, and rated all items as a 5-point Likert-type scale with responses ranging from often to never. The Revised Dyadic Adjustment Scale (RDAS) has three subscales: dyadic consensus, dyadic satisfaction, and dyadic cohesion. RDAS has adequate internal consistency estimates and reliability coefficients (0.94). In Gündoğdu's study, the reliability coefficient was determined as 0.87 (18). In this study, the Cronbach's alpha value was determined as 0.88. In our study, reliability confirmatory factor analysis was performed for three sub-dimensions and the three sub-dimensions identified by Busby et al. (1995) (20) were confirmed. The Cronbach's alpha values of the dimensions were determined as 0.88 for the satisfaction factor, 0.80 for the consensus factor, and 0.83 for the cohesion factor.

Data analysis: In the evaluation of the data; number, percentage, mean and standard deviation were used as descriptive statistics, and parametric and nonparametric methods were used in dependent and independent groups according to data characteristics. The results were evaluated at the level of significance $p < 0.05$ at the 95% confidence interval.

RESULTS

While the mean age of healthy pregnant women was 27.18 ± 5.55 , the mean age of risky pregnant was 29.61 ± 6.72 , and the difference between them was statistically significant ($t = -2.805$, $p < 0.05$). While the median duration of marriage of healthy pregnant women was 5 (1-19), it was 7 (1-26) of risky pregnant women, and the difference between them was statistically significant ($z = -2.453$, $p < 0.05$). While the median BMI of healthy pregnant was 23.44 (15.81-44.06), it was 25.28 (15.62-166.67) of risky pregnant, and the difference between them was statistically significant ($z = -2.427$, $p < 0.05$). While no statistically significant difference was found in healthy and risky pregnancy groups in terms of

sociodemographic characteristics, educational status, spouse education status, employment status, spouse working status, social security, smoking, place of residence, family type, a significant difference was found in income status ($\chi^2= 38.573$, $p<0.001$). There was a statistical difference in terms of regular control ($\chi^2=10.521$, $p<0.001$). While all of the healthy pregnancy group had regular controls, 5% of the risky pregnancy group did not have regular controls (Table-1).

In the intergroup comparison of obstetric characteristics, the mean weight gained during pregnancy was 7.00 ± 4.80 in the healthy pregnancy group, while it was 9.45 ± 5.27 in the risky pregnancy group, and there was a statistically significant difference between them ($t= -3.447$, $p<0.001$). There was no statistically significant difference between healthy and risky pregnant groups in terms of gravida, parity and miscarriage/curettage ($p>0.05$) (Table-2).

Diagnoses of risky pregnancy were 18.3% Diabetes Mellitus (DM), 15.8% Intrauterine Growth Retardation (IUGR), 11.7% Polyhydramnios or Oligohydramnios, 10.0% Preterm or Postterm Action Threat, 9.2% Hypertension (HT) (Table-3).

In the intergroup comparison of Marriage Satisfaction and Dyadic Adjustment Scale scores, the median marriage satisfaction score was 21 (7-25)/85.05 in the healthy pregnancy group, while it was 23 (7-25)/117.95 in the risky pregnancy group, and there was a significant difference between them ($z= -4,038$, $p<0.001$). While the median score of the "The Revised Dyadic Adjustment Scale" was 54 (18-67)/87.11 in the healthy pregnancy group, it was 60 (25-75)/115.89 in the risky pregnancy group, and there was a statistically significant difference between them ($z= -3.501$, $p<0.001$). While there was no difference between the groups in the dimension of dyadic consensus, which was one of the sub-dimensions of the dyadic adjustment scale, there was a significant difference in the sub-dimensions of dyadic satisfaction and dyadic cohesion. It was determined that marital

satisfaction and dyadic adjustment, and satisfaction and consensus which are sub-dimensions of dyadic adjustment were better in the risky pregnant group than in the healthy pregnant group (Table-4).

In the comparison of dyadic adjustment and marital satisfaction data according to sociodemographic and obstetric characteristics, no difference was found in terms of age, education, status and smoking ($p>0.05$). It was seen that the education level of the spouse creates a statistically significant difference in marital satisfaction ($p<0.05$), and the difference in the Mann-Whitney tests (bonferroni-corrected) was due to the literate group. It was seen that there was a statistically significant difference in marital satisfaction according to income status, and in the Mann-Whitney tests (bonferroni-corrected), those with low-income status had higher marital satisfaction than those with equal income-expenditure ratio ($p<0.05$). Considering the obstetric characteristics, dyadic adjustment, and marital satisfaction of primiparous and primigravid patients were statistically significantly higher ($p<0.05$). The dyadic adjustment of the pregnant women who did not have miscarriage/curettage was statistically significantly higher ($p<0.05$) and there was no difference in terms of marital satisfaction ($p>0.05$) (Table-5).

In the correlation analysis, which is not stated in the table, there was a negative, significant, weak relationship between marital satisfaction with the duration of marriage ($\rho= -.214$, $p= 0.002$) and a positive, significant, weak relationship with the gestational week ($\rho=.165$, $p= 0.01$). There was no significant relationship between dyadic adjustment and other variables. Marriage satisfaction and dyadic adjustment scores did not differ in terms of risk factors in the risk subgroup analysis of high-risk pregnant women ($p>0.05$).

There was a positive, moderately significant relationship between "The Revised Dyadic Adjustment Scale" and "The Satisfaction with Marriage Scale" ($\rho= .602$, $p<0.001$) (Figure-1).

Table-1. Intergroup comparison of socio-demographic and general health characteristics.

Socio-demographic and general health characteristics	Healthy pregnant group		Risky pregnant group		Total		Analysis*
	n	Mean±SD	n	Mean±SD	n	Mean±SD	
Age	101	27.18±5.55	101	29.61±6.72	202	28.40±6.27	t= -2.805 p= 0.006
	n	Med(min-max)/Mean rank	n	Med(min-max)/Mean rank	n	Med(min-max)	
Duration of marriage	101	5 (1-19)/91.45	101	7 (1-26)/111.55	202	5 (1-26)	z= -2.453 p= 0.014
BMI	101	23.44 (15.81-44.06)/91.55	101	25.28 (15.62-166.67)/111.48	202	23.95 (15.62-166.67)	z= -2.427 p= 0.015
	n	%	n	%	n	%	
Education							
Literate	9	8.9	9	8.9	18	8.9	
Primary education	29	28.7	43	42.6	72	35.6	
High school	36	35.6	34	33.7	70	34.7	$\chi^2 = 6.208$
University and above	27	26.4	15	14.9	42	20.8	p= 0.102
Spouse's Education							
Literate	5	5.0	3	3.0	8	4.0	
Primary education	32	31.7	42	41.6	74	36.6	
High school	43	42.6	32	31.7	75	37.1	$\chi^2 = 3.680$
University and above	21	20.8	24	13.8	45	22.3	p= 0.298
Employment Status							
Working	22	21.8	15	14.9	37	18.3	$\chi^2 = 1.621$
Not working	79	78.2	86	85.1	165	81.7	p= 0.203
Spouse's Employment Status							
Working	95	94.1	92	91.1	187	92.6	$\chi^2 = 0.648$
Not working	6	5.9	9	8.9	15	7.4	p= 0.421
Health Insurance							
Yes	84	83.2	87	86.1	171	84.7	$\chi^2 = 0.343$
No	17	16.8	14	13.9	31	15.3	p= 0.558
Smoking							
Yes	11	10.9	13	12.9	24	11.9	
Left	4	4.0	6	5.9	10	5.0	$\chi^2 = 0.662$
No	86	85.1	82	81.2	168	83.2	p= 0.718
Income status							
Less than expenses	12	11.9	53	52.5	65	32.2	
Equals expenses	78	77.2	40	39.6	118	58.4	$\chi^2 = 38.573$
More than expenses	11	10.9	8	7.9	19	9.4	p< 0.001
Living place							
Province	57	56.4	57	56.4	114	56.4	
District	39	38.6	34	33.7	73	36.1	$\chi^2 = 2.009$
Town/village	5	5.0	10	9.9	15	7.4	p= 0.366
Family type							
Nuclear family	87	86.1	79	78.2	166	82.2	$\chi^2 = 2.163$
Extended family	14	13.9	22	21.8	36	17.8	p= 0.141
Regular check status							
Yes	101	100.0	91	90.1	192	95.0	$\chi^2 = 10.521$
No	0	0.0	10	9.9	10	5.0	p< 0.001
Total	101	100.0	101	100.0	202	100.0	

*:t= Student's t-test; z=Mann-Whitney U test, χ^2 =Chi-square; Fisher Exact: Fisher's Exact Test

Table-2. Intergroup comparison of obstetric characteristics.

Obstetrical Characteristics	Healthy pregnant group		Risky pregnant group		Total		Analysis*
	n	Mean±SD	n	Mean±SD	n	Mean±SD	
Weight gained during pregnancy	101	7.00 ±4.80	101	9.45±5.27	202	8.22±5.18	t= -3.447 p<0.001
	n	Med(min-max)/Mean rank	n	Med(min-max)/Mean rank	n	Med(min-max)	
Pregnancy Week	101	24 (4-39)/73.45	101	33 (12-40)/129.55	202	29.5(4-40)	z= -6.828 p< 0.001
	n	%	n	%	n	%	
Parity							
Primiparous	37	36.6	41	40.6	78	38.6	$\chi^2= 0.334$
Multiparous	64	63.4	60	59.4	124	61.4	p= 0.563
Gravida							
Primigravid	35	34.7	32	31.7	67	33.2	$\chi^2= 0.201$
Multigravida	66	65.3	69	68.3	135	66.8	p= 0.654
Abortion/ curettage							
No	70	69.3	67	66.3	137	67.8	$\chi^2= 0.204$
Yes	31	30.7	34	33.7	65	32.2	p= 0.651

*:t= Student's t-test; z=Mann-Whitney U test; χ^2 =Chi-square

Table-3. Causes of risky pregnancy.

Risky Pregnancy Causes (n=101)*	n	%	% case
Hypertension (High Blood Pressure)	11	9.2	11.0
Problems in Weight Gain (body mass index BMI>30 and BMI<18)	2	1.7	2.0
Intrauterine Growth Retardation	19	15.8	19.0
Polyhydramnios or Oligohydramnios	14	11.7	14.0
Bleeding	9	7.5	9.0
Thromboembolic Diseases	2	1.7	2.0
Presentation Anomalies	1	0.8	1.0
Cervical Insufficiency	4	3.3	4.0
Diabetes Mellitus	22	18.3	22.0
Preterm or Postterm Action Threat	12	10.0	12.0
Multiple pregnancy	3	2.5	3.0
Premature Membrane Rupture	8	6.7	8.0
Rh Immunization	1	0.8	1.0
Other (cholestasis (4), decrease in baby movements (3), infections (3), myoma uteri(1), anemia (1))	12	10.0	12.0
Total	120	100.0	120.0

*: More than one option is marked.

Table-4. Intergroup comparison of marital satisfaction and dyadic adjustment.

Scale scores	Healthy pregnant group		Risky pregnant group		Analysis *
	n	Mean±SD Med(min-max)/Mean rank	n	Mean±SD Med (min-max)/ Mean rank	
The Satisfaction with Marriage Scale	101	19.71±4.61 21 (7-25)/85.05	101	22.01±3.68 23 (7-25) / 117.95	z= -4.038 p<0.001
The Revised Dyadic Adjustment Scale (RDAS)	101	53.00±9.58 54 (18-67)/87.11	101	57.10±9.06 60 (25-75)/115.89	z= -3.501 p<0.001
Dyadic Consensus subscale (RDAS)	101	24.51±4.94 25 (7-0)/86.35	101	26.74±3.99 28 (11-30)/116.65	z= -3.729 p<0.001
Dyadic Satisfaction subscale (RDAS)	101	15.03± 3.85 16 (4-20)/92.73	101	16.34±2.73 17 (8-20)/110.27	z= -2.148 p= 0.032
Dyadic Cohesion subscale (RDAS)	101	13.45±3.85 14 (4-20)/96.19	101	14.02±4.27 15 (4-20)/110.81	z=-1.297 p=0.195

*: z=Mann-Whitney U test

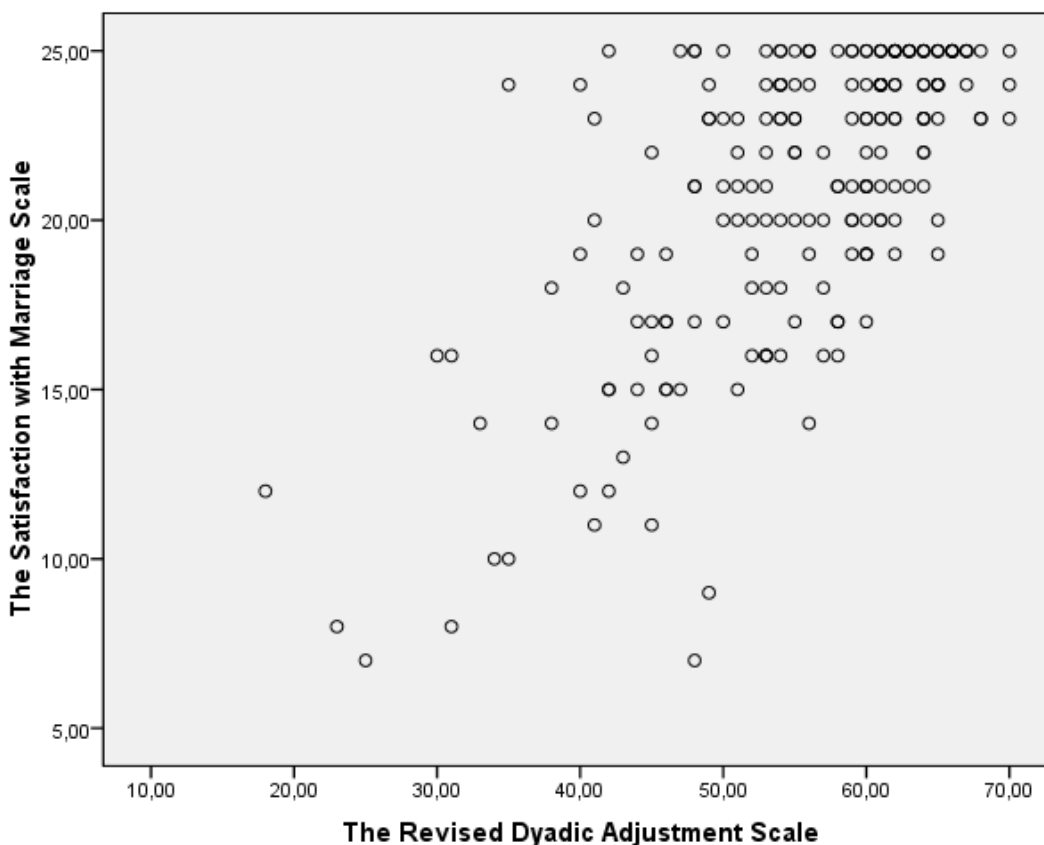


Figure-1. Distribution of the scores obtained from “The Satisfaction with Marriage Scale” and “The Revised Dyadic Adjustment Scale”.

Table-5. Comparison of dyadic adjustment and marriage satisfaction by variables.

Sociodemographic and Obstetric Characteristics	The Revised Dyadic Adjustment Scale		Analysis*	The Satisfaction with Marriage Scale		Analysis*
	n (%)	Med (Min-Max) /Mean Rank		n (%)	Med (Min-Max) /Mean Rank	
Age						
<35	166(82.2)	58(23-70)/103.81	z= -1.207 p=0.277	166(82.2)	23(7-25)/104.85	z= -1.766 p=0.077
≥35	36(17.8)	55.5(18-70)/90.85		36(17.8)	20.5(7-25)/86.06	
Education						
Literate	18(8.9)	52 (38-65)/79.19	$\chi^2 = 5.550$ df=3 p= 0.136	18(8.9)	20.5(12-25) /87.14	$\chi^2 = 2.431$ df=3 p= 0.488
Primary education	72(35.6)	56 (23-70)/95.31		72(35.6)	21.5(7-25)/99.28	
High school	70(34.7)	59 (18-70)/107.00		70(34.7)	22 (8-25)/101.56	
University and above	42(20.8)	60 (35-68)/112.51		42(20.8)	23 (7-25)/11136	
Spouse's Education						
Literate ¹	8(4.0)	46 (38-70)/62.94	$\chi^2 = 6.405$ df=3 p= 0.093	8(4.0)	17 (12-24)/48.88	$\chi^2 = 8.286$ df=3 p= 0.040 (1-2) (1-3) (1-4)
Primary education ²	74(36.6)	55.5 (18-78)/94.28		74(36.6)	22 (7-25)/98.45	
High school ³	75(37.1)	59 (35-70)/109.43		75(37.1)	23 (7-25)/104.21	
University and above ⁴	45(22.3)	58 (31-68)/107.01		45(22.3)	23 (8-25)/111.37	
Income status						
Less than expenses ¹	65(32.2)	59(25-70)/109.22	$\chi^2 = 5.854$ df=2 p= 0.054	65(32.2)	24(7-25)/113.31	$\chi^2 = 7.278$ df=2 p= 0.020 (1-2)
Equals expenses ²	118(58.4)	55(18-68)/93.75		118(58.4)	21(7-25)92.30	
More than expenses ³	19(9.4)	60(41-70)123.26		19(9.4)	23(11-25)/118.26	
Cigaret						
No	168(83.2)	57(18-70)/102.66	$\chi^2 = 1.476$ df=2 p= 0.478	168(83.2)	23(7-25)/104.26	$\chi^2 = 4.102$ df=2 p= 0.129
Yes	24(11.9)	54(25-68)/89.04		24(11.9)	19.5(7-25)/79.19	
Left	10(5.0)	59.5(35-65)/11.90		10(5.0)	22(12-25)/108.75	
Parity						
Primiparous	78(38.6)	60(31-70)/114.34	z= -2.478 p=0.013	78(38.6)	23.5(8-25)/120.22	z= -3.646 p=0.000
Multiparous	124(61.4)	55(18-70)/93.42		124(61.4)	21(7-25)/89.72	
Gravida						
Primigravid	67(33.2)	60(35-70)/113.85	z= -2.118 p=0.034	67(33.2)	23(10-25)/117.94	z= -2.843 p=0.004
Multigravid	135(66.8)	55(18-70)/95.37		135(66.8)	22(7-25)/93.34	
Abortion/ curettage						
No	137(67.8)	58(25-70)/107.23	z= -2.023 p=0.043	137(67.8)	23(7-25)/106.89	z= -1.921 p=0.055
Yes	65(32.2)	55(18-70)/89.43		65(32.2)	21(7-25)/90.14	

*: χ^2 =Kruskal Wallis Test; z= Mann-Whitney U Test

DISCUSSION

Women with advanced maternal age have a high risk of maternal and perinatal complications. In a meta-analysis, it was shown that the higher the maternal age, the higher the risk of adverse pregnancy outcomes (21). In our study, it was determined that the mean age of high-risk pregnant women was significantly higher than the mean age of those without risk, although our risky pregnant group was under the age of 35, which is considered the advanced age limit. In the study of Zengin, it was reported that the mean age of risky pregnant women was high (22). The duration of marriage was also found to be higher in risky pregnant women in parallel with age.

BMI of ≥ 25 during pregnancy is an important risk factor for pregnancy loss, pregnancy complications, birth complications, fetal and maternal mortality (23). In our study, the median BMI of the risky pregnant and the mean weight gained during pregnancy were statistically significantly higher in the healthy pregnancy group ($p < 0.001$). It was determined that the income of the majority of the risky pregnancy group was less than their expenses and this situation was statistically significant ($p < 0.001$). In the study of Çevik, it was determined that the income level of pregnant women at risk was low (24). In our study, while all the healthy pregnancy group had regular controls recommended by the physician, 5% of the risky pregnancy group did not have regular controls. The Turkish Ministry of Health states that prenatal care services should be provided at least four times and more in risky pregnancies (25).

Pregnant women in the risk group were those who are hospitalized in the clinic. It is thought that the rate of hospitalization of risky pregnant women in the last trimester is high (the risky pregnancy group had third trimester pregnancy). Diagnoses causing risky pregnancy in the risky pregnancy group were 18.3% DM, 15.8% IUGR, 11.7% Polyhydramnios or Oligohydramnios, 10.0% Preterm or Postterm Action Threat, 9.2% HT. In the study of Karataş Baran et al., the risk factors frequently seen in pregnant women with risky pregnancies; abortion imminency/bleedings (23.7%), problems in weight gain (18.7%), thrombo-embolic disease (15.4%), thyroid disease (14.7%), habitual abortion history (12.2%), having delivered 3 or more times (10.3%), DM (10.9%), fetal anomaly (8.3%), HT

(7.7%), Cardiac disease (6.4%), Polyhydramnios/Oligohydramnios (5.8%), cervical insufficiency (4.5%), multiple pregnancy (4.5%) (26). The reason for the difference in risky pregnancy diagnosis rates is thought to be due to the fact that risky pregnancy data were collected in the outpatient clinic in this study, while in our study they were collected in the clinic.

In this study, marriage satisfaction and dyadic adjustment were found to be better in the risky pregnant group than in the healthy pregnant group. In the sub-dimensions of satisfaction factor and consensus factor, dyadic adjustment score in risky pregnant was higher than healthy pregnant. In the study of Bülbül and Mucuk, different from our study of dyadic adjustment, it was found to be lower in risky pregnant women compared to healthy pregnant (4). In the study of Gümüştaş et al., it was determined that pregnancy and spousal relations were similar in risky and healthy pregnant women, and being healthy or risky pregnancy did not affect this relationship (27). The nature of the relationship between spouses can affect the degree of support they will provide when one of the spouses needs it or when there is a crisis in the family. The existence of a mutually supportive, sharing, or participatory marital relationship between spouses facilitates solutions to unexpected or expected problems (28). Considering that the social support of the woman during the pregnancy period and, most importantly, the support of the spouse is necessary for the maintenance of maternal well-being (29), it is thought that this result in our study has a positive effect on the well-being of pregnant women at risk. Lederman et al. (2013), it was found that pregnant women hospitalized due to high-risk pregnancy and their spouses re-examined their roles in order to cope with the high-risk pregnancy diagnosis, became closer in this process, shared increasing responsibilities, supported each other in matters such as preparation for childbirth, fostering motherhood and paternity roles (30).

In the comparison of dyadic adjustment and marital satisfaction data according to sociodemographic and obstetric characteristics, no difference was found in terms of age, education, status, and smoking ($p > 0.05$). In the literature, it has been observed that as the level of education increases, marital adjustment also increases (31,32). Consistent with our study,

Kublay (2013)'s study found that marital adjustment did not differ according to education level (33). In our study, it was determined that there was a statistically significant difference in the marital satisfaction of the spouse education status ($p < 0.05$) and the dyadic adjustment of the literate group was lower than the other education levels. It is thought that the increase in the education level of the spouse leads to an increase in the problem-solving skills of the spouse, resulting in this conclusion. Considering the obstetric characteristics, dyadic adjustment, and marital satisfaction of primiparous and primigravid patients were statistically significantly higher ($p < 0.05$). In the literature, when marital adjustment was examined according to the number of children variable, it was observed that the group with no children had higher marital adjustment than those with children (31-33). Similarly, in the study of Çakmak-Tolan (2015), it was observed that married participants who had no children or had one child had higher marital adjustment than married participants with two children (34). It is stated that raising children can significantly reduce marital satisfaction and marital adjustment (35). With the increase in the number of children, the decrease in dyadic adjustment may negatively affect the sexual life between couples, and may also cause a decrease in the time and energy spent on children, communication and sharing between spouses.

Marriage adjustment defines satisfaction and happiness in marital life as a result of couples' harmonious union (36). In our study, increasing marital satisfaction increases dyadic adjustment. Although the terms marital adjustment and marital satisfaction are often used interchangeably due to the high correlation between them, they are two different concepts (36).

CONCLUSION

Marriage satisfaction and dyadic adjustment of the risky pregnancy group and pregnant women without children are at a better level than healthy pregnant women. Risky pregnant women need more support than healthy pregnant women. A woman who receives adequate social support can seek help from those around her for a healthy pregnancy and can reduce pregnancy complications by increasing beneficial health

practices and behaviors. Experienced health problems can enable couples to reconsider their responsibilities and roles and establish a closer and supportive relationship. It is thought that marital adjustment plays an important role in coping with these problems in pregnant women with health problems.

Midwives should include the family, especially the spouse, in the antenatal care services while providing education and counseling services in the perinatal period. Involving the family and especially the spouses in the process will be effective in increasing marital satisfaction, marital adjustment and effectively coping with health problems by activating support systems.

Limitations

This study is limited to the results obtained from the hospital where the research was conducted. This study is the presentation of the current state of marital satisfaction according to the results of cross-sectional analyzes.

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Consent to participate: Informed consent was obtained from the participants.

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