THE RELATIONS AMONG ATTACHMENT STYLES, EMOTION REGULATION STRATEGIES, DEATH ATTITUDES, AND HEALTH PROMOTING BEHAVIORS: EXTREME SPORTS PARTICIPANTS VS. NON-PARTICIPANTS

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ABSTRACT

THE RELATIONS AMONG ATTACHMENT STYLES, EMOTION REGULATION STRATEGIES, DEATH ATTITUDES, AND HEALTH PROMOTING BEHAVIORS: EXTREME SPORTS PARTICIPANTS VS. NON-PARTICIPANTS

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The purpose of the present study was to investigate the relations among attachment styles, emotion regulation strategies, death attitudes, and their possible effects on health promoting behaviors among those who participate versus do not participate in extreme sports. Data of the study included 109 extreme sport participants and 202 participants who do not engage in extreme sport activities. Multiple mediation analyses were conducted in order to examine paths among attachment styles, emotion regulation strategies, death attitudes, and health promoting behaviors. Different non-adaptive emotion regulation strategies mediated insecure attachment styles−health promoting behaviors relation in two groups of the current study. In extreme sport sample, lack of awareness about emotions and lack of goals while dealing with negative emotions mediated anxious attachment style–health promoting behaviors relation, and lack of goals while dealing with negative emotions mediated avoidant attachment style−health promoting behaviors relation. In participants who do not engage in extreme sport activities, lack of clarity about

emotions mediated anxious attachment style−health promoting behaviors relation. Similarly, different death attitudes mediated insecure attachment styles−health promoting behaviors relation in two groups. In extreme sport sample, approach acceptance of death mediated insecure attachment styles−health promoting behaviors relation, whereas in participants who do not engage in extreme sport activities, escape acceptance of death mediated avoidant attachment−health promoting behaviors relation. Findings and their implications, as well as the strengths and limitations of the study, were discussed in the light of the literature.

Keywords: Attachment, Emotion Regulation, Death Attitudes, Health Promoting Behaviors

ÖZ

BAĞLANMA STİLLERİ, DUYGU REGÜLASYON STRATEJİLERİ, ÖLÜM TUTUMLARI VE SAĞLIK DAVRANIŞLARI ARASINDAKİ İLİŞKİ: EKSTREM SPOR YAPAN VE YAPMAYAN KATILIMCILAR

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Bu çalışmanın amacı bağlanma stillerinin, duygu regülasyon stratejilerinin ve ölüm tutumlarının sağlık davranışları üzerindeki olası etkilerini ekstrem spor yapan ve yapmayan kişilerde incelemektir. Çalışmanın verileri 109 ekstrem spor yapan katılımcı ile 202 ekstrem spor yapmayan katılımcıyı içermektedir. Bağlanma stillerinin, duygu regülasyon stratejilerinin, ölüm tutumlarının ve sağlık davranışlarının ilişkilerini belirlemek için çoklu aracı değişken analizi yapılmıştır. Güvensiz bağlanma−sağlık davranışları arasındaki ilişkiye iki grupta farklı adaptif olmayan duygu regülasyon stratejileri aracılık etmiştir. Ekstrem spor grubunda, duyguların farkında olmama ve olumsuz duygularla baş ederken hedeflerin olmaması kaygılı bağlanma−sağlık davranışları ilişkisine aracılık etmiştir; ayrıca olumsuz duygularla baş ederken hedeflerin olmaması kaçıngan bağlanma−sağlık davranışları ilişkisine de aracılık etmiştir. Ekstrem spor yapmayan katılımcılarda, duyguların net olmaması kaygılı bağlanma−sağlık davranışları ilişkisine aracılık etmiştir. Benzer şekilde, farklı ölüm tutumları iki grupta güvensiz bağlanma−sağlık

davranışları ilişkisine aracılık etmiştir. Ekstrem spor grubunda, ölüme yaklaşan kabul güvensiz bağlanma stilleri−sağlık davranışları ilişkisine aracılık ederken, ekstrem spor aktivitelerinde bulunmayan kişilerde, ölüme kaçış kabulü kaçıngan bağlanma−sağlık davranışları ilişkisine aracılık etmiştir. Sonuçlar ve çıkarımları, aynı zamanda çalışmanın güçlü ve zayıf yönleri literatür ışığında tartışılmıştır.

Anahtar Kelimeler: Bağlanma, Duygu Regülasyonu, Ölüm Tutumu, Sağlık Geliştirici Davranışlar

To my family, my source of strength and belief

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INTRODUCTION

In the past, the leading cause of death was infectious diseases such as tuberculosis, diarrhea, and pneumonia; however, since 1900, it was changed to chronic diseases such as heart disease, cancer, and diabetes (Brannon & Feist, 2007). Nowadays, the leading cause of mortality, 60% of the deaths, were found to be the result of the chronic diseases such as heart disease, cancer, chronic respiratory diseases, diabetes, and stroke all around the world (World Health Organization, 2015). Since chronic diseases were strongly related with unhealthy lifestyles and behaviors, people can use health promoting behaviors to be protected from chronic diseases (Brannon & Feist, 2007).

1.1 Health Promoting Behaviors

Health promoting behaviors were defined as activities that help to reach the actual human potential by enhancing wellness and health in order to maintain the integrity of individual in different environmental conditions (Pender, Murdaugh, & Parsons, 2006). Health promoting behaviors have a multidimensional structure and they include self- actualization, health responsibility, exercise, good nutrition, interpersonal support, and stress management (Walker, 1987). Some of the health promoting behaviors are having regular medical check-up, teeth cleaning within a year, brushing teeth twice a day, taking vitamin or mineral supplements, eating breakfast habitually, eating three meals a day, doing exercise, and having good hygiene (Scharfe & Eldredge, 2001). Coronary heart disease is one of the leading causes of death and it is strongly related with smoking, inactive lifestyle, and unhealthy diet. In order to reduce the risk of coronary heart disease, people can stop smoking, eat healthy and low cholesterol diet, do exercise regularly, and take

medical treatment. Thus, as mentioned before, by performing health promoting behaviors we can protect ourselves from chronic conditions.

Even though there has been an increase in awareness about healthy behaviors and lifestyles, people varied in terms of their adherence to health promoting activities and engagement in health risk behaviors (Fardy et al., 1995). Health risk behaviors were defined as individual actions that raise the risks of injuries and diseases (Steptoe & Wardle, 2004). Examples of health risk behaviors include smoking, drinking alcohol, using illegal drugs, driving without a seatbelt, consuming fast food, and being underweight or overweight (Scharfe & Eldredge, 2001). Since the characteristics of individuals have a central role in both health promoting behaviors and health risk behaviors, researchers studied several psychological variables in different groups in order to determine the variability of these behaviors in different populations.

1.2 Attachment

One of the psychological variables that were found to be related with health promoting behaviors was attachment styles of people. Attachment was described as a consistent and persistent bond that developed in the relationship between the child and the caregiver. Therefore, the child seeks the proximity of the caregiver especially in the times of stress (Thompson, 2002). According to Bowlby, all the infants are predisposed to develop this proximity or selective bond with their caregiver figure (1958, 1969, 1973, 1980). Moreover, these bonds are essential for the internal working models or mental representations related to self, world, and the relation of self with world in order to enhance psychological and social development in future years. For instance, if the caregiver is responsive and supportive to the needs of the child, an internal working model of attachment security was developed. But, if the caregiver is not responsive or available, child may develop secondary attachment strategies which were hyperactivation (clinging behavior, being coercive, and anxious), and deactivation (being distant to other people, suppressing emotions, and avoidance). This critical attachment system was

important not only to obtain proximity from attachment figure but also to explore environment with the help of caregiver's secure base.

Ainsworth and her colleagues developed "Strange Situation Experiment" in order to observe these exploration behaviors of 12-18 month-old children when they were separated from their primary attachment figure, left with the experimenter who was a stranger, and then met their primary significant attachment figure again (Ainsworth & Bell, 1970). After this process, they classified the children in three categories of attachment; namely, secure, anxious/ambivalent, and avoidant. When the attachment figure was not in the room, secure children explored the environment, communicated with the experimenter; also whenever the figure came to the room, they showed happiness and shared their exploration experiences with that figure. However; anxious/ambivalent children became anxious, communicated with the experimenter limitedly, were unwilling to explore the environment, also not able to relax when the attachment figure came again. Moreover, avoidant children were not affected seriously when they were separated from primary attachment figure, did not communicate with the experimenter, and did not show any interest for the return of their attachment figure.

The lifelong stability of these three attachment styles was studied by Hazan and Shaver (1987) for intimate relationships and they found that experiences in romantic relationships were steady with participants' childhood attachment styles by their internal working models. Researchers repeated these results by indicating that attachment style in the early childhood years continues in adolescence and adult years, in which the attachment figure has changed from caregiver to close significant others such as romantic partner (Bowlby, 1979; Weiss, 1982). Similar to the children, adults who were stressful may seek their romantic partner, the new attachment figure, in order to regulate their emotional well-being, obtain comfort, support, and care (Collins & Feeney, 2010).

Bartholomew and Horowitz (1991) developed an adult attachment scale by integrating both Bowlby's internal working model (self and others) and Ainsworth's

two attachment dimensions (anxious and avoidant). They indicated that combinations of these two dimensions resulted in four different attachment patterns. Accordingly, secure people have positive internal working models for both others and themselves, low on both anxiety and avoidance dimensions. Preoccupied individuals have positive models for others but negative models for themselves, low on avoidance but high on anxiety. Dismissing people have negative working models for others but positive models for themselves, in other words high avoidance but low anxiety. Lastly, fearful individuals have negative internal working models both for themselves and others, high in avoidance and high in anxiety.

In the literature, it was revealed that secure individuals who are in a relationship engage in health promoting behaviors and talk about their symptoms, whereas insecure attachment style is related with more risks and fewer health promoting behaviors (Pietromonaco, Uchino, & Schetter, 2013; Savada, Busseri, Molnar, Perrier, & DeCourville, 2009; Scharfe & Eldredge, 2001) such as substance abuse, risky sexual behavior non-adherence to medical treatment, poorer diet, poorer body image, less exercise, and not talking about their symptoms in both adolescents (Cooper, Shaver, & Collins, 1998) and young adults (Feeney, Peterson, Gallois, & Terry, 2000). Specifically, anxious/ambivalent individuals reported their symptoms in a ruminative way, and their health care utilization rates were higher than other attachment styles. These individuals were also more likely to have sexually transmitted diseases, unexpected pregnancies, substance abuse related disorders, lack of fitness and exercise. On the other hand, avoidant individuals were reluctant to seek medical help for their complaints, because they had trouble in trusting professional health care providers. Therefore; they delayed or missed their appointments and showed poor adherence to their medical regimens. Avoidant attachment style individuals did also display some unhealthy behaviors such as smoking, cocaine use, alcohol abuse, high calorie intake, and lack of seatbelt use (Ahrens, Ciecharowski, & Katan, 2012; Feeney & Ryan, 1994). Similarly, in Paredes, Ferreira, and Pereira's study (2014), attachment styles and health care utilization, eating habits, and exercise were indicated to be related. For instance,

insecure attachment styles namely anxious and avoidance dimensions were linked to risky sexual behavior and smoking.

In brief, attachment, a consistent bond that develops in the relationship between the child and caregiver, was found to be related with health promoting behaviors of the individuals. While secure attachment style is related with health promoting behaviors and talking about symptoms; insecure attachment style is related with health compromising behaviors such as substance abuse, risky sexual behaviors, non-adherence to medical treatment, not talking about symptoms, less exercise, poorer diet, and poorer body image.

1.3 Emotion Regulation

Emotion regulation strategies of individuals were also found to be related with the health promoting behaviors. Emotion regulation was defined as individual differences in terms of frequency, intensity and duration of emotions (Oatley, Keltner, & Jenkins, 2006). According to Thompson (1994), emotion regulation processes include extrinsic and intrinsic sources in order to monitor, evaluate and modify emotional responses for accomplishing goals. Cassidy (1994) used emotion regulation for the adjustment or the balance of emotions. Another emotion regulation definition suggested that it refers to modification of emotional reactions and coping strategies in order to regulate the frequency, intensity and duration of the emotional experience (Gross, 2002). Healthy emotion regulation was described as the arrangement of the affect experiences instead of suppressing or removing distressing emotions (Rugancı, 2008). Moreover, Gratz and Roemer (2004) defined difficulties of emotion regulation in terms of constructs such as clarity about the emotions, lack of awareness and understanding of emotions, impulsiveness in the control of behavior while dealing with difficult emotions, nonacceptance of negative emotions, limited use of healthy emotion regulation strategies to regulate emotions, and difficulties in accomplishing goals while experiencing negative emotions. In sum, emotion regulation strategies were conceptualized by different researchers in terms of modulation of emotional arousal, awareness,

comprehension, and acceptance of emotions; and also as the ability to behave appropriately regardless of the difficulties of the emotional state.

Healthy emotional regulation was indicated as activation of healthy behavioral self-regulation; hence, better emotion regulation strategies may encourage health promoting behaviors, which influence mortality and morbidity (Aldwin, Park, Jeong, & Nath, 2014). Difficulties in emotion regulation strategies were indicated to have an effect on health behaviors by impairments in symptom recognition, difficulties in communicating about health problems, delay of health related help seeking behavior, adherence to diet regimens, making screening, doing exercise, using effective coping strategies, and seeking social support (DeSteno, Gross, & Kubzansky, 2013). In terms of emotions, happiness was related with safe sex practices; whereas, difficulties in regulating fear of one's disease may lead an individual to think that treatment regimens would be unsuccessful (DeSteno, Gross, & Kubzansky, 2013).

Individuals' emotional states may also affect their eating behaviors; people were found to eat in order to decrease an unpleasant feeling most of the time (Barthomeuf, Droit-Volet, & Rousset, 2009). In Isasi, Ostrovsky, and Wills's study (2013), there was a positive relationship between effective emotion regulation strategies and healthy weight related behaviors such as intake of fruits or vegetables and engagement in greater physical activity. However, difficulties in emotion regulation were related with unhealthy lifestyle behaviors such as consuming higher amounts of fast food and inactivity in daily life. Keenan (2013) also emphasized that difficulty in regulating emotions are more likely to be related with eating disorder behaviors. Moreover, it was found that smokers have significantly poorer emotion regulation skills and rely on less effective emotion regulation strategies, such as suppression, compared to nonsmokers.

Inefficacy to manage emotions may result in psychological and physical struggle that can appear as a stress. Stress brings a physiological change which increases the vulnerability for disease over time. Pennebaker (1993, 1995) found that emotion

inhibition increases stress and ruminative thoughts; then, inhibition causes cumulative stress in both body and mind, which resulted in vulnerability to stress relevant diseases. It was concluded that positive emotional functioning is important not only to relate to nonexistence of emotional distress but also physical health by enhancing our ability to meet demands of the environment. The relevant literature suggested that one of the effective emotion regulation strategies known as emotional disclosure ability, such as discussing verbally or writing emotions, have favorable effects on health outcomes (Consedine, Magai, & Bonanno, 2002; Appleton & Kubzansky, 2014). Specifically, patients who experienced their first myocardial infarction and wrote their emotions were found to use less medication and had significantly lower blood pressure, fewer cardiological symptoms, and fewer medical appointments than control group (Willmott, Harris, Gellaitry, Cooper, & Horne, 2011). In addition to the relation of emotion regulation strategies with cardiovascular diseases, cancer was also suggested to be related with one of emotional regulation difficulties known as alexithymia or failure to express emotions (Temoshok, 1987).

When the background of emotion regulation strategies was investigated in early years of life, emotional expressions were included as crying, physical aggression, and temper tantrums in order to regulate their emotions without the help of language (Tremblay, 2004). The development of emotions and emotion regulation strategies are one of the consequences of parental interventions. Parents were indicated as the external emotion regulators of their children, they can sooth children's distress, support against emotional challenges, and help the evolution of self-regulatory processes (Thompson, 1994). In other words, emotion regulation is encouraged by the caregiver, and then the child internalizes these strategies gradually in order to calm himself/herself or to foster different interpretations regarding daily events (Cicchetti, Ganiban, & Barnett, 1991).

The bond between the child and the caregiver can affect not only the attachment style but also emotion regulation strategies of the child in the upcoming years (Fraley & Shaver, 1997; Mikulincer, Shaver, & Pereg, 2003; Shaver & Mikulincer,

2002). Bowlby (1973) pointed out that discontinuance of the attachment security is a risk factor for psychological and emotional problems in later years. Secondary attachment strategies that were initially adaptive in family environment can be dysfunctional in later relationships, since these strategies encouraged the activation or suppression of negative emotions (Shaver & Mikulincer, 2002).

It was indicated that while people were thinking about their upsetting memories, activation of the mental representation of their attachment figures enhanced emotional recovery, especially in securely attached individuals (Selçuk, Zayas, Günaydın, Hazan, & Kross, 2012). In their childhood, securely attached individuals approach their primary attachment figure in order to reduce their distressing emotions; thus, they learned to calm themselves with their internalized primary attachment figures (as cited in Rugancı, 2008). Securely attached individuals do not repress or suppress their negative emotions; rather, they actively use healthy emotion regulation strategies such as awareness of their emotions, problem solving, seeking social support, and access to distressing memories without devastation (Mikulincer & Orbach, 1995).

Avoidant people try to regulate their emotional state by inhibiting their emotions that are contradictory to their deactivated attachment style. Especially, the emotions that are relevant with the threat or vulnerability (e.g., fear, anger, shame, guilt, sadness, and anxiety) are affected by these inhibitory processes. Due to their inhibition or deactivation processes, avoidant people usually suppress their emotion related memories or thoughts (Shaver & Mikulincer, 2014). Avoidant attachment style was found to be related with becoming distant to the sources of their stress; in other words, avoidant individuals try to avoid distressful emotions, events and memories rather than actively coping with them (Dozier & Kobak, 1992; Mikulincer, Shaver, & Pereg, 2003; Shaver & Mikulincer, 2002).

Anxiously attached individuals were observed as increasing their anxiety or distress by ruminating negative events and emotions, using emotion focused coping style, becoming sensitive to signals of separation, and thinking that he or she cannot

overcome problems without other people's support (Kobak & Sceery, 1988; Mikulincer, Shaver, & Pereg, 2003; Mallinckrodt, 2000). Contrary to secure and avoidant people, anxious people exaggerate threats and their vulnerability in order to take their attachment figures' attention, support, and care. They have pessimistic beliefs about their capability in stress management, exaggerate the seriousness of the threats, become sensitive to internal stress indicators, ruminate actual and potential threats, and make self-harming decisions that direct them to failure (Shaver & Mikulincer, 2014).

In sum; healthy emotion regulation strategies can encourage health promoting behaviors, which in turn influence mortality and morbidity. Effective emotion regulation strategies were indicated to have an effect on healthy diet regimens and greater engagement in physical activity. However, difficulties in emotion regulation are related with impairments in symptom recognition, difficulties in communicating about health problems, delay in help seeking behavior related to health concerns, seeking social support, making screening and adherence to treatment. In terms of attachment styles, securely attached individuals use active and healthy emotion regulation strategies such as awareness of emotions, problem solving strategies, seeking social support and dealing with drastic memories without devastation. However, avoidant people regulate their emotions by inhibition and deactivation of emotions, becoming distant to the sources of distress; also anxious people try to deal with difficult emotions by ruminate about negative events and emotions, becoming sensitive to the signals of separation, and not trusting oneself to overcome problems.

1.4 Death Attitude

Kübler-Ross' books (1969, 1981) had a pioneering role in the popularity of death studies. Kübler-Ross stated five emotional stages namely denial, anger, bargaining, depression, and acceptance in the encounter with death. In the denial phase, a temporary shock to very disturbing event "death" results in the formation of the false imaginations of reality. When the individual realizes that denial was not

helpful, frustration may result in anger expression and blaming others. Then a bargaining phase begins between the individual, who encountered with death, and God. Next, the individual becomes depressive with the realization of the certainty of the death. In the last stage, the individual usually gives up struggling and accepts the inevitable feature of death. Several criticism were raised against Kübler-Ross' stage theory of dying. For example, no evidence has been stated the movement from one stage through another, the importance of the differences between individuals' lives has been neglected, and the resources and characteristics of the social environment have not been recognized (Kastenbaum, 1998). Also, the neglect of the individual coping strategies were emphasized (Corr, 1993). In brief, the pioneering study of Kübler-Ross resulted in not only several criticisms but also a vast body of research in the study of death.

One of the most widely studied concepts in death research was fear of death or death anxiety, a universal construct. In an existential point of view, individuals try to pursue a personal meaning in their lives, and death was an obstacle to matter of meaning; however, finding a personal meaning for one's life reduces fear of death (Frankl, 2009). In other words, individuals who perceive their lives as meaningful and fulfilling experience have less fear of death and more acceptance of death (Lewis & Butler, 1974). In the literature, the reasons of fear of death was stated as anxiety about loss of self and unknown feature of death, fear about suffering and pain, concerns for left behind family members, lost opportunities for the reparation in relationships, and inadequacy against death (Feifel & Branscomb, 1973; Fry, 1990; Wass, Berardo, & Neimeyer, 1988). It was stated that, rigid believers in after life and no believers in religion or after life had less fear of death than people who were uncertain about religion or death (Wong, Reker, & Gesser, 1993). Besides, to diminish fear of death individuals may avoid thinking or talking about death (Wong, Reker, & Gesser, 1993). Hence, death avoidance is used as a defense mechanism in order to remove death related thoughts from consciousness.

Fear of death, death avoidance and death acceptance are related concepts; nonetheless, they are not opposites of the each other, they co-exist in a tough

harmony (Feifel, 1990). Death acceptance, the last stage of the Kübler-Ross' theory, was defined as psychological preparation for the unavoidable and undeniable end of the life. According to Wong, Reker, and Gesser (1993), death acceptance is related with successful aging. In their studies with elderly people, they found that greater number of older adults are not afraid of dying and want to talk about death easefully. According to their conceptual analyses regarding death attitudes, they identified three different types of death acceptance. First, neutral acceptance was described as simply accepting death as an unchangeable fact of the end of life, perceiving death without fear or welcome, trying to do best in the course of life. Second, approach acceptance was identified as an attitude of happy after life that can be rooted in religiosity. Religious people were found to believe in after life and show more approach acceptance than other people. Third, if death was a welcomed alternative for painful and anguished life, that attitude is considered as escape acceptance. If an individual is suffering from life, death can be perceived as an escape from problems of existence.

Death attitudes of individuals were found to be important in terms of the enhancement of physical health and promotion of health promoting behaviors. Vail et al. (2012) indicated that mortality awareness may motivate people to enhance their physical health. Similarly, if death concerns are obvious, people display health related behaviors since they acknowledge the strong relationship between their own mortality and healthcare or medical treatment (Knight & Elfenbein, 1996). In other words, people are motivated to engage in healthy behaviors especially when they think that the health promoting behaviors weaken the link between the health risk and death (Cooper, Goldenberg, & Arndt, 2010). Even though there were some individual differences among people according to terror management theory, conscious thoughts of death increase the intentions of using sunscreen (Routledge, Arndt, & Goldenberg, 2004), doing fitness and exercise (Arndt, Schimel, & Goldenberg, 2003), and reduce smoking intensity among smokers (Arndt et al., 2011). Furthermore, Martin and Salovey (1996) reported that death acceptance has

a positive relationship with physical exercise; and accepting death without a relief or an escape acceptance is related with lower levels of drinking while driving.

Attachment styles of people were also found to be related with the individuals' death attitudes. For instance, Mikulincer and colleagues (1990) indicated securely attached individuals have lower levels of fear of death than people with anxious or avoidant attachment. This finding can be discussed with Bowlby's studies suggesting that secure individuals have lower levels of fear of danger than anxious and avoidant individuals, because they do not feel helpless or alone due to their secure attachment bonds. On the other hand, anxious attachment style was found to be positively correlated with fear of death, since these people have some difficulties in coping with the threat of personal death. Moreover, individuals with anxious attachment style are sensitive to fear of rejection and being forgotten in their relationships; therefore, they may be afraid of the loss of their social identity in death. Interestingly; in a more recent study of Mikulincer and Florian (2000), individuals with avoidant attachment displayed lower levels of fear of death. This tendency of individuals with avoidant attachment may be related with their higher use of repression and denial defense mechanisms in order to reduce emotional expressions of fear of death.

In brief, mortality awareness and death acceptance are positively correlated with enhancement of physical health, adherence to medical treatment, doing fitness and exercise, and non-smoking behavior. On the other hand, death anxiety and death fear are related with inadequate health care and irresponsibility regarding health promoting behavior. In terms of attachment styles, secure individuals display lower levels of death fear than anxious and avoidant individuals. Avoidant individuals also show lower levels of death anxiety than anxious individuals since avoidant attachment style is strongly related with repression and denial defense mechanisms.

1.5 Extreme Sports

In the health psychology literature besides health promoting behaviors, health risk behaviors, which increase the risks of mortality and morbidity were also studied

(Rosal et al., 2011; Yusef, Giles, Croft, Anda, & Casper, 1998). These behaviors include alcohol and tobacco consumption, physical inactivity, unhealthy dietary habits, risky sexual practices, unintentional and intentional injuries, and poor health practices (Eaton et al., 2010; van der Star & van den Berg, 2011). Health psychology literature had an assumption that these health risk behaviors or unhealthy behaviors can reflect the hidden problems or psychopathologies, since health promoting behaviors are the rational choice (Willig, 2008).

People doing dangerous or extreme sports, which were defined as leisure activities where the outcome of a mismanaged mistake or accident is injury or even death, can be regarded as performing health risk behaviors (Brymer, 2005). Bennett, Henson and Zhang (2002) preferred to use action sports for the term of extreme sports and indicated that "Action sport is a label that is placed on sports that are not mainstream or traditional and often include risk, danger, or unconventional rules and/or techniques." These sports are considered as lifestyle sports, because they included both leisure time, physical exercise, and a kind of spiritual journey (Puchan, 2004). Some of the extreme sport activities are BASE jumping (buildings, antennae, span, earth), extreme skiing, big wave surfing, waterfall kayaking, high level mountaineering, cave diving, 40 meter deep dive, ice climbing, kite surfing, rallying, rafting, rock climbing, skydiving, and windsurfing (Celsi, Rose, & Leigh, 1993).

Although extreme sports rise in popularity in recent years, participation in this kind of sports includes unpredictable environmental conditions and personal performance variables that may be associated with unintentional injuries (Caine, 2012). According to Centers for Disease Control and Prevention, unintentional injuries are the fourth leading cause of death with 130,557 deaths in United States in 2013 (NCHS, 2015). In adolescence and adulthood years, the most common source of unintentional deaths was found as sport-related injuries (Brannon & Feist, 2004). For instance, the injury rate in some extreme sports was calculated as 8.4 injuries per 1000 hours of exposure in snow kiting (Moroder, Runer, Hoffelner, Frich, Resch, & Tauber, 2011), 1.79 injuries per 1000 hours of surfing (Furness et

al., 2015), 4.2 injuries per 1000 hours of rock climbing (Klauser, Bodner, Frauscher, Gabl, & Nedden, 1999), and 3 injuries per 1000 hours of snowboarding (Made & Elmqvist, 2004).

In the traditional perspective, participation in extreme sports is related with risk taking and adrenaline seeking. Participants are perceived as psychopathological for their risk taking behavior and death wish (Brymer & Oades, 2009). However, it was revealed that extreme sport participants have a positive psychological relation with their environment, and they describe their extreme sport experiences as "being 'at one' with the natural world" (Brymer, Downey, & Gray, 2009). Moreover, participants display humility and courage, since they experience fear and risks of death, and the awareness that nature is more powerful than human beings (Brymer & Oades, 2009).

Although there was no research linking attachment styles of individuals with extreme sport participation, individuals performing stressful sport exercises were indicated to deal with strangeness and unfamiliarity in those sports activities in accordance with their own attachment systems (Forrest, 2008). In Robinson and Trail's study (2005), it was stated that individuals can be attached to the sport objects such as motorcycle in motorcycling racing; however, there has not been any study indicating the possible link between the attachment styles of extreme sport participants and their relationship with the sport object or risky environment.

It was indicated in Willig's (2008) study that extreme sport experience had a paradoxical nature which combines opposite feelings and sensations such as pleasure and pain, feeling safe and feeling at risk, feeling arousal and calmness at the same time. These contradictory feelings may reflect a difficulty in emotion regulation in extreme sport participants. Similarly, Woodman and colleagues (2008) proposed that individuals engage in high risk sport or extreme sport activities in order to regulate their difficulties in emotional reactions, rather than identifying and expressing their emotions in a healthy way. Difficulty in identifying and expressing emotions to other people is conceptualized as "alexithymia" and it was found that

high risk sports may help alexithymic people to regulate their emotions, specifically their anxiety by experiencing a significant drop in their anxiety after extreme sport activity. Also, engaging in emotion activating extreme sport activities was found to be attractive for alexithymic individuals most of the time (Woodman, Hardy, Barlow, & Le Scanff, 2010). On the contrary, in Brymer and Schweitzer's (2013) study, extreme sport participants were found to be less anxious than general population. Although they had a sense of fear and anxiety while doing extreme sports, they encounter with these difficult emotions effectively by not avoiding but accepting it. Some of the extreme sport participants explained that fear is an essential element of survival, it keeps people alive. Moreover, the management of fear in extreme sport environment was generalized by these participants to other aspects of life such as facing with the fear of death or fear of uncertainty in daily life (Brymer & Schweitzer, 2013). In terms of emotional stability, being able to control one's emotions to remain calm and balanced, high risk sport athletes were found to have more emotional stability than non-risk sport athletes and non-athletes (Kajtna, Tusak, Baric, & Burnik, 2004).

In extreme sports, death is a possibility; however, most of the participants of extreme sports indicated that they focused on the present moment rather than the worst scenario (Willig, 2008). Griffith and Hart (2005) found that skydivers have lower levels of death fear than non-skydivers on three dimensions namely death of self, death of others, and dying of others. In terms of death acceptance, Griffith et al. (2013) stated that skydivers had higher death acceptance scores than nursing home residents, volunteer firefighters, and control group members. Similarly, Brymer and Schweitzer (2013) found that most of the extreme sport participants accepted the inevitable nature of death, and vulnerability of being human. However, in most of the studies, occupations with death risk and death exposure such as nurses (Meisenhelder, 1994), police officers and firefighters (Hunt, Lester, & Ashton, 1983), and suicide intervention workers (Neimeyer & Dingemans, 1980) are found have higher levels of fear of death or death anxiety scores.

In sum, mismanaged mistake or accident in extreme sports can resulted in a serious injury or even death. Thus, engagement in extreme sport activities can be regarded as one of the health risk behaviors. Health psychology literature has an assumption that health risk behaviors can be the result of hidden psychological problems or even psychopathologies. Although extreme sport participants are perceived as psychopathological for their risk taking behaviors in the traditional perspective, in recent studies they were reported as having positive relationships with their environment and display humility and courage in daily life. In terms of emotion regulation strategies, extreme sport participants were found to be more alexithymic, having difficulty in identifying and expressing emotions, than general population. However, they cope with difficult emotions such as fear and anxiety in an effective way. Moreover, there are complicated results for their fear of death and death acceptance scores in the literature.

1.6 The Present Study

The purpose of the present study was to investigate the relationship among attachment styles, emotion regulation strategies, death attitudes, and their possible effects on health promoting behaviors among those who participate versus do not participate in extreme sports.

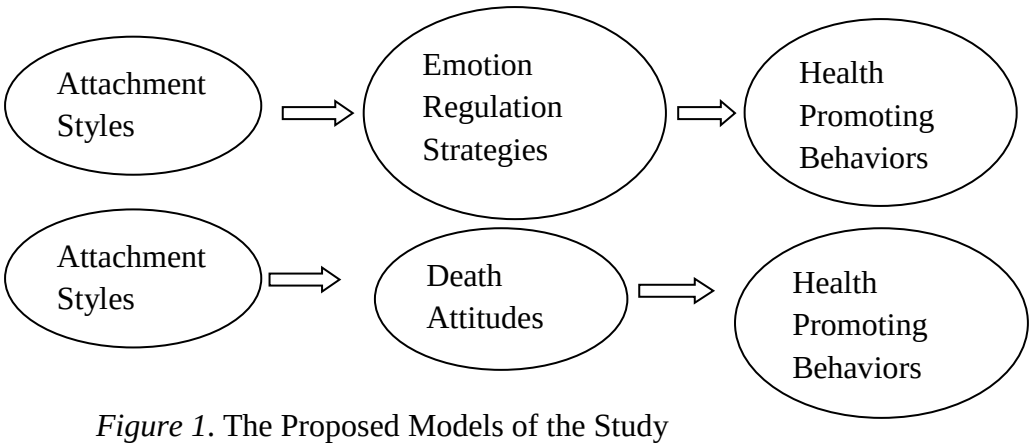

Figure 1. The Proposed Models of the Study

Note . These two models will be tested in individuals who do and do not participate in extreme sport activities

Health promoting behaviors are individual activities and behaviors in order to enhance wellness and health (Pender, Murdaugh, & Parsons, 2006). Some of the health promoting behaviors are discussing health concerns, doing physical exercise, eating fruits and vegetables, eating three times per day, doing relaxation exercises, checking cholesterol levels, discussing personal concerns with others, and expressing feelings (Walker, 1987). Although healthy behaviors and lifestyles has been more emphasized nowadays, engagement in health risk behaviors such as smoking, drinking alcohol, driving with alcohol, driving without a seatbelt, using illegal drugs, and consuming fast food, is common (Scharfe & Eldredge, 2001). Psychological variables, such as attachment styles, emotion regulation strategies, and death attitudes, can be regarded as important determinants of health promoting behaviors' and health risk behaviors' variability in different populations.

Attachment, which was defined as a consistent and persistent bond between the child and caregiver relationship, is related with health promoting behaviors of the individuals (Thompson, 2002). Securely attached individuals engage in health promoting behaviors, however, insecurely attached individuals (anxious and avoidant type of attachment) perform health risk behaviors (Pietromonaco, Uchino, & Schetter, 2013) such as substance abuse, risky sexual behavior, poorer diet, non-adherence to medical treatment, not doing physical exercise, and not discussing health concerns (Cooper, Shaver, & Collins, 1998). Specifically, anxious attachment style was found to be related with sexually transmitted diseases, substance abuse, and lack of exercise; whereas, avoidant attachment style was associated with non-adherence to medical treatment because of not trusting health care providers, high calorie diet, and lack of seatbelt use while driving (Ahrens, Ciecharowski, & Katan, 2012; Feeney & Ryan, 1994).

The bond between the child and the caregiver not only have an impact on attachment styles of the individuals but also on the emotion regulation strategies in the upcoming years. Emotion regulation was described as the modification of emotional reactions and coping strategies in order to regulate the frequency, intensity, and duration of the emotional experience (Gross, 2002). It was found in

the literature that healthy emotion regulation strategies encourage health promoting behaviors by adhering to diet regimens, making screening, doing physical exercise, using effective coping strategies, and seeking social support (DeSteno, Gross, & Kubranzky, 2013). On the other hand, difficulties in emotion regulation may result in stress exposure, which elevates vulnerability to stress relevant diseases such as cardiovascular diseases (Appleton & Kubzansky, 2014; Boehm & Kubransky, 2012; Suls & Bunde, 2004) and cancer (Temoshok, 1987).

Besides attachment styles and emotion regulation strategies, death attitudes of the individuals were also found to influence the enhancement of physical health and improvement in health promoting behaviors. Although Vail and colleagues (2012) found that higher levels of death anxiety and fear was related with lower levels of health care behaviors, Bozo, Tunca, and Şimşek (2009) indicated that people with higher levels of death anxiety report more health promoting behaviors than people who were in the control condition. Accepting death as an unchangeable fact of the end of life has a significant relationship with higher levels of physical exercise and lower levels of substance abuse (Martin & Salovey, 1996). Moreover, if people think that the health promoting behaviors reduces the strength of the link between health risk and death, they are motivated to engage in health promoting behaviors (Cooper, Goldenberg, & Arndt, 2010).

In contrast to health promoting behaviors, health risk behaviors can reflect psychopathology or a hidden problem according to health psychology literature and some populations seem to be more related with unhealthy and risk taking behaviors. For instance, people who did dangerous or extreme sports, leisure activities where the outcome of a mismanaged mistake or accident may result in injury or death, are regarded as health risk behaviors (Brymer, 2005). These sports are considered as lifestyle sports, since they can include leisure time, physical exercise, and a kind of spiritual journey (Puchan, 2004).

As mentioned above, the aim of the current study is to examine the relations among attachment styles, emotion regulation strategies, death attitudes, and their possible

effects on health promoting behaviors among those who participate versus do not participate in extreme sports. This study is a pioneering in trying to provide an insight into health promoting behaviors based on attachment styles, emotion regulation strategies, and death attitudes of individuals. Moreover, it is a new approach to analyze these measures based on the data obtained from participants who are doing extreme sports, which are leisure activities related with health risk behaviors. This study can also provide an insight regarding mentioned measures in Turkish culture. For this purpose, several statistical analyses will be run. First, the possible differences among the levels of demographic variables (extreme sport participation, gender, education, income level, marital status, province, psychological health status, and physical health status) in terms of study variables (attachment styles, emotion regulation strategies, death attitudes, and health promoting variables) will be examined. Second, correlation coefficients among the study variables and the internal consistency coefficients of the measures will be calculated. Third, multiple mediation analyses will be conducted in order to examine paths among attachment styles, emotion regulation strategies, death attitudes, and health promoting behaviors. Therefore, in the current study, eight multiple mediation analyses will be conducted in eight different sets of analyses.

1.7 Research Questions and Hypotheses

1. Are there any significant relations among attachment styles, emotion regulation strategies, death attitudes, and health promoting behaviors of the participants who do and do not engage in extreme sport activities?

2. Do emotion regulation strategies and death attitudes mediate the relations between attachment styles and health promoting behaviors?

2.a. Dimensions of the emotion regulation strategies were hypothesized to mediate the relations between attachment styles and health promoting behaviors in participants who engage in extreme sport activities.

2.b. Dimensions of the emotion regulation strategies were hypothesized to mediate the relations between attachment styles and health promoting behaviors in participants who do not engage in extreme sport activities.

2.c. Dimensions of the death attitudes were hypothesized to mediate the relations between attachment styles and health promoting behaviors in participants who engage in extreme sport activities.

2.d. Dimensions of the death attitudes were hypothesized to mediate the relations between attachment styles and health promoting behaviors in participants who do not engage in extreme sport activities.

CHAPTER 2

METHOD

2.1 Participants

This study consisted of 109 participants who were engaging in extreme sport activities and 202 participants who were not engaging in any extreme sport activities. Participants were recruited from different cities of Turkey via online survey system called “Qualtrics: Online Survey Software & Insight Platform”.

Participants engaging in extreme sports were interested in different kinds of sports (see Table 1). Of the 109 participants who were engaging in extreme sport activities, there were 41 female participants (37.6 %) and 68 (62.4 %) male participants with ages ranging between 18 and 40 (M = 27.7, SD = 6.2). While 77 of the participants (70.64 %) were employed, 3 of them (2.75 %) were unemployed, and the remaining 29 (26.61 %) participants were students In terms of marital status, 91 of the participants (83.5 %) were married and 18 (16.5 %) of them were single. While more than half of the participants (n = 68, % 62.4) were university graduates, 32 of them (29.4%) were graduate school graduates, and only 9 of the participants (8.3 %) graduated from high school, Majority of the participants (n = 88, 80.7 %) reported that they are in middle income level, whereas 8 of them (7.3 %) reported their income level as low and 13 of them (11.9%) as high. In terms of residential status of the participants, most of them (n = 80, 73.4 %) were living in metropolitan cities (e.g., İstanbul, Ankara, İzmir etc.), 24 of them (22 %) were living in other cities, and only 4 of them (3.7 %) were living in small towns. Twenty of the participants (18.3 %) stated that they had experienced at least one psychological problem in their lives, whereas 89 of them (81.7 %) have not experienced any psychological problems. In terms of their physical health history,

23 of them (21.1 %) reported at least one physical health problem, while the rest of them (*n* =85 of them, 78 %) had not experienced any physical health problem in their lifespan (see Table 2).

There were 202 participants who were not engaging in any extreme sport activities. Of these participants, 162 (80.2 %) were female and 40 (19.8 %) were male, whose ages ranged between 18 and 40 (*M* = 24.8, *SD* = 4.75). Most of the participants, (*n* = 158, 78.2 %) were single, while 43 participants (21.3 %) were married. More than half of the participants (*n* = 122, 60.4 %) graduated from university, while 58 participants (% 28.71) graduated from graduate school, and only 22 participants (10.9 %) graduated from high school. In terms of their monthly income level, most of them (*n* = 259, 83.3 %) belonged to middle income group, 32 (10.3%) of them reported high income, and only 18 participants (5.8 %) reported low income. More than half of the participants (*n* = 115, 56.93 %) were working in different occupational areas (see Table 3), 85 of them (42.07 %) were students, and 1 of them were unemployed (0.5 %). Of the participants who were not engaged in any extreme sport activities, 151 (74.8 %) stated metropolitan cities (e.g., İstanbul, Ankara, and İzmir), 46 (20.8 %) reported cities, and 5 (2.5 %) indicated small towns as the place they spent most of their lives. In terms of their psychological health history, while 48 of the participants (23.8 %) reported at least one psychological health problem; 154 of them (76.2 %) did not report any psychological disorder history. Forty-three of the participants (21.3 %) indicated that they had experienced at least one physical health problem in their lives; while 155 of them (76.7 %) did not report any physical health problem.

Table 1

Types of Sport Activities that were Performed by Extreme Sports Group Participants (N= 109)

Type of the Extreme Sport	Frequency (%)
Base jumping	9 (8.26 %)
Cave diving	1 (0.92 %)
40 meter deep dive	13 (11.93 %)
Kite surfing	2 (1.83 %)
High level mountaineering	8 (7.34 %)
Mountain bicycling	1 (0.92 %)
Paragliding	51 (46.79 %)
Rallying	1 (0.92 %)
Rafting	2 (1.83 %)
Rock climbing	13 (11.93 %)
Sky diving	1 (0.92 %)
Snowboard	3 (2.75 %)
Multiple extreme sports	4 (3.67 %)

Table 2

Demographic Characteristics of the Participants Doing Extreme Sport (N = 109)

Variables	Frequency (%)	Mean (*SD*)
Age		27.7 (6.20)
Gender		
Female	41 (37.6 %)	
Male	68 (62.4 %)	
Marital Status		
Single	91 (83.5 %)	
Married	18 (16.5 %)	
Education Level		
High School	9 (8.3 %)	
University	68 (62.4 %)	
Graduate	32 (29.4 %)	
Income Level		
Low	8 (7.3 %)	
Middle	88 (80.7 %)	
High	13 (11.9 %)	
Employment Status		
Yes	77 (70.64 %)	
No	32 (29.36 %)	
If No, Reason		
Student	29 (26.61 %)	
Unemployed	3 (2.75 %)	
Missing	4 (3.67 %)	
Type of Occupation		
Academician	4 (% 5.19)	
Psychologist	5 (% 6.49)	
Banking and Finance	4 (% 5.19)	
Teacher	6 (% 7.79)	
Architecture and Engineering	15 (% 19.48)	
Public-Servant	5 (% 6.49)	
Social Worker	2 (% 2.6)	
Biologist	2 (% 2.6)	
Professional in Extreme Sports	5 (% 6.49)	
Tourism	2 (% 2.6)	
Doctor & Nurse & Dentist	3 (% 3.9)	
Other	24 (% 31.17)	
Province		
Metropolitan	80 (73.4 %)	
City	24 (22 %)	
Small town	4 (3.7 %)	
History of Psychological Disorder		
Yes	20 (18.3 %)	
No	89 (81.7 %)	
History of Physical Disorder		
Yes	23 (21.1 %)	
No	85 (78 %)	
Missing	1 (0.9 %)	

Table 3

Demographic Characteristics of the Participants who do not Engage in Extreme Sports (N = 202)

Variables	Frequency (%)	Mean (*SD*)
Age		24.80 (4.75)
Gender		
Female	162 (80.2 %)	
Male	40 (19.8 %)	
Marital Status		
Single	158 (78.2 %)	
Married	43 (21.3 %)	
Missing	1 (0.5 %)	
Education Level		
High School	22 (10.9 %)	
University	122 (60.4 %)	
Graduate	58 (28.7 %)	
Income Level		
Low	18 (5.8 %)	
Middle	259 (83.3 %)	
High	32 (10.3 %)	
Employment Status		
Yes	115 (56.93 %)	
No	86 (42.57 %)	
If No, Reason		
Student	85 (42.07 %)	
Unemployed	1 (0.5 %)	
Missing	1 (0.5 %)	
Type of Occupation		
Academician	29 (25.22 %)	
Psychologist	10 (8.70 %)	
Banking and Finance	3 (2.61 %)	
Teacher	12 (10.43 %)	
Architecture and Engineering	17 (14.78 %)	
Public-Servant	2 (1.74 %)	
Sociologist	2 (1.74 %)	
Graphic Designer	2 (1.74 %)	
Directors/Managers/Secretary	2 (1.74 %)	
Child Development Specialist	2 (1.74 %)	
Doctor & Nurse	3 (2.61 %)	
Other	31 (26.96 %)	
Province		
Metropolitan	151 (74.8 %)	
City	46 (22.8 %)	
Small town	5 (2.5 %)	
History of Psychological Disorder		
Yes	48 (23.8 %)	
No	154 (76.2 %)	
History of Physical Disorder		
Yes	43 (21.3 %)	
No	155 (76.7 %)	
Missing	4 (2 %)	

2.2 Instruments

2.2.1 Demographic Information Form. This form included questions about participants' age, gender, marital status, employment status, socio-economic status, education level, province, physical and psychological health status, and participation in the extreme sport activities.

2.2.2 Attachment. Experiences in Close Relationships-Revised (ECR-R) scale was developed by Fraley, Waller, and Brennan (2000) in order to measure adult attachment dimensions. The scale consists of 36 items, in which 18 items are used for the measurement of anxiety dimension (e.g., I am afraid that I will lose my partner's love), whereas the other 18 items are used for the measurement of avoidance dimension (e.g., I often worry that my partner will not want to stay with me). This scale is a 5-point Likert type scale and response alternatives range from 1 (strongly disagree) to 5 (strongly agree). The scale was adapted into Turkish by Selçuk, Günaydın, Sümer, and Uysal (2005), and the reliability of this version was found to be .90 for avoidance dimension and .86 for anxiety dimension. In terms of validity, anxiety dimension showed strong negative correlations with self esteem (r = -.32, p < .01) and relationship satisfaction (r = -.23, p < .05); and strong positive correlations with reassurance anxiety (r = .55, p < .01), separation anxiety (r = .34, p < .01), and satisfying others (r = .44, p < .01). For avoidance dimension, there were negative correlations with self esteem (r = -.19, p < .01) and relationship satisfaction (r = -.49, p < .01); and positive correlations with reassurance anxiety (r = .17, p < .01) and enjoyment of loneliness (r = .15, p < .05). In the current study, ECR-R was used to assess attachment styles of the participants with a Cronbach's alpha internal consistency reliability of .91 for anxiety dimension and .92 for avoidance dimension.

2.2.3 Emotion Regulation. Difficulty of Emotion Regulation Scale (DERS) was developed by Gratz and Roemer (2004). It consists of 6 subscales, namely lack of awareness about emotional responses (e.g., I am attentive to my feelings), lack of clarity about emotional responses (e.g., I am confused about how I feel), non

acceptance of emotional responses (e.g., When I am upset, I feel like I am weak), lack of strategies while dealing with negative emotions (e.g., When I am upset, I believe that there is nothing I can do to make myself feel better), impulse control difficulties while dealing with negative emotions (e.g., When I am upset, I lose control over my behaviors), and lack of goal directed behavior while dealing with negative emotions (e.g., When I am upset, I have difficulty getting work done). It is composed of 36 items and the items are rated on a 5-point Likert type scale ranging between 1 (almost never) and 5 (almost always). The scale was adapted into Turkish by Rugancı and Gençöz (2010), and the total internal consistency reliability of this version was .93. In the Turkish adaptation of the scale, alpha coefficients were .82 for the lack of clarity about emotions, .90 for the lack of goal directed behavior while dealing with negative emotions, .90 for impulse control difficulties while dealing with negative emotions, .83 for non acceptance of emotional responses, .89 for lack of strategies while dealing with negative emotions, and .75 for lack of awareness about emotional responses. In terms of concurrent validity of DERS, the total scores of DERS and Brief Symptom Inventory revealed strong correlations (r = .58, p < .001). The correlations between subscales of DERS and Brief Symptom Inventory ranged between r = .39 and r = .54 (p < .001) except for lack of awareness about emotions, which showed a weak correlation (r = .16, p < .01). In terms of criterion validity of DERS, participants who had higher levels of psychological distress indicated more difficulties in emotion regulation than participants who had lower levels of psychological distress [$t(173) = -11.04$, p < .001]. In the present study, the internal consistency reliabilities of the subscales as calculated by Cronbach's alpha were .67 for lack of awareness of emotional responses, .91 for lack of clarity of emotional responses, .90 for non-acceptance of emotional responses, .90 for limited access to effective strategies, .88 for difficulties in controlling impulses, and .90 for difficulties in engaging goal directed behavior.

2.2.4 Attitudes towards Death. Death Attitude Profile-Revised (DAP-R) was developed by Wong, Reker, and Gesser (1994) in order to measure the attitudes of the participants towards death. This scale is composed of 32 items measured on a

7-point Likert-type scale ranging from 1 (strongly disagree) to 7 (strongly agree). The scale consists of 5 subscales, namely fear of death (e.g., The fact that death will mean the end of everything as I know it frightens me), death avoidance (e.g., Whenever the thought of death enters my mind, I try to push it away), neutral acceptance (e.g., Death is a natural aspect of life), approach acceptance (e.g., I believe that I will be in heaven after I die), and escape acceptance (e.g., I see death as a relief from the burden of life). Alpha coefficients of the original study ranged between .65 (neutral acceptance) and .97 (approach acceptance). The Turkish adaptation of the DAP-R was studied by Çevik and Kav (2013) and the reliability of Turkish version was found to have a Cronbach's Alpha coefficient of .80. The average content validity index was found as .99. In terms of criterion validity, moderate and strong religious believers differed in approach acceptance of death [$t(300) = -5.47$, $p < .001$], fear of death [$t(300) = 2.63$, $p < .01$] and death avoidance[$t(300) = 2.03$, $p < .05$]. In the present study internal consistency reliability of the subscales were .83 for fear of death, .74 for death avoidance, .69 for neutral acceptance of death, .94 for approach acceptance of death, and .91 for escape acceptance of death.

2.2.5 Health Promoting Behaviors. Health Promoting Lifestyle Profile II (HPLP-II) developed by Walker, Sechrist, and Pender (1987) was used to assess participants' level of health promoting behaviors. This scale was adapted to Turkish by Bozo, Tunca, and Şimşek (2009). HPLP-II is a 52-item scale consisting 6 subscales, namely self-actualization (e.g., Feel I am growing and changing in positive ways), health responsibility (e.g., Report any unusual signs or symptoms to a physician or other health professional), exercise (e.g., Follow a planned exercise program), stress management (e.g., Take some time for relaxation every day), interpersonal support (e.g., Discuss my problems and concerns with people close to me), and nutrition (e.g., Eat 2-4 servings of fruit each day). The scale is a 4-point Likert type scale and response alternatives range from 1 (never) to 4 (routinely). The Turkish version of HPLP-II has a high internal consistency reliability of .93. In terms of criterion validity, participants who had higher levels of death anxiety had

higher levels of health promoting behaviors than participants who had lower levels of death anxiety. In the present study, the internal consistency reliability of the scale calculated by Cronbach's alpha was .92.

2.3 Procedure

After being approved by Research Center for Applied Ethics in Middle East Technical University, instruments of the study were transformed into an online survey system called "Qualtrics: Online Survey Software & Insight Platform". Informed consent was obtained from each participant; participants were informed about the purpose of the research and assured for their right to refuse to participate in the study or to withdrawn from the study at any time. The data of the participants who were not doing extreme sports were collected from Middle East Technical University students through online survey invitations. The survey was also announced in social network services. Participants who engaged in extreme sports were recruited from different sport clubs in several cities of Turkey by online survey invitations. Application of the questionnaires took approximately 25 minutes. All the participants were debriefed after the administration of the questionnaires about details of the study and contact information of the researcher. Data gathering process took place between October 2014 and March 2015. After performing preliminary analyses, eight multiple mediation analyses (Hayes, 2013) were conducted in order to test the hypotheses of the current study.

Table 4

Glossary of the Mediator Variables

Concept	**Definition**
Lack of clarity about emotions	Having difficulty making sense out of feelings, confusion about feelings, not clear about feelings
Lack of awareness about emotions	Having difficulty in attention on feelings, acknowledging emotions when upset, believing that feelings are important and valid, caring about feelings
Non acceptance of emotional responses	When upset, feeling guilty, ashamed, embarrassed, angry, irritated, and weak for feeling that way
Impulse control difficulties while dealing with negative emotions	When upset, losing control over behaviors, having difficulty controlling behaviors, becoming out of control, feeling out of control
Lack of goal directed behavior while dealing with negative emotions	When upset, having difficulty concentrating, focusing on other things, getting work done, thinking about anything else
Lack of strategies while dealing with negative emotions	When upset, starting to feel very bad about oneself, feeling that emotions are overwhelming, believing that it will take a long time to feel better, inability to find a way to feel better
Fear of death	Fear about loss of self and unknown feature of death and inadequacy against death
Death avoidance	Avoid thinking or talking about death
Neutral acceptance of death	Simply accepting death as an unchangeable fact of the end of life, perceiving death without fear or welcome, trying to do best in the course of life
Approach acceptance of death	An attitude of happy after life that can be rooted in religiosity
Escape acceptance of death	An individual is suffering from life, death can be perceived as an escape from problems of existence, death is a welcomed alternative for painful and anguished life

CHAPTER 3

RESULTS

3.1 Preliminary Analyses

This section presents descriptive statistics for the study variables, differences among the levels of demographic variables in terms of these variables, and finally correlational analyses among all of the variables included in the study. For the main analyses (multiple mediation analyses), please look at page 69.

3.1.1 Descriptive Statistics for Main Variables of the Study

Descriptive statistics (i.e., number of the participants, mean, standard deviation, minimum score, and maximum score) for all the variables used in this study are presented in the Table 5.

3.1.2 Differences among the Levels of Demographic Variables in terms of Study Measures

3.1.2.1 Differences among the Levels of Demographic Variables in terms of Attachment Styles

Several one way between subjects Multivariate Analysis of Variances (MANOVA) were conducted with 8 independent (participation in extreme sport activities, gender, education level, socio-economic status, marital status, province, psychological health status, physical health status) and 2 dependent variables (i.e., anxious attachment style and avoidant attachment style, the subscales of the Experiences in Close Relationships-Revised) (Table 6). In case the MANOVA results were significant, to determine the main effects of independent variables on dependent variables univariate analyses were calculated. Bonferroni correction was

performed to control Type I error for MANOVA; for both dependent variables, .025 significance level was used.

Table 5

Descriptive Statistics for the Study Variables

Variables	*N*	Mean	*SD*	Min-Max
Experiences in Close Relationships-R				
Anxiety	311	2.53	.78	1 - 4.61
Avoidance	311	1.95	.70	1 - 4.56
Difficulty of Emotion Regulation Scale				
Lack of awareness of emotional responses	311	2.19	.58	1 – 4.67
Lack of clarity of emotional responses	311	2.28	.87	1 - 5
Nonacceptance of emotional responses	311	2.02	.92	1 - 5
Limited access to effective strategies	311	2.20	.87	1 – 4.75
Difficulties in controlling impulses	311	2.14	.86	1 - 5
Difficulties in goal directed behavior	311	3.12	.97	1 - 5
Death Attitude Profile-R				
Fear of death	311	4.36	1.40	1.14 - 7
Death avoidance	311	4.27	1.39	1 - 7
Neutral acceptance	311	5.88	.92	2 - 7
Approach acceptance	311	3.43	1.61	1 – 6.80
Escape acceptance	311	2.87	1.64	1 - 7
Health Promoting Lifestyle Profile-R-II	311	2.61	.37	1.42 – 3.77

A one way between subjects MANOVA was calculated to investigate attachment style differences between the levels of participation in extreme sport activities. The result was significant [Multivariate $F(2, 308) = 3.21$, $p < .05$, Wilks' $\lambda = .98$, partial $\eta^2 = .02$]. However, there was not any significant difference for neither anxious attachment style scores [$F(1, 309) = 4.06$, $p > .025$; Wilks' $\lambda = .98$, partial $\eta^2 = .01$] nor avoidant attachment style scores [$F(1, 309) = .03$, $p > .025$; ; Wilks' $\lambda = .98$, partial $\eta^2 = .00$] between the levels of participation in extreme sport activities.

In order to investigate attachment style differences between genders, a one way between subjects MANOVA was calculated and it was found to be significant

between genders [Multivariate $F(2, 308) = 5.22$, $p < .01$, Wilks' $\lambda = .97$, partial $\eta^2 = .03$]. There was a significant difference for anxious attachment style scores between genders [$F(1, 309) = 7.50$, $p < .025$; Wilks' $\lambda = .97$, partial $\eta^2 = .02$]. Female participants ($m = 2.62$, $sd = .82$) had higher anxious attachment style scores than male participants *(*$m = 2.37$, $sd = .66$). However, there was not any significant difference for avoidant attachment style scores between genders [$F(1, 309) = .01$, $p > .025$; Wilks' $\lambda = .98$, partial $\eta^2 = .00$].

A one way between subjects MANOVA was calculated to investigate attachment style differences among the education levels of the participants and it was found to be significant [Multivariate $F(4, 614) = 3.68$, $p < .01$, Wilks' $\lambda = .95$, partial $\eta^2 = .02$]. Analysis revealed significant results for anxious attachment style [$F(2, 308) = 5.13$, $p < .025$; Wilks' $\lambda = .95$, partial $\eta^2 = .03$]. Tukey post hoc comparison was conducted and it was found that high school graduates ($m = 2.89$, $sd = .85$) had significantly higher anxious attachment style scores than graduate school graduates ($m = 2.38$, $sd = .68$); however, there was not any significant difference between these participants and university graduates ($m = 2.54$, $sd = .79$). There was not any significant difference among education levels of participants on avoidant attachment style scores [$F(2, 308) = 3.63$, $p > .025$; Wilks' $\lambda = .95$, partial $\eta^2 = .02$].

In order to investigate attachment style differences among the levels of socio-economic status, a one way between subjects MANOVA was calculated and it was found to be non-significant [Multivariate $F(4, 610) = .82$, $p > .05$, Wilks' $\lambda = .99$, partial $\eta^2 = .01$].

Another one way between subjects MANOVA was calculated in order to examine attachment style differences between the levels of marital status and it was found to be significant [Multivariate $F(2, 307) = 12.06$, $p < .001$, Wilks' $\lambda = .93$, partial $\eta^2 = .07$]. There was a significant difference between single and married participants in terms of their anxious attachment style scores [$F(1, 308) = 20.60$, $p < .025$; Wilks' $\lambda = .93$, partial $\eta^2 = .06$]. Single participants ($m = 2.62$, $sd = .78$) had significantly higher anxious attachment style scores than married participants ($m = 2.13$, $sd =$

.63). Similarly, there was a significant difference between single and married participants in terms of their avoidant attachment style scores [$F(1, 308) = 15.87$, $p < .025$, Wilks' $\lambda = .93$, partial $\eta^2 = .05$] and single participants ($m = 2.02$, $sd = .68$) have significantly higher avoidant attachment scores than married participants ($m = 1.64$, $sd = .72$).

Moreover, a one way between subjects MANOVA was calculated in order to investigate attachment style differences between province categories and found to be non-significant, [Multivariate $F(4, 612) = 1.02$, $p > .05$, Wilks' $\lambda = .99$, partial $\eta^2 = .01$].

Another one way between subjects MANOVA was examined in order to investigate attachment style differences between psychological disorder history categories and found as significant [Multivariate $F(2, 308) = 7.73$, $p < .01$, Wilks' $\lambda = .95$, partial $\eta^2 = .05$]. The participation in different categories of psychological disorder history differed not only in terms of anxious attachment style [$F(1, 309) = 14.21$, $p < .025$; Wilks' $\lambda = .95$, partial $\eta^2 = .04$] but also in terms of avoidant attachment style [$F(1, 309) = 8.81$, $p < .025$; Wilks' $\lambda = .95$, partial $\eta^2 = .03$]. Participants who reported a psychological disorder history ($m = 2.84$, $sd = .84$) had significantly higher anxious attachment style scores than participants who did not report ($m = 2.44$, $sd = .74$). Moreover, participants with a psychological disorder history ($m = 2.17$, $sd = .85$) had significantly higher avoidant attachment style scores than participants who did not have a psychological disorder history ($m = 1.89$, $sd = .64$).

Lastly, in order to investigate attachment style differences between physical disorder history categories, one way between subjects MANOVA was calculated and found to be non-significant [Multivariate $F(2, 303) = .04$, $p > .05$, Wilks' $\lambda = 1.00$, partial $\eta^2 = .00$].

Table 6

Differences among the Levels of Demographic Variables in terms of Attachment Styles

Variable	Anxiety			Avoidance		
	Mean	*SD*	*F*	Mean	*SD*	*F*
Extreme Sport Participation						
No	2.59	.80	4.06	1.94	.73	.03
Yes	2.41	.71		1.95	.66	
Gender						
Woman	2.62[a]	.82	7.50*	1.95	.73	.01
Man	2.37[b]	.66		1.94	.64	
Education						
High school	2.89[a]	.85	5.13*	2.05	.70	3.63
University	2.54[ab]	.79		2.01	.68	
Graduate	2.38[b]	.68		1.78	.73	
SES						
Low	2.69	.70	.61	2.20	.68	1.64
Middle	2.53	.76		1.95	.70	
High	2.44	.95		1.83	.71	
Marital Status						
Single	2.62[a]	.78	20.60*	2.02[a]	.68	15.87*
Married	2.13[b]	.63		1.64[b]	.72	
Province						
Metropolis	2.56	.79	1.21	1.95	.71	1.40
City	2.42	.73		1.89	.62	
Small town	2.76	.88		2.31	.98	
History of Psychological Disorder						
Yes	2.84[a]	.84	14.21*	2.17[a]	.85	8.81*
No	2.44[b]	.74		1.89[b]	.64	
History of Physical Disorder						
Yes	2.51	.76	.03	1.95	.63	.01
No	5.53	.78		1.94	.72	

Note 1. * $p < .05$, ** $p < .01$

Note 2. Means that do not share the same subscript are significantly different from each other

3.1.2.2 Differences among the Levels of Demographic Variables in terms of Difficulties in Emotion Regulation Strategies

Another series of one way between subjects MANOVAs were conducted to compare the levels of demographic variables on subscales of Difficulties in Emotion Regulation Scale, which are lack of clarity about emotions, lack of awareness about emotions, impulse control difficulties while dealing with negative emotions, non-acceptance of emotional responses, lack of goal directed behaviors while dealing with negative emotions, and lack of strategies while dealing with negative emotions (Table 7). If one way between subjects MANOVA results were found to be significant, for main effects on dependent variables, univariate analyses were calculated and Bonferroni correction was done and significance level was found as .008 for six dependent variables.

A one way between subjects MANOVA was examined in order to investigate difficulties in emotion regulation strategies' differences between the levels of participation in extreme sport activities and found as non-significant [Multivariate $F(6, 304) = 1.85$, $p > .05$, Wilks' $\lambda = .97$, partial $\eta^2 = .04$].

In order to examine difficulties in emotion regulation strategies' differences in gender categories, a one way between subjects MANOVA was calculated and found to be significant [Multivariate $F(6, 304) = 5.49$, $p < .001$, Wilks' $\lambda = .90$, partial $\eta^2 = .10$]. There was a significant difference for lack of clarity about emotions [$F(1, 309) = 12.75$, $p < .008$; Wilks' $\lambda = .90$, partial $\eta^2 = .04$]. Female participants ($m = 2.41$, $sd = .85$) had higher lack of clarity about emotions than male participants ($m = 2.04$, $sd = .85$). However, there was not a significant difference for lack of awareness about emotions [$F(1, 309) = .43$, $p > .008$; Wilks' $\lambda = .90$, partial $\eta^2 = .00$]. MANOVA results were found to be significant for gender in terms of impulse control difficulties while dealing with negative emotions [$F(1, 309) = 19.13$, $p < .008$; Wilks' $\lambda = .90$, partial $\eta^2 = .06$]. Women ($m = 2.29$, $sd = .91$) had higher impulse control difficulties while dealing with negative emotions than men ($m = 1.86$, $sd = .67$). Moreover, there was a significant difference for gender in terms of

non-acceptance of emotional responses [$F(1, 309) = 13.40$, $p < .008$; Wilks' $\lambda = .90$, partial $\eta^2 = .04$]. Female *(m* = 2.16, *sd* = .96) participants had higher levels of non-acceptance of emotional responses scores than male participants *(m* = 1.76, *sd* = .79). On the other hand, there was not a significant difference on lack of goals while dealing with negative emotions [$F(1, 309) = 3.37$, $p > .008$; Wilks' $\lambda = .90$, partial $\eta^2 = .01$]. There was also a significant difference for lack of strategies while dealing with negative emotions [$F(1, 309) = 13.14$, $p < .008$; Wilks' $\lambda = .90$, partial $\eta^2 = .04$]. Women (*m* = 2.33, *sd* = .90) had higher lack of strategies while dealing with negative emotions than men (*m* = 1.96, *sd* = .77).

A one way between subjects MANOVA was calculated in order to investigate difficulties in emotion regulation strategies' differences among the levels of education and found as significant [Multivariate $F(12, 606) = .88$, $p < .05$, Wilks' $\lambda = .93$, partial $\eta^2 = .04$]. There was not a significant difference for lack of clarity about emotions [$F(2, 308) = 4.00$, $p > .008$; Wilks' $\lambda = .93$, partial $\eta^2 = .03$], lack of awareness about emotions [$F(2, 308) = .30$, $p > .008$; Wilks' $\lambda = .93$, partial $\eta^2 = .00$], non-acceptance of emotional responses [$F(2, 308) = .82$, $p > .008$; Wilks' $\lambda = .93$, partial $\eta^2 = .01$], lack of goals while dealing with negative emotions [$F(2, 308) = 1.46$, $p > .008$; Wilks' $\lambda = .93$, partial $\eta^2 = .01$], and lack of strategies while dealing with negative emotions [$F(2, 308) = 3.54$, $p > .008$; Wilks' $\lambda = .93$, partial $\eta^2 = .02$]. On the other hand, there was a significant difference for impulse control difficulties while dealing with negative emotions [$F(2, 308) = 6.29$, $p < .008$; Wilks' $\lambda = .93$, partial $\eta^2 = .04$]. Tukey post hoc comparison was conducted and it was found that high school graduates (*m* = 2.55, *sd* = .99) have significantly higher levels of impulse control difficulties while dealing with negative emotions than graduate school graduates (*m*= 1.94, *sd* = .71). However, there was not any significant difference between these participants and university graduates (*m* = 2.17, *sd* = .87).

Another one way between subjects MANOVA was examined in order to investigate difficulties in emotion regulation strategies' differences in the levels of socio-

economic status of the participants and found as non-significant [Multivariate $F(12, 602) = 1.15$, $p > .05$, Wilks' $\lambda = .96$, partial $\eta^2 = .02$].

In order to investigate difficulties in emotion regulation strategies' differences between the levels of marital status, one way between subjects MANOVA was calculated and found to be significant [Multivariate $F(6, 303) = 2.38$, $p < .05$, Wilks' $\lambda = .96$, partial $\eta^2 = .05$]. However, in univariate analyses, there were not any significant differences for lack of clarity about emotions [$F(1, 308) = 5.91$, $p > .008$; Wilks' $\lambda = .96$, partial $\eta^2 = .02$], lack of awareness about emotions [$F(1, 308) = .29$, $p > .008$; Wilks' $\lambda = .96$, partial $\eta^2 = .00$], impulse control difficulties while dealing with emotions [$F(1, 308) = 2.57$, $p > .008$; Wilks' $\lambda = .96$, partial $\eta^2 = .01$], non-acceptance of emotional responses [$F(1, 308) = 3.74$, $p > .008$; Wilks' $\lambda = .96$, partial $\eta^2 = .01$], lack of goals while dealing with negative emotions [$F(1, 308) = 3.23$, $p > .008$; Wilks' $\lambda = .96$, partial $\eta^2 = .01$], and lack of strategies while dealing with negative emotions [$F(1, 308) = .43$, $p > .008$; Wilks' $\lambda = .96$, partial $\eta^2 = .00$].

Additionally, a one way between subjects MANOVA was calculated in order to investigate differences among the levels of province in terms of difficulties in emotion regulation strategies and found to be non-significant [Multivariate $F(12, 604) = .63$, $p > .05$, Wilks' $\lambda = .98$, partial $\eta^2 = .01$].

In order to investigate the differences between participants with and without psychological disorder history in terms of difficulties in emotion regulation strategies, a one way between subjects MANOVA was calculated and found to be significant [Multivariate $F(6, 304) = 6.07$, $p < .001$, Wilks' $\lambda = .89$, partial $\eta^2 = .11$]. In terms of psychological disorder history, there was not a significant difference for lack of awareness about emotions [$F(1, 309) = 5.67$, $p > .008$; Wilks' $\lambda = .89$, partial $\eta^2 = .02$] and lack of goals while dealing with negative emotions [$F(1, 309) = 6.44$, $p > .008$; Wilks' $\lambda = .89$, partial $\eta^2 = .02$]. On the other hand, there were significant results for all other subscales of the Difficulties in Emotion Regulation Strategies. First, there was a significant difference for lack of clarity about emotions [$F(1, 309) = 15.27$, $p < .008$; Wilks' $\lambda = .89$, partial $\eta^2 = .05$]; participants who reported a

psychological disorder history *(m* = 2.64, *sd* = 1.00) were higher on lack of clarity about emotions than participants who did not report any psychological disorder *(m* = 2.16, *sd* = .80). Second, between the levels of psychological disorder history, there was a significant difference for impulse control difficulties while dealing with negative emotions [$F(1, 309) = 23.29$, $p < .008$; Wilks' $\lambda = .89$, partial $\eta^2 = .07$]. That is, participants who reported a psychological disorder history *(m* = 2.57, *sd* = 90) were higher on impulse control difficulties than participants who did not report any psychological disorder *(m* = 2.02, *sd* = .81). Third, there was a significant difference for non-acceptance of emotional responses between the levels of psychological disorder history [$F(1, 309) = 23.15$, $p < .008$; Wilks' $\lambda = .89$, partial $\eta^2 = .07$]. Participants who reported a psychological disorder history (*m* = 2.48, *sd* = 1.13) had higher levels of non-acceptance of emotional responses than participants who did not report any psychological disorder (*m* = 1.89, *sd* = .82). Fourth and last, in terms of psychological disorder history, there was a significant difference for lack of strategies while dealing with negative emotions [$F(1, 309) = 30.62$, $p < .008$; Wilks' $\lambda = .89$, partial $\eta^2 = .09$]. Participants who reported a psychological disorder history *(m* = 2.69, *sd* = 83) had higher levels of lack of strategies while dealing with negative emotions than participants who did not report *(m* = 2.06, *sd* = 84).

Lastly, one way between subjects MANOVA was examined in order to investigate difficulties in emotion regulation strategies' differences between the participants with and without physiological disorder history and found as non-significant [Multivariate $F(6, 299) = .64$, $p > .05$, Wilks' $\lambda = .99$, partial $\eta^2 = .01$].

Table 7

Differences among the Levels of Demographic Variables in terms of Difficulties in Emotion Regulation

Variable	Lack of Clarity			Lack of Awareness			Impulse			Nonacceptance			Lack of Goals			Lack of Strategies		
	M	*SD*	*F*	*M*	*SD*	*F*	*M*	*SD*	*F*	*M*	*SD*	*F*	*M*	*SD*	*F*	*M*	*SD*	*F*
Extreme Sport																		
No	2.33	.84	1.89	2.20	.59	.27	2.24	.88	7.62	2.12	.92	6.32	3.22	.93	5.36	2.31	.86	9.78
Yes	2.19	.92		2.16	.56		1.96	.79		1.85	.91		2.95	1.02		1.99	.86	
Gender																		
Woman	2.41[a]	.85	12.75*	2.17	.58	.43	2.29[a]	.91	19.13*	2.16[a]	.96	13.40*	3.20	.95	3.37	2.33[a]	.90	13.14*
Man	2.04[b]	.85		2.22	.57		1.86[b]	.67		1.76[b]	.79		2.99	.99		1.96[b]	.77	
Education																		
High school	2.65	1.10	4.00	2.20	.55	.30	2.55[a]	.99	6.29*	2.22	1.00	.82	3.37	.95	1.46	2.58	1.01	3.54
University	2.28	.83		2.17	.54		2.17[ab]	.87		2.01	.94		3.13	.98		2.18	.87	
Graduate	2.15	.82		2.22	.67		1.94[b]	.71		1.97	.87		3.03	.94		2.12	.80	
SES																		
Low	2.62	1.02	3.72	2.29	.65	.56	2.21	.97	.18	2.08	.96	.50	3.28	1.12	1.41	2.46	.96	.93
Middle	2.30	.86		2.19	.58		2.14	.83		2.03	.94		3.14	.94		2.19	.85	
High	1.96	.79		2.11	.52		2.07	1.03		1.87	.84		2.87	1.10		2.12	.98	
Marital Status																		
Single	2.34	.89	5.91	2.18	.58	.29	2.18	.86	2.57	2.07	.95	3.74	3.17	.98	3.23	2.21	.87	.43
Married	2.04	.74		2.22	.56		1.98	.84		1.82	.80		2.92	.92		2.13	.90	
Province																		
Metropolitan	2.26	.87	.34	2.18	.59	.30	2.14	.85	.33	2.00	.91	.66	3.09	.98	.93	2.21	.88	.46
City	2.36	.83		2.21	.52		2.12	.87		2.07	.95		3.23	.95		2.14	.87	
Small town	2.29	1.14		2.31	.82		2.37	1.01		2.33	1.26		3.40	.63		2.43	.80	
Psychological Disorder History																		
Yes	2.64[a]	1.00	15.27*	2.33	.69	5.67	2.57[a]	.90	23.29*	2.48[a]	1.13	23.15*	3.39	.95	6.44	2.69[a]	.83	30.62*
No	2.16[b]	.80		2.15	.54		2.02[b]	.81		1.89[b]	.82		3.05	.96		2.06[b]	.84	
Physical Disorder History																		
Yes	2.14	.75	1.85	2.13	.49	.66	2.02	.85	1.45	1.99	.88	.10	3.08	.98	.10	2.17	.80	.07
No	2.30	.88		2.19	.58		2.16	.85		2.03	.92		3.13	.97		2.20	.88	

Note 1. * $p < .05$, ** $p < .01$

Note 2. Means that do not share the same subscript are significantly different from each other

3.1.2.3 Differences among the levels of Demographic Variables in terms of Death Attitudes

A series of one way between subjects MANOVAs were conducted to compare the levels of demographic variables on subscales of Death Attitude Profile-Revised, which are fear of death, death avoidance, lack of neutral acceptance, lack of approach acceptance, and lack of escape acceptance (Table 8). If one way between subjects MANOVA results were found to be significant, for main effects on dependent variables, univariate analyses were calculated. Bonferroni correction was done in order to control Type I error for MANOVA and the significance level was found as .01 for five dependent variables.

One way between subjects MANOVA was examined in order to investigate death attitude differences between the levels of participation in extreme sport activities and it was found significant [Multivariate $F(5, 305) = 3.32$, $p < .01$, Wilks' $\lambda = .95$, partial $\eta^2 = .05$]. There was not any significant difference for death avoidance [$F(1, 309) = 1.80$, $p > .01$, Wilks' $\lambda = .95$, partial $\eta^2 = .01$], lack of approach acceptance of death [$F(1, 309) = 4.03$, $p > .01$, Wilks' $\lambda = .95$, partial $\eta^2 = .01$], and lack of escape acceptance of death [$F(1, 309) = 3.84$, $p > .01$, Wilks' $\lambda = .95$, partial $\eta^2 = .01$]. On the other hand, there was a significant difference for fear of death [$F(1, 309) = 7.25$, $p < .01$, Wilks' $\lambda = .95$, partial $\eta^2 = .02$]; participants who engage in extreme sport activities had higher levels of fear of death scores ($m = 4.65$, $sd = 1.33$) than participants who do not engage in these activities ($m = 4.21$, $sd = 1.41$). Moreover, there was a significant difference for lack of neutral acceptance of death [$F(1, 309) = 7.68$, $p < .01$, Wilks' $\lambda = .95$, partial $\eta^2 = .02$]; participants who engage in extreme sport activities ($m = 6.07$, $sd = .95$) had higher levels of lack of neutral acceptance (in other words lower levels of neutral acceptance) than participants who do not engage in extreme sport activities ($m = 5.77$, $sd = .89$).

In order to investigate death attitude differences between gender categories, a one way between subjects MANOVA was calculated and it was found to be significant [Multivariate $F(5, 305) = 3.84$, $p < .01$, Wilks' $\lambda = .94$, partial $\eta^2 = .06$]. There was

not any significant difference for death avoidance [$F(1, 309) = 3.30$, $p > .01$, Wilks' $\lambda = .94$, partial $\eta^2 = .01$], lack of approach acceptance [$F(1, 309) = 4.41$, $p > .01$, Wilks' $\lambda = .94$, partial $\eta^2 = .01$], and lack of escape acceptance [$F(1, 309) = 1.86$, $p > .01$, Wilks' $\lambda = .94$, partial $\eta^2 = .01$]. However, there was a significant difference for fear of death [$F(1, 309) = 12.58$, $p < .01$, Wilks' $\lambda = .94$, partial $\eta^2 = .04$]; men ($m = 4.74$, $sd = 1.36$) had higher levels of fear of death scores than women ($m = 4.16$, $sd = 1.36$). Besides, there was a significant difference for lack of neutral acceptance of death [$F(1, 309) = 7.18$, $p < .01$, Wilks' $\lambda = .94$, partial $\eta^2 = .02$]; men ($m = 6.04$, $sd = .92$) had higher levels of lack of neutral acceptance scores (in other words lower levels of neutral acceptance) than women ($m = 5.78$, $sd = .91$).

Another one way between subjects MANOVA was calculated in order to investigate death attitude differences among the levels of education and it was found to be significant [Multivariate $F(10, 608) = 2.84$, $p < .01$, Wilks' $\lambda = .91$, partial $\eta^2 = .05$]. However, in univariate analyses, there was not any significant difference for the subscales, namely fear of death [$F(2, 308) = 1.19$, $p > .01$, Wilks' $\lambda = .91$, partial $\eta^2 = .01$], death avoidance [$F(2, 308) = 1.89$, $p > .01$, Wilks' $\lambda = .91$, partial $\eta^2 = .01$], lack of neutral acceptance [$F(2, 308) = 2.85$, $p > .01$, Wilks' $\lambda = .91$, partial $\eta^2 = .02$], lack of approach acceptance [$F(2, 308) = 3.31$, $p > .01$, Wilks' $\lambda = .91$, partial $\eta^2 = .02$], and lack of escape acceptance [$F(2, 308) = 1.04$, $p > .01$, Wilks' $\lambda = .91$, partial $\eta^2 = .01$].

One way between subjects MANOVA was examined in order to investigate death attitude differences among the levels of socio-economic status of the participants and it was found as non-significant [Multivariate $F(10, 604) = 1.14$, $p > .05$, Wilks' $\lambda = .96$, partial $\eta^2 = .02$].

In order to investigate death attitude differences between the levels of marital status, a one way between subjects MANOVA was calculated and it was found as significant [Multivariate $F(5, 304) = 2.33$, $p < .05$, Wilks' $\lambda = .96$, partial $\eta^2 = .04$]. Despite this significant result, there was not any significant difference for death attitude subscales, namely, fear of death [$F(1, 308) = 1.72$, $p > .01$, Wilks' $\lambda = .96$,

partial η^2 = .01], death avoidance [F(1, 308) = .86, p > .01, Wilks' λ = .96, partial η^2 = .00], lack of neutral acceptance [F(1, 308) = .63, p > .01, Wilks' λ = .96, partial η^2 = .00], lack of approach acceptance [F(1, 308) = 3.68, p > .01, Wilks' λ = .96, partial η^2 = .01], and lack of escape acceptance [F(1, 308) = 2.66, p > .01, Wilks' λ = .96, partial η^2 = .01].

One way between subjects MANOVA was calculated in order to examine differences among the levels of province in terms of death attitudes of the participants and it was found to be significant [Multivariate F(10, 606) = 1.97, p < .05, Wilks' λ = .94, partial η^2 = .03]. However, there was not any significant difference for death attitude subscales, which are fear of death [F(2, 307) = 1.90, p > .01, Wilks' λ = .94, partial η^2 = .01], death avoidance [F(2, 307) = 3.70, p > .01, Wilks' λ = .94, partial η^2 = .02], lack of neutral acceptance [F(2, 307) = .09, p > .01, Wilks' λ = .94, partial η^2 = .00], lack of approach acceptance [F(2, 307) = 4.28, p > .01, Wilks' λ = .94, partial η^2 = .03], and lack of escape acceptance [F(2, 307) = 1.43, p > .01, Wilks' λ = .94, partial η^2 = .01].

In order to investigate the differences between participants with and without psychological disorder history in terms of death attitudes, another one way between subjects MANOVA was calculated and it was found as significant [Multivariate F(5, 305) = 4.87, p < .001, Wilks' λ = .93, partial η^2 = .07]. Among the levels of psychological disorder history, there was not any significant difference for fear of death [F(1, 309) = 1.23, p > .01, Wilks' λ = .93, partial η^2 = .00], death avoidance [F(1, 309) = 1.59, p > .01, Wilks' λ = .93, partial η^2 = .01], lack of neutral acceptance of death [F(1, 309) = 3.00, p > .01, Wilks' λ = .93, partial η^2 = .01], and lack of approach acceptance of death [F(1, 309) = 1.03, p > .01, Wilks' λ = .93, partial η^2 = .00]. However, there was a significant difference for lack of escape acceptance of death [F(1, 309) = 16.07, p < .01, Wilks' λ = .93, partial η^2 = .05]. Participants who reported a psychological disorder history (m = 3.56, sd = 1.70) had higher levels of lack of escape acceptance of death than participants without psychological disorder history (m = 2.68, sd = 1.57). In other words, participants who reported psychological disorder history had lower levels of escape acceptance

of death than participants who did not report (In escape acceptance of death, death is a welcomed alternative for painful and anguished life).

A final one way between subjects MANOVA was examined in order to investigate death attitude differences between the participants with and without physiological disorder history and it was found to be significant [Multivariate $F(5, 300) = 3.53$, $p < .01$, Wilks' $\lambda = .94$, partial $\eta^2 = .06$]. In univariate analyses, there was not any significant difference for fear of death [$F(1, 304) = .71$, $p > .01$, Wilks' $\lambda = .94$, partial $\eta^2 = .00$], lack of neutral acceptance [$F(1, 304) = .42$, $p > .01$, Wilks' $\lambda = .94$, partial $\eta^2 = .00$], lack of approach acceptance [$F(1, 304) = 1.56$, $p > .01$, Wilks' $\lambda = .94$, partial $\eta^2 = .01$], and lack of escape acceptance [$F(1, 304) = 1.68$, $p > .01$, Wilks' $\lambda = .94$, partial $\eta^2 = .01$]. On the other hand, there was a significant difference for death avoidance [$F(1, 304) = 10.94$, $p > .01$, Wilks' $\lambda = .94$, partial $\eta^2 = .04$]; participants who reported a physiological disorder history ($m = 4.77$, $sd = 1.50$) had higher levels of death avoidance than participants without a physiological disorder history ($m = 4.13$, $sd = 1.34$).

Table 8

Differences among the Levels of Demographic Variables in terms of Death Attitudes

Variables	Fear of Death			Death Avoidance			Lack of Neutral Acceptance			Lack of Approach Acceptance			Lack of Escape Acceptance		
	M	*SD*	*F*	*M*	*SD*	*F*	*M*	*SD*	*F*	*M*	*SD*	*F*	*M*	*SD*	*F*
Extreme Sport Participation															
No	4.21[a]	1.41	7.25*	4.19	1.43	1.80	5.77[a]	.89	7.68*	3.57	1.54	4.03	3.00	1.68	3.84
Yes	4.65[b]	1.33		4.41	1.33		6.07[b]	.95		3.18	1.71		2.62	1.53	
Gender															
Women	4.16[a]	1.38	12.58*	4.16	1.41	3.30	5.78[a]	.91	7.18*	3.57	1.55	4.41	2.96	1.63	1.86
Men	4.74[b]	1.36		4.46	1.34		6.04[b]	.92		3.17	1.69		2.70	1.64	
Education															
High school	4.27	1.60	1.19	4.73	1.59	1.89	5.61	.80	2.85	3.40	1.30	3.31	2.90	1.78	1.04
University	4.46	1.42		4.22	1.33		5.84	.99		3.60	1.67		2.96	1.67	
Graduate	4.19	1.25		4.21	1.44		6.04	.77		3.08	1.53		2.66	1.51	
SES															
Low	4.83	1.45	1.10	4.88	1.18	1.94	5.77	.95	.14	3.44	1.84	1.78	3.40	1.89	1.24
Middle	4.34	1.40		4.24	1.42		5.88	.93		3.50	1.60		2.87	1.64	
High	4.28	1.27		4.13	1.25		5.86	.83		2.93	1.50		2.64	1.44	
Marital Status															
Single	4.42	1.43	1.72	4.30	1.42	.86	5.90	.92	.63	3.35	1.62	3.68	2.95	1.68	2.66
Married	4.15	1.25		4.12	1.30		5.80	.95		3.79	1.55		2.57	1.43	
Province															
Metropolitan	4.34	1.37	1.90	4.17	1.39	3.70	5.88	.91	.09	3.29	1.54	4.28	2.78	1.56	1.43
City	4.50	1.46		4.65	1.30		5.85	.99		3.93	1.78		3.14	1.81	
Small town	3.56	1.27		3.82	1.71		5.78	.78		3.37	1.44		3.16	2.10	
History of Psychological Disorder															
Yes	4.20	1.39	1.23	4.46	1.42	1.59	5.71	.98	3.00	3.61	1.44	1.03	3.56[a]	1.70	16.07*
No	4.41	1.40		4.22	1.33		5.92	.90		3.38	1.67		2.68[b]	1.57	
History of Physical Disorder															
Yes	4.51	1.54	.71	4.77[a]	1.50	10.94*	5.81	.84	.42	3.20	1.71	1.56	2.63	1.64	1.68
No	4.34	1.36		4.13[b]	1.34		5.90	.95		3.49	1.57		2.93	1.65	

Note 1. * $p < .05$, ** $p < .01$

Note 2. Means that do not share the same subscript are significantly different from each other

3.1.2.4 Differences among the Levels of Demographic Variables in terms of Health Promoting Behaviors

Several independent samples *t*-test and one way between subjects analysis of variance analyses were conducted to investigate differences among the levels of demographic variables on health promoting behaviors (Table 9).

An independent samples *t*-test was calculated to compare the levels of participation in extreme sport activities in terms of health promoting behaviors and a significant result was yielded, $t(309) = -2.93$, $p < .01$. Specifically, participants who engage in extreme sport activities ($m = 2.70$, $sd = .40$) had higher health promoting behavior scores than participants who do not perform extreme sports ($m = 2.57$, $sd = .35$).

In order to compare health promoting behaviors differences between genders, an independent samples *t*-test was calculated and it was found as non-significant, $t(309) = -.28$, $p > .05$.

Another one way between subjects analysis of variance (ANOVA) was calculated to investigate health promoting behavior differences among the education levels and it was also found to be non-significant, $F(2, 308) = 2.54$, $p > .05$.

Additionally, in order to investigate health promoting behavior differences among the levels of socio-economic status, a one way between subjects ANOVA was calculated and it was found as non-significant, $F(2, 306) = 2.03$, $p > .05$.

In order to examine differences between the levels of marital status on health promoting behaviors, an independent samples *t*-test was calculated and it was found as non-significant, $t(308) = .49$, $p > .05$.

One way between subjects ANOVA was conducted in order to investigate health promoting behavior differences between province categories and no statistically significant difference was found, $F(2, 307) = .20$, $p > .05$.

Moreover, in order to investigate differences between physical disorder history categories in terms of health promoting behaviors, an independent samples *t*-test was calculated and it was found as non-significant, $t(309) = -1.34$, $p > .05$.

Lastly, an independent samples *t*-test was conducted in order to examine health promoting behavior differences between physical disorder history categories and it was found as non-significant, $t(304) = 1.20$, $p > .05$.

Table 9

Differences among the Levels of Demographic Variables in terms of Health Promoting Behaviors

Variable	Health Promoting Behaviors			
	Mean	*sd*	*t*	*F*
Extreme Sport Participation				
No	2.57[a]	.35	-2.93**	
Yes	2.70[b]	.40		
Gender				
Women	2.61	.34	-.28	
Men	2.62	.42		
Education				
High school	2.50	.45		2.54
University	2.61	.37		
Graduate	2.67	.33		
SES				
Low	2.46	.34		2.03
Middle	2.62	.38		
High	2.68	.28		
Marital Status				
Single	2.62	.38	.49	
Married	2.59	.33		
Province				
Metropolitan	2.62	.38		.20
City	2.59	.36		
Small town	2.66	.34		
History of Psychological Disorder				
Yes	2.56	.38	-1.34	
No	2.63	.37		
History of Physical Disorder				
Yes	2.66	.37	1.20	
No	2.60	.38		

Note 1. * $p < .05$, ** $p < .01$

Note 2. Means that do not share the same subscript are significantly different from each other

3.1.2.5 Group Comparisons on the Measures of the Study

As a summary table, Table 10 presents means, standard deviations, and results of significance tests for participants who engage in extreme sport activities and the ones who do not engage in extreme sport activities.

Table 10.
Extreme Sport and No-Extreme Sport Group Comparisons on All of the Measures

Variables	Extreme Sport		No Extreme Sport		Significance Test
	m	*sd*	*m*	*sd*	
Attachment		Multivariate $F(2, 308) = 3.21, p < .05$, Wilks' $\lambda = .98$, partial $\eta^2 = .02$			
Anxiety	2.59	.80	2.41	.71	$F(1, 311) = 4.06$
Avoidance	1.95	.66	1.94	.73	$F(1, 311) = .03$
Difficulties in Emotion Regulation Strategies		Multivariate $F(6, 304) = 1.85, p > .05$, Wilks' $\lambda = .97$, partial $\eta^2 = .04$			
Lack of awareness	2.16	.56	2.20	.59	$F(1, 311) = .27$
Lack of clarity	2.19	.92	2.33	.84	$F(1, 311) = 1.89$
Nonacceptance	1.85	.91	2.12	.92	$F(1, 311) = 6.32$
Limited strategies	1.99	.86	2.31	.86	$F(1, 311) = 9.78$
Difficulties in impulses	1.96	.79	2.24	.88	$F(1, 311) = 7.62$
Difficulties in goal behavior	2.95	1.02	3.22	.93	$F(1, 311) = 5.36$
Death Attitude		Multivariate $F(5, 305) = 3.32, p < .01$, Wilks' $\lambda = .95$, partial $\eta^2 = .05$			
Fear of death	4.65	1.33	4.21	1.41	$F(1, 311) = 7.25$*
Death avoidance	4.41	1.33	4.19	1.43	$F(1, 311) = 1.80$
Lack of Neutral acceptance	6.07	.95	5.77	.89	$F(1, 311) = 7.68$*
Lack of Approach acceptance	3.18	1.71	3.57	1.54	$F(1, 311) = 4.03$
Lack of Escape acceptance	2.62	1.53	3.00	1.68	$F(1, 311) = 3.84$
Health Promoting Behaviors	2.70	.40	2.57	.35	$t(309) = -2.93$*

Note. * $p < .05$

3.1.3 Correlational Analyses among the Measures of the Study

3.1.3.1 Correlational Analyses among the Measures of the Study for Participants who Engage in Extreme Sport Activities

Pearson correlation coefficients among the variables of this study for participants who engage in extreme sport activities are presented in Table 11.

Correlational analyses revealed that the dependent variable, health promoting behaviors, is negatively correlated with avoidant attachment style (r = -.28, p < .01), lack of clarity about emotions (r = -.25, p < .05), lack of awareness about emotions (r = -.31, p < .01), non-acceptance of emotional responses (r = -.22, p < .05), lack of goal directed behavior while dealing with negative emotions (r = -.31, p < .01), lack of strategies while dealing with negative emotions (r = -.22, p < .05), and lack of escape acceptance of death (r = -.19, p < .05).

There was a positive correlation between anxious attachment style and avoidant attachment style of participants who engage in extreme sport activities (r = .51, p < .01). Also anxious attachment style was positively correlated with all the subscales of Difficulties in Emotion Regulation Scale. That is to say, anxious attachment style was positively correlated with lack of clarity about emotions (r = .64, p < .01), lack of awareness about emotions (r = .24, p < .05), impulse control difficulties while dealing with negative emotions (r = .59, p < .01), non-acceptance of emotional responses (r = .67, p < .01), lack of goal directed behavior while dealing with negative emotions (r = .59, p < .01), and lack of strategies while dealing with negative emotions (r = .62, p < .01). Moreover, anxious attachment style was negatively correlated with fear of death (r = -.28, p < .01) and lack of neutral acceptance of death (r = -.20, p < .05); however positively correlated with lack of approach acceptance of death (r =.25, p < .05) and lack of escape acceptance of death (r = .21, p < .05).

Avoidant attachment style was also positively correlated with all the subscales of the Difficulties in Emotion Regulation Strategies, namely lack of clarity about

emotions (r = .54, p < .01), lack of awareness about emotions (r = .21, p < .05), impulse control difficulties while dealing with negative emotions (r = .36, p < .01), non-acceptance of emotional responses (r = .50, p < .01), lack of goal directed behavior while dealing with negative emotions (r = .21, p < .05), and lack of strategies while dealing with negative emotions (r = .44, p < .01). Besides, avoidant attachment style was positively correlated with lack of approach acceptance of death (r = .28, p < .01) and lack of escape acceptance of death (r = .36, p < .01).

Lack of clarity about emotions was positively correlated with all the other subscales of Difficulties in Emotion Regulation Strategies, which was lack of awareness about emotions (r = .40, p < .01), impulse control difficulties while dealing with negative emotions (r = .63, p < .01), non-acceptance of emotional responses (r = .62, p < .01), lack of goal directed behavior while dealing with negative emotions (r = .42, p < .01), and lack of strategies while dealing with negative emotions (r = .44, p < .01). This subscale was negatively correlated with fear of death (r = -.22, p < .01), lack of neutral acceptance of death (r = -.21, p < .05), and health promoting behavior (r = -.25, p < .05), while positively correlated with lack of approach acceptance of death (r = .28, p < .05), lack of escape acceptance of death (r = .27, p < .01).

Lack of awareness about emotions was positively correlated with lack of clarity about emotions (r = .40, p < .01), impulse control difficulties while dealing with negative emotions (r = .31, p < .01), non-acceptance of emotional responses (r = .24, p < .05), lack of goal directed behavior while dealing with negative emotions (r = .19, p < .05), lack of strategies while dealing with negative emotions (r = .28, p < .01); however, negatively correlated with fear of death (r = -.23, p < .05) and lack of neutral acceptance of death (r = -.24, p < .05).

Impulse control difficulties while dealing with negative emotions was positively correlated with lack of clarity about emotions (r = .63, p < .01), lack of awareness about emotions (r = .31, p < .01), non-acceptance of emotional responses (r = .57, p < .01), lack of goal directed behavior while dealing with negative emotions (r = .56,

$p < .01$), lack of strategies while dealing with negative emotions ($r = .77$, $p < .01$). This subscale was also positively correlated with lack of escape acceptance of death ($r = .22$, $p < .05$), but negatively correlated with lack of neutral acceptance of death ($r = -.25$, $p < .01$).

Non-acceptance of emotional responses was positively correlated with lack of clarity about emotions ($r = .62$, $p < .01$), lack of awareness about emotions ($r = .24$, $p < .05$), impulse control difficulties while dealing with negative emotions ($r = .57$, $p < .01$), lack of goal directed behavior while dealing with negative emotions ($r = .46$, $p < .01$), lack of strategies while dealing with negative emotions ($r = .68$, $p < .01$), lack of approach acceptance of death ($r = .22$, $p < .05$), and lack of escape acceptance of death ($r = 31$, $p < .01$).

Lack of goal directed behavior while dealing with negative emotions was positively correlated with lack of clarity about emotions ($r = .42$, $p < .01$), lack of awareness about emotions ($r = .19$, $p < .05$), impulse control difficulties while dealing with negative emotions ($r = .56$, $p < .01$), non-acceptance of emotional responses ($r = .46$, $p < .01$), lack of strategies while dealing with negative emotions ($r = .58$, $p < .01$), and lack of escape acceptance ($r = .23$, $p < .05$); however negatively correlated with fear of death ($r = -.20$, $p < .05$) and lack of neutral acceptance of death ($r = -.22$, $p < .05$).

Lack of strategies while dealing with negative emotions was positively correlated with lack of clarity about emotions ($r = .66$, $p < .01$), lack of awareness about emotions ($r = .28$, $p < .01$), impulse control difficulties while dealing with negative emotions ($r = .77$, $p < .01$), non-acceptance of emotional responses ($r = .68$, $p < .01$), lack of goal directed behavior while dealing with negative emotions ($r = .58$, $p < .01$). This subscale was negatively correlated with fear of death ($r = -.21$, $p < .05$) and lack of neutral acceptance of death ($r = -.26$, $p < .01$), while positively correlated with lack of approach acceptance ($r = .26$, $p < .01$) and lack of escape acceptance ($r = .30$, $p < .01$).

Fear of death, a subscale of Death Attitude Profile-Revised, was negatively correlated with lack of clarity about emotions (r = -.22, p < .05), lack of awareness about emotions (r = -.23, p < .05), lack of goal directed behavior while dealing with negative emotions (r = -.20, p < .05), and lack of strategies while dealing with negative emotions (r = -.21, p < .05). However, this subscale was positively correlated with death avoidance (r = .43, p < .01) and lack of neutral acceptance of death (r = .50, p < .01).

Death avoidance was positively correlated with fear of death (r = .43, p < .01) and lack of neutral acceptance of death (r = .23, p < .05). Lack of neutral acceptance of death was negatively correlated with lack of clarity about emotions (r = -.21, p < .05), lack of awareness about emotions (r = -.24, p < .05), impulse control difficulties while dealing with difficult emotions (r = -.25, p < .01), lack of goal directed behavior while dealing with difficult emotions (r = -.22, p < .01), and lack of strategies while dealing with difficult emotions (r = -.26, p < .01); however, it was positively correlated with fear of death (r = .50, p < .01) and death avoidance (r = .23, p < .05).

Lack of approach acceptance of death was positively correlated with lack of clarity about emotions (r = .24, p < .05), non-acceptance of emotional responses (r = .22, p < .05), lack of strategies while dealing with difficult emotions (r = .26, p < .01), and lack of escape acceptance of death (r = .25, p < .01). Lack of escape acceptance of death was positively correlated with lack of clarity about emotions (r = .27, p < .01), impulse control difficulties while dealing with negative emotions (r = .22, p < .05), non-acceptance of emotional responses (r = .31, p < .01), lack of goal directed behavior while dealing with negative emotions (r = .23, p < .05), lack of strategies while dealing with negative emotions (r = .30, p < .01), and lack of approach acceptance of death (r = .25, p < .01).

Table 11

Correlations among the Study Variables for Participants who Engage in Extreme Sport Activities

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1.Anxiety	(.89)													
2.Avoidance	.51**	(.90)												
3.Lack of clarity	.64**	.54**	(.92)											
4.Lack of awareness	.24**	.21*	.40**	(.65)										
5.Impulsiveness	.59**	.36**	.63**	.31**	(.87)									
6.Nonacceptance	.67**	.50**	.62**	.24*	.57**	(.91)								
7.Lack of goals	.59**	.21**	.42**	.16*	.56**	.46**	(.90)							
8.Lack of strategies	.62**	.44**	.66**	.28**	.77**	.68**	.58**	(.91)						
9.Fear of death	-.28**	-.03	-.22*	-.23*	-.18	-.13	-.20*	-.21*	(.83)					
10.Death avoidance	-.09	-.01	-.00	-.14	-.16	-.04	-.08	-.08	.43**	(.70)				
11.Lack of neutral acceptance	-.20*	-.03	-.21*	-.24*	-.25**	-.05	-.22*	-.26**	.50**	.23*	(.66)			
12.Lack of approach acceptance	.25*	.28**	.24*	-.04	.18	.22*	.07	.26**	-.01	-.02	-.04	(.95)		
13.Lack of escape acceptance	.21*	.36**	.27**	.01	.22*	.31**	.23*	.30**	.03	.10	.10	.25**	(.89)	
14. Health promoting behaviors	-.19	-.28**	-.25*	-.31**	-.15	-.22*	-.31**	-.22*	.17	-.01	.18	.14	-.19*	(.93)

Note 1. * $p < .05$, ** $p < .01$

Note 2. Scores shown within the parentheses on the diagonal represent the Cronbach's alpha coefficients of the variables for participants who engage in extreme sport activities

3.1.3.2 Correlational Analyses among the Measures of the Study for Participants who do not Engage in Extreme Sport Activities

Correlational analyses among the variables of this study for participants who do not engage in extreme sport activities are presented in Table 12.

The dependent variable health promoting behaviors, was negatively correlated with anxious attachment style (r = -.33, p < .01), avoidant attachment style (r = -.32, p < .01), lack of clarity about emotions (r = -.35, p < .01), lack of awareness about emotions (r = -.30, p < .01), impulse control difficulties while dealing with negative emotions (r = -.30, p < .01), non-acceptance of emotional responses (r = -.28, p < .01), and lack of strategies while dealing with negative emotions (r = -.33, p < .01). Moreover, health promoting behaviors were positively correlated with fear of death (r = .16, p < .05) and lack of neutral acceptance of death (r = .22, p < .05).

Anxious attachment style, one of the independent variables of the study, was positively correlated with avoidant attachment style (r = .57, p < .01) and all of the subscales of Difficulties in Emotion Regulation Strategies; lack of clarity about emotions (r = .42, p < .01), lack of awareness about emotions (r = .24, p < .01), impulse control difficulties while dealing with negative emotions (r = .58, p < .01), non-acceptance of emotional responses (r = .50, p < .01), lack of goal directed behaviors while dealing with negative emotions (r = .24, p < .01), and lack of strategies while dealing with negative emotions (r = .59, p < .01). Anxious attachment style was negatively correlated with the death avoidance (r = -.15, p < .05), lack of neutral acceptance (r = -.19, p < .01), and positively correlated with the lack of escape acceptance of death (r = .28, p < .01) subscales of the Death Attitude Profile-Revised.

The other independent variable, avoidant attachment style was positively correlated with lack of clarity about emotions (r = .32, p < .01), lack of awareness about emotions (r = .28, p < .01), impulse control difficulties while dealing with negative emotions (r = .36, p < .01), non-acceptance of emotional responses (r = .38, p < .01), lack of strategies while dealing with negative emotions (r = .34, p < .01), and

lack of escape acceptance of death (r = .16, p < .01), while negatively correlated with fear of death (r = -.17, p < .05).

Lack of clarity about emotions was positively correlated with all the other subscales of the Difficulties in Emotion Regulation Strategies, which are lack of awareness about emotions (r = .45, p < .01), impulse control difficulties while dealing with negative emotions (r = .44, p < .01), non-acceptance of emotional responses (r = .50, p < .01), lack of goal directed behaviors while dealing with negative emotions (r = .26, p < .01), and lack of strategies while dealing with negative emotions (r = .48, p < .01). This subscale was negatively correlated with fear of death (r = -.24, p < .01), death avoidance (r = -.15, p < .05), lack of neutral acceptance of death (r = -.14, p < .05); and positively correlated with lack of escape acceptance of death (r = .26, p < .01).

There was a positive correlation between lack of awareness about emotions and lack of clarity about emotions (r = .45, p < .01), impulse control difficulties while dealing with negative emotions (r = .27, p < .01), non-acceptance of emotional responses (r = .26, p < .01), lack of strategies while dealing with negative emotions (r = .26, p < .01). However, there was a negative correlation between lack of awareness about emotions and fear of death (r = -.16, p < .05), death avoidance (r = -.16, p < .05), and lack of neutral acceptance of death (r = -.18, p < .01).

Impulse control difficulties while dealing with negative emotions was positively correlated with all other subscales of the Difficulties in Emotion Regulation Strategies, namely lack of clarity about emotions (r = .44, p < .01), lack of awareness about emotions (r = .27, p < .01), non-acceptance of emotional responses (r = .49, p < .01), lack of goal directed behaviors while dealing with negative emotions (r = .56, p < .01), and lack of strategies while dealing with negative emotions (r = .73, p < .01). Impulse control difficulties while dealing with negative emotions was also negatively correlated with fear of death (r = -.19, p < .01) and lack of neutral acceptance of death (r = -.24, p < .01), but positively correlated with

lack of escape acceptance of death ($r = .32$, $p < .01$) subscales of the Death Attitude Profile-Revised.

There was a positive correlation between non-acceptance of emotional responses and lack of clarity about emotions ($r = .50$, $p < .01$), lack of awareness about emotions ($r = .26$, $p < .01$), impulse control difficulties while dealing with negative emotions ($r = .49$, $p < .01$), lack of goal directed behaviors while dealing with negative emotions ($r = .41$, $p < .01$), and lack of strategies while dealing with negative emotions ($r = .62$, $p < .01$). This subscale of emotion regulation difficulties was negatively correlated with fear of death ($r = -.23$, $p < .01$) and death avoidance ($r = -.16$, $p < .05$), while positively correlated with lack of escape acceptance of death ($r = .22$, $p < .01$) subscale of the death attitudes.

Lack of goal directed behaviors while dealing with negative emotions was positively correlated with lack of clarity about emotions ($r = .26$, $p < .01$), impulse control difficulties while dealing with emotions ($r = .56$, $p < .01$), non-acceptance of emotional responses ($r = .41$, $p < .01$), lack of strategies while dealing with emotions ($r = .57$, $p < .01$), and lack of escape acceptance of death ($r = .14$, $p < .01$); and negatively correlated with fear of death ($r = -.17$, $p < .05$) and lack of neutral acceptance of death ($r = -.14$, $p < .05$).

A positive correlation was found between lack of strategies while dealing with negative emotions and lack of clarity about emotions ($r = .45$, $p < .01$), lack of awareness about emotions ($r = .26$, $p < .01$), impulse control difficulties while dealing with negative emotions ($r = .73$, $p < .01$), non-acceptance of emotional responses ($r = .62$, $p < .01$), lack of goal directed behaviors while dealing with negative emotions ($r = .57$, $p < .01$), and lack of escape acceptance of death ($r = .28$, $p < .01$); however, a negative correlation was revealed between lack of strategies while dealing with negative emotions and fear of death ($r = -.15$, $p < .05$), and lack of neutral acceptance of death ($r = -.17$, $p < .05$).

Fear of death, a subscale of the death attitudes, was negatively correlated with all of the subscales of emotion regulation difficulties, namely lack of clarity about

emotions (r = -.24, p < .01), lack of awareness about emotions (r = -.16, p < .05), impulse control difficulties while dealing with negative emotions (r = -.19, p < .01), non-acceptance of emotional responses (r = -.23, p < .01), lack of goal directed behaviors while dealing with negative emotions (r = -.17, p < .05), and lack of strategies while dealing with negative emotions (r = -.15, p < .05). This subscale was also positively correlated with some of the subscales of death attitudes, i.e., death avoidance (r = .60, p < .01), lack of neutral acceptance of death (r = .52, p < .01), and lack of escape acceptance of death (r = .15, p < .05).

Death avoidance was negatively correlated with lack of clarity about emotions (r = -.15, p < .05), lack of awareness about emotions (r = -.16, p < .05), non-acceptance of emotional responses (r = -.16, p < .05), while positively correlated with fear of death (r = .60, p < .01), lack of neutral acceptance of death (r = .28, p < .01), and lack of escape acceptance of death (r = .19, p < .01).

A negative correlation was found between lack of neutral acceptance of death and most of the subscales of emotion regulation difficulties, which were lack of clarity about emotions (r = -.14, p < .05), lack of awareness about emotions (r = -.18, p < .01), impulse control difficulties while dealing with negative emotions (r = -.24, p < .01), lack of goal directed behaviors while dealing with negative emotions (r = -.14, p < .05), and lack of strategies while dealing with negative emotions (r = -.17, p < .05). However, positive correlations were found between lack of neutral acceptance of death and fear of death (r = .52, p < .01), death avoidance (r = .28, p < .01). Lack of approach acceptance of death was only positively correlated with lack of escape acceptance of death (r = .45, p < .01).

Lack of escape acceptance of death was positively correlated with lack of clarity about emotions (r = .26, p < .01), impulse control difficulties while dealing with negative emotions (r = .32, p < .01), non-acceptance of emotional responses (r = .22, p < .01), lack of goal directed behaviors while dealing with negative emotions (r = .14, p < .05), lack of strategies while dealing with negative emotions (r = .28, p

< .01), fear of death (r = .15, p < .05), death avoidance (r = .19, p < .01), and lack of approach acceptance of death (r = .45, p < .01).

Table 12

Correlations among the Study Variables for Participants who do not Engage in Extreme Sport Activities

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1.Anxiety	(.91)													
2.Avoidance	. 57**	(.92)												
3.Lack of clarity	.42**	.32**	(.91)											
4.Lack of awareness	.24**	.28**	.45**	(.65)										
5.Impulsiveness	.58**	.36**	.44**	.27**	(.89)									
6.Nonacceptance	.50**	.38**	.50**	.26**	.49**	(.89)								
7.Lack of goals	.24**	.11	.26**	.05	.56**	.41**	(.89)							
8.Lack of strategies	.59**	.34**	.45**	.26**	.73**	.62**	.57**	(.88)						
9.Fear of death	-.24**	-.17*	-.24**	-.16**	-.19**	-.23**	-.17*	-.15*	(.83)					
10.Death avoidance	-.15**	-.09	-.15**	-.16**	-.11	-.16**	-.04	-.03	.60**	(.77)				
11.Lack of neutral acceptance	-.19**	-.10	-.14**	-.18**	-.24**	-.09	-.14*	-.17*	.52**	.28**	(.59)			
12.Lack of approach acceptance	.12	.05	.05	.09	.09	.13	.06	.06	.04	.06	.01	(.93)		
13.Lack of escape acceptance	.28**	.16*	.26**	.04	.32**	.22**	.14*	.28**	.15*	.19**	.08	.45**	(.92)	
14. Health promoting behaviors	-.33**	-.32**	-.35**	-.30**	-.30**	-.28**	-.11	-.33*	.16*	.02	.22**	.08	-.12	(.90)

Note 1. * $p < .05$, ** $p < .01$

Note 2. Scores shown within the parentheses on the diagonal represent the Cronbach's alpha coefficients of the variables for participants who do not engage in extreme sport activities

3.1.4 Hiearchical Regression Analysis

A hierarchical regression analysis was conducted with health promoting behaviors as the dependent variable. Gender and extreme sport participation variables were entered in the first step to control for their effects. Attachment variables (anxiety and avoidance) were entered in the second step, and all the hypothesized mediators (i.e., 6 subscales of the difficulties in emotion regulation strategies and five subscales of the death attitudes) were entered in the third step. The results of the hierarchical regression analysis are presented in Table 13.

This hierarchical regression analysis revealed that in the first step, gender and extreme sport participation contributed the model significantly, $F(2, 308) = 4.83$, $p < .01$, and these variables accounted for 3 % of the variance in health promoting behaviors. Extreme sport participation was significantly associated with health promoting behaviors ($\beta = .19$, $t(308) = 3.09$, $p < .01$). Participants who perform extreme sport activities engaged in more health promoting behaviors than participants who do not engage in extreme sport activities. In the second step, after controlling for gender and extreme sport participation, attachment variables had significant associations with health promoting behaviors, $\Delta F(2, 306) = 19.25$, $p < .001$, and attachment variables accounted for 11 % of the variance in health promoting behaviors. Specifically, anxious ($\beta = -.16$, $t(306) = -2.53$, $p < .05$) and avoidant ($\beta = -.21$, $t(306) = -3.31$, $p < .01$) attachment styles were significantly related with health promoting behaviors. Participants who had higher levels of anxious and avoidant attachment styles were less likely to engage in health promoting behaviors. In the last step, after controlling for gender, participation in extreme sport activities, and attachment styles; subscales of the difficulties in emotion regulation and death attitudes were added and this model was also found significant, $\Delta F(11, 295) = 4.69$, $p < .001$. Subscales of the difficulties in emotion regulation and death attitudes accounted for 13 % of the variance in health promoting behaviors. In the last step, when all the variables were entered in the model, the significant variables were lack of awareness about emotions ($\beta = -.17$, $t(295) = -2.90$, $p < .01$), lack of neutral acceptance of death ($\beta = .14$, $t(295) = 2.23$,

$p < .05$), lack of approach acceptance of death ($\beta = .21$, $t(295) = 3.76$, $p < .001$), and lack of escape acceptance of death ($\beta = -.14$, $t(295) = -2.32$, $p < .05$). In other words, the participants having difficulties in being aware of their emotions, reported less health promoting behaviors. Higher levels of neutral acceptance of death or acceptance of death as a natural part of life was related with lower levels of health promoting behaviors. The participants with higher approach acceptance of death attitudes, in other words the ones who think that there will be a happy after life reported less health promoting behaviors. The participants with higher escape acceptance of death attitudes, i.e. the ones who perceive death as the end of existential sufferings and pain engaged in less health promoting behaviors. All of the variables in the model accounted for 27 % of the variance in the health promoting behaviors.

Table 13

Summary of the Hierarchical Regression Analysis for the Variables Predicting Health Promoting Behaviors

Variables	ΔF	*df*	β	*t*	R^2	ΔR^2
Step 1	4.83	2, 308			.03	.03
Gender		308	-.07	-1.05		
Extreme sport participation		308	.19	3.09**		
Step 2	19.25	2, 306			.14	.11
Gender		306	-.09	-1.49		
Extreme sport participation		306	.19	3.15**		
Anxiety		306	-.16	-2.53*		
Avoidance		306	-.21	-3.31**		
Step 3	4.69	11, 295			.27	.13
Gender		295	-.09	-1.58		
Extreme sport participation		295	.16	2.80**		
Anxiety		295	-.02	-.30		
Avoidance		295	-.17	2.64**		
Lack of clarity		295	-.08	-1.11		
Lack of awareness		295	-.17	-2.90**		
Impulsiveness		295	.04	.51		
Non acceptance		295	-.05	-.75		
Lack of goals		295	-.05	-.73		
Lack of strategies		295	-.06	-.63		
Fear of death		295	.08	1.08		
Death avoidance		295	-.10	-1.65		
Lack of neutral acceptance		295	.14	2.23*		
Lack of approach acceptance		295	.21	3.76***		
Lack of escape acceptance		295	-.14	-2.32*		

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

3.2 Multiple Mediation Analyses

In this study, mediation hypotheses were tested according to bootstrapping indirect paths method (Hayes, 2013; Preacher & Hayes, 2008). Bootstrapping strategy, which is used in order to estimate and test hypotheses, develops a thousand of random samples from the sample data and generates a range of confidence intervals. In multiple mediator models, bootstrapping method has several advantages. First, it does not require large sample size which is needed in structural equation modeling. Second, normality of sampling distribution is not assumed as in Sobel test. Third, bootstrapping method does not require significant "a" (effect of independent variable on the mediator) and "b" (effect of mediator on the dependent variable) paths which are required criteria for Baron and Kenny's mediation method (1986). Fourth and last, this method can support several mediators; therefore, it has control over Type 1 and Type 2 errors. An indirect effect is acknowledged as significant if that variable's 95 % bootstrapping confidence intervals from 1000 bootstrap samples do not include zero. In the present study, multiple mediation hypotheses were tested using SPSS Macros provided by Preacher and Hayes (2008).

3.2.1 Multiple Mediation Analyses for Participants who Engage in Extreme Sport Activities

3.2.1.1 Multiple Mediation Roles of Difficulties in Emotion Regulation Scale Subscales in the Anxious Attachment Style−Health Promoting Behaviors Relation

In order to examine the hypothesized anxious attachment style−health promoting behaviors relation with the mediation of emotion regulation strategies in extreme sport group (hypothesized relations are presented as Model 1), a multiple mediation model including 6 mediators, the subscales of the Difficulties in Emotion Regulation Scale, was tested. Table 14 shows the summary of the results. As can be seen in Figure 2, lack of goal directed behavior while dealing with negative emotions and lack of awareness of emotions mediated the anxious attachment style−health promoting behaviors relation. First, the more the individuals had

anxious attachment style, the more they had lack of goal directed behavior while dealing with their negative emotions (a_1 = .84, p < .001), which in turn decreased their health promoting behaviors (b_1 = -.12, p < .05) in extreme sport group. Second, increases in anxious attachment style led to decreases in health promoting behaviors (b_2 = -.18, p < .05) through higher levels of lack of awareness of emotions (a_2 = .19, p < .05). Neither the direct effect of anxious attachment style on health promoting behaviors (c = -.11, p > .05), nor the total effect of anxious attachment style on health promoting behaviors through all the mediator variables (c' = .06, p > .05) were significant in participants who engage in extreme sport activities. As can be seen in Table 13, the total indirect effect of anxious attachment style on health promoting behaviors through all mediators (B = -.17, SE = .07) was significant since the bias corrected confidence intervals ranged between -.31 and -.03. In general, the model was significant [F(7, 101) = 3.26, p <.01] and this model predicted 18 % of the variance in health promoting behaviors from anxious attachment style through 6 different types of difficulties in emotion regulation. For anxious attachment style, bias corrected confidence intervals for the indirect effects (B = -.10, SE = .05 for lack of goals while dealing with negative emotions, B = -.03, SE = .02 for lack of awareness of emotions) based on the 1000 bootstrap samples were above zero.

Table 14

Bootstrap Results for Indirect Effects in Multiple Mediation Model 1

	Unstandardized Coefficients		95% Bias Corrected Confidence Intervals		Standardized Coefficients	
Indirect Effect	B	Standard Error	Lower	Upper	β	Standard Error
Total	-.17*	.07	-.31	-.03	-.17	.08
Lack of Awareness About Emotions	-.03*	.02	-.09	-.00	-.03	.02
Lack of Goal Directed Behavior While Dealing Difficult Emotions	-.11*	.05	-.23	-.02	-.10	.05

Note. * $p < .05$

Table 15

The Summary of the Findings for Model 1

Independent Variable	Mediator	Dependent Variable	Mediation	Confidence Interval
Anxious Attachment	Lack of Clarity	Health Promoting Behaviors	No	Not Significant
Anxious Attachment	Lack of Awareness	Health Promoting Behaviors	Yes	Significant
Anxious Attachment	Impulsiveness	Health Promoting Behaviors	No	Not Significant
Anxious Attachment	Nonacceptance of Emotions	Health Promoting Behaviors	No	Not Significant
Anxious Attachment	Lack of Goals	Health Promoting Behaviors	Yes	Significant
Anxious Attachment	Lack of Strategies	Health Promoting Behaviors	No	Not Significant

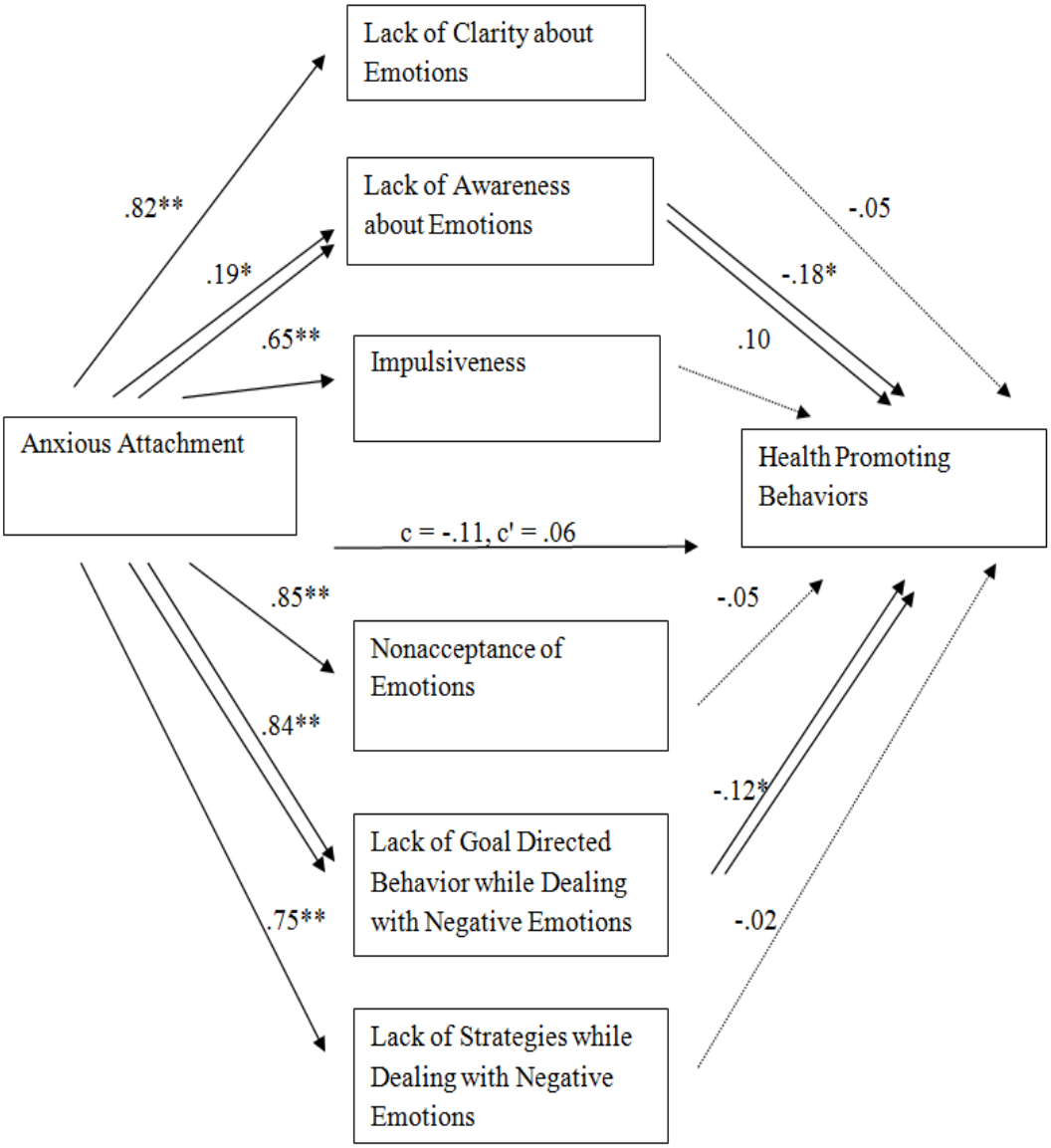

Figure 2. The path model (Model 1) and unstandardized regression coefficients indicating lack of awareness and lack of goals as the mediators of the relation between anxious attachment style and health promoting behaviors in participants who are participating in extreme sport activities

Note 1. * $p < .05$, ** $p < .001$
Note 2. Dashed lines show non-significant paths
Note 3. Double lines show mediation

3.2.1.2 Multiple Mediation Roles of Death Attitude Profile-Revised Subscales in the Anxious Attachment Style−Health Promoting Behaviors Relation

Another multiple mediation model including 5 subscales of Death Attitude Profile-Revised as mediators were tested in order to examine the hypothesized anxious attachment style−health promoting behaviors relation in extreme sport group (hypothesized relations are presented as Model 2). Table 15 shows the summary of the results. Lack of approach acceptance of death mediated the anxious attachment style−health promoting behaviors relation as can be seen in Figure 3. Increases in anxious attachment style resulted in increases in lack of approach acceptance of death (a = .59, p < .05), which in turn increased their health promoting behaviors (b = .06, p < .05). In other words, as anxious attachment style increased, approach acceptance of death decreased, which in turn increased their health promoting behaviors. The direct effect of anxious attachment style on health promoting behaviors was not significant (c =-.11, p > .05), similarly the total effect of anxious attachment style on health promoting behaviors through 5 mediators (c' = -.08, p > .05) was not significant, either. The total indirect effect of anxious attachment style on health promoting behaviors through all mediators (B = -.02, SE = .03) was not significant since bias corrected confidence intervals ranged between -.09 and .04. Overall, the model was significant [F(6, 102) = 2.94, p < .05] and this model predicted 15 % of the variance in health promoting behaviors from anxious attachment style through 5 subscales of death attitudes. Also, for anxious attachment style, a bias corrected confidence interval for the indirect effect of lack of approach acceptance of death (B = .03, SE = .02) based on the 1000 bootstrap samples was above zero (Table 16).

Table 16

The Summary of the Findings for Model 2

Independent Variable	Mediator	Dependent Variable	Mediation	Confidence Interval
Anxious Attachment	Fear of Death	Health Promoting Behaviors	No	Not Significant
Anxious Attachment	Death Avoidance	Health Promoting Behaviors	No	Not Significant
Anxious Attachment	Lack of Neutral Acceptance	Health Promoting Behaviors	No	Not Significant
Anxious Attachment	Lack of Approach Acceptance	Health Promoting Behaviors	Yes	Significant
Anxious Attachment	Lack of Escape Acceptance	Health Promoting Behaviors	No	Not Significant

Table 17

Bootstrap Results for Indirect Effects in Multiple Mediation Model 2

	Unstandardized Coefficients		95% Bias Corrected Confidence Intervals		Standardized Coefficients	
Indirect Effect	B	Standard Error	Lower	Upper	β	Standard Error
Total	-.02*	.03	-.09	.04	-.02	.03
Lack of Approach Acceptance of Death	-.03*	.02	.00	.08	.03	.02

Note. * $p < .05$

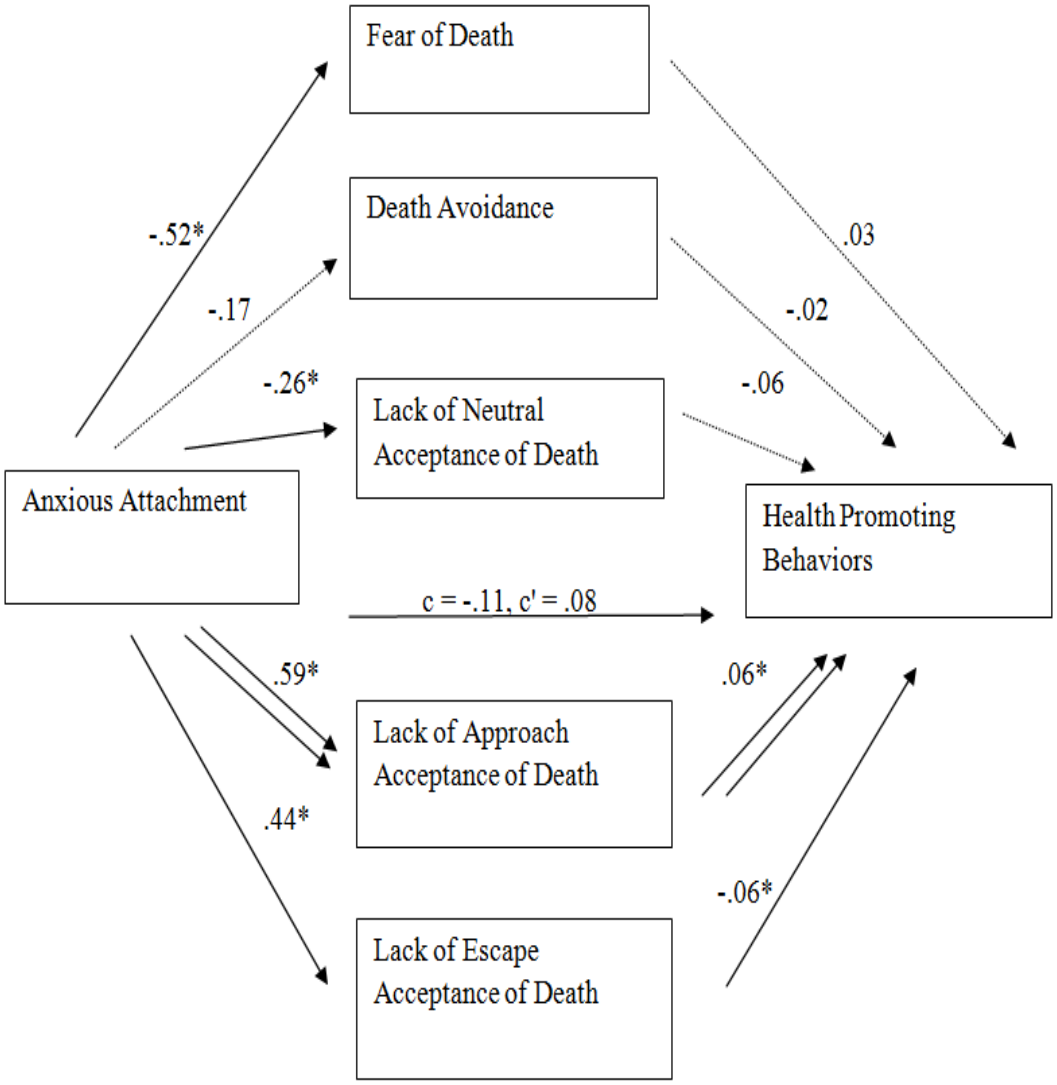

Figure 3. The path model (Model 2) and unstandardized regression coefficients indicating lack of approach acceptance of death as the mediator of the relation between anxious attachment style and health promoting behaviors in participants who are participating in extreme sport activities

Note 1. * $p < .05$, ** $p < .001$
Note 2. Dashed lines show non-significant paths
Note 3. Double lines show mediation

3.2.1.3 Multiple Mediation Roles of Difficulties in Emotion Regulation Scale Subscales in the Avoidant Attachment Style−Health Promoting Behaviors Relation

To examine the possible avoidant attachment style−health promoting behaviors relation with the mediation of emotion regulation strategies in extreme sport group (hypothesized relations are presented as Model 3), a multiple mediation model including 6 mediators were tested. Table 17 shows the summary of the results. Lack of goal directed behavior while experiencing negative emotions mediated the avoidant attachment style−health promoting behaviors relation as can be seen in Figure 4. The more the individuals had avoidant attachment style, the more they had lack of goal directed behavior while dealing with negative emotions (a = .32, p < .05), which in turn decreased their health promoting behaviors in extreme sport group (b = -.12, p < .01). The direct effect of avoidant attachment style on health promoting behaviors was significant (c =-.17, p < .01), similarly the total effect of avoidant attachment style on health promoting behaviors through all mediators (c' = -.14, p < .05) was significant, too. The total indirect effect of avoidant attachment style on health promoting behaviors through all mediators (B = -.03, SE = .05) was significant since the bias corrected confidence intervals ranged between -.13 and .06. In general, the model was significant [F(7, 101) = 3.85, p < .001] and this multiple mediation model predicted 16 % of the variance in health promoting behaviors from avoidant attachment style through 6 subscales of difficulties in emotion regulation scale. Furthermore, for avoidant attachment style, a bias corrected confidence interval for the indirect effect (B = -.04, SE = .03 for lack of goals while experiencing negative emotions) based on the 1000 bootstrap samples was above zero (Table 18).

Table 18

The Summary of the Findings for Model 3

Independent Variable	Mediator	Dependent Variable	Mediation	Confidence Interval
Avoidant Attachment	Lack of Clarity	Health Promoting Behaviors	No	Not Significant
Avoidant Attachment	Lack of Awareness	Health Promoting Behaviors	No	Not Significant
Avoidant Attachment	Impulsiveness	Health Promoting Behaviors	No	Not Significant
Avoidant Attachment	Nonacceptance of Emotions	Health Promoting Behaviors	No	Not Significant
Avoidant Attachment	Lack of Goals	Health Promoting Behaviors	Yes	Significant
Avoidant Attachment	Lack of Strategies	Health Promoting Behaviors	No	Not Significant

Table 19

Bootstrap Results for Indirect Effects in Multiple Mediation Model 3

	Unstandardized Coefficients		95% Bias Corrected Confidence Intervals		Standardized Coefficients	
Indirect Effect	B	Standard Error	Lower	Upper	β	Standard Error
Total	-.03*	.05	-.13	.06	-.04	.05
Lack of Goals While Dealing with Difficult Emotions	-.04*	.03	-.11	-.00	-.04	.02

Note. * $p < .05$

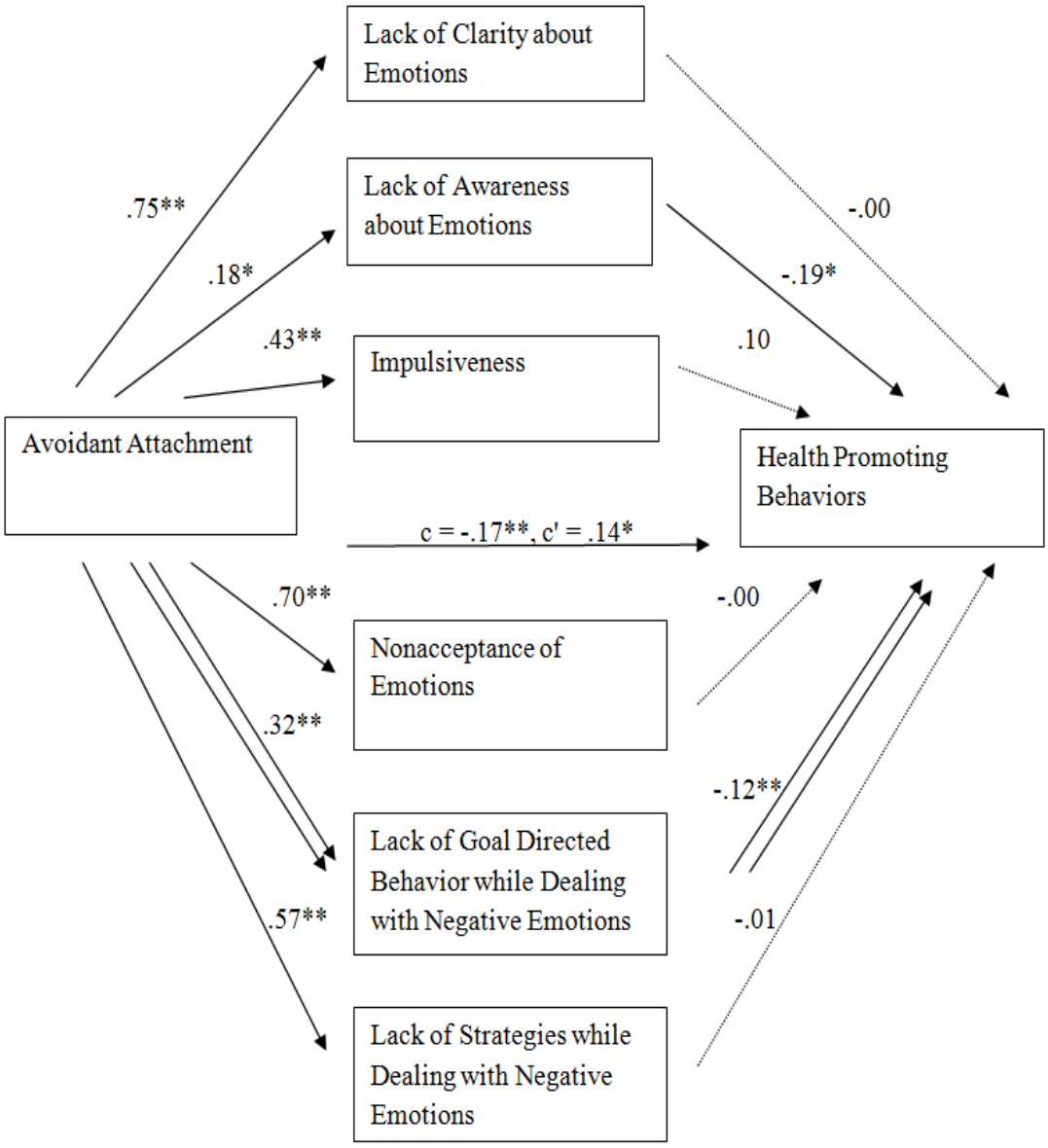

Figure 4. The path model (Model 3) and unstandardized regression coefficients indicating lack of goals as the mediator of the relation between avoidant attachment style and health promoting behaviors in participants who are participating in extreme sport activities

Note 1. * p <.05, ** p <.01
Note 2. Dashed lines show non-significant paths
Note 3. Double lines show mediation

3.2.1.4 Multiple Mediation Roles of Death Attitude Profile-Revised Subscales in the Avoidant Attachment Style−Health Promoting Behaviors Relation

Another multiple mediation model including 5 subscales of Death Attitude Profile-Revised as mediators were tested in order to examine the possible avoidant attachment style−health promoting behaviors relation in extreme sport group (hypothesized relations are presented as Model 4). Table 19 shows the summary of the results. Lack of approach acceptance of death mediate the avoidant attachment style−health promoting behaviors relation as can be seen in Figure 5. Increases in the avoidant attachment style led to increases in the lack of approach acceptance of death (a = .72, p < .01), which in turn increased health promoting behaviors (b = .06, p < .05). In other words, when avoidant attachment style increased, approach acceptance of death decreased, which resulted in higher levels of health promoting behaviors. Both the direct effect of avoidant attachment style on health promoting behaviors (c =-.17, p < .01), and the total effect of avoidant attachment style on health promoting behaviors through all mediators (c =-.17, p < .01) were significant. As can be seen in Table 20, the total indirect of avoidant attachment style on health promoting behaviors through 5 mediators (B = .00, SE = .03) was not significant, because the bias corrected confidence intervals ranged between -.06 and .07. Overall, the model was significant [F(6, 102) = 4.16, p < .01] and this model predicted 15 % of the variance in health promoting behaviors from avoidant attachment style through 5 subscales of death attitudes. Also, for avoidant attachment style, a bias corrected confidence interval for the indirect effect (B = .04, SE = .02 for lack of approach acceptance) based on the 1000 bootstrap samples was above zero.

Table 20

The Summary of the Findings for Model 4

Independent Variable	Mediator	Dependent Variable	Mediation	Confidence Interval
Avoidant Attachment	Fear of Death	Health Promoting Behaviors	No	Not Significant
Avoidant Attachment	Death Avoidance	Health Promoting Behaviors	No	Not Significant
Avoidant Attachment	Lack of Neutral Acceptance	Health Promoting Behaviors	No	Not Significant
Avoidant Attachment	Lack of Approach Acceptance	Health Promoting Behaviors	Yes	Significant
Avoidant Attachment	Lack of Escape Acceptance	Health Promoting Behaviors	No	Not Significant

Table 21

Bootstrap Results for Indirect Effects in Multiple Mediation Model 4

	Unstandardized Coefficients		95% Bias Corrected Confidence Intervals		Standardized Coefficients	
Indirect Effect	B	Standard Error	Lower	Upper	β	Standard Error
Total	.00*	.03	-.06	.07	.00	.03
Lack of Approach Acceptance of Death	.04*	.02	.01	.10	.04	.03

Note. * $p < .05$

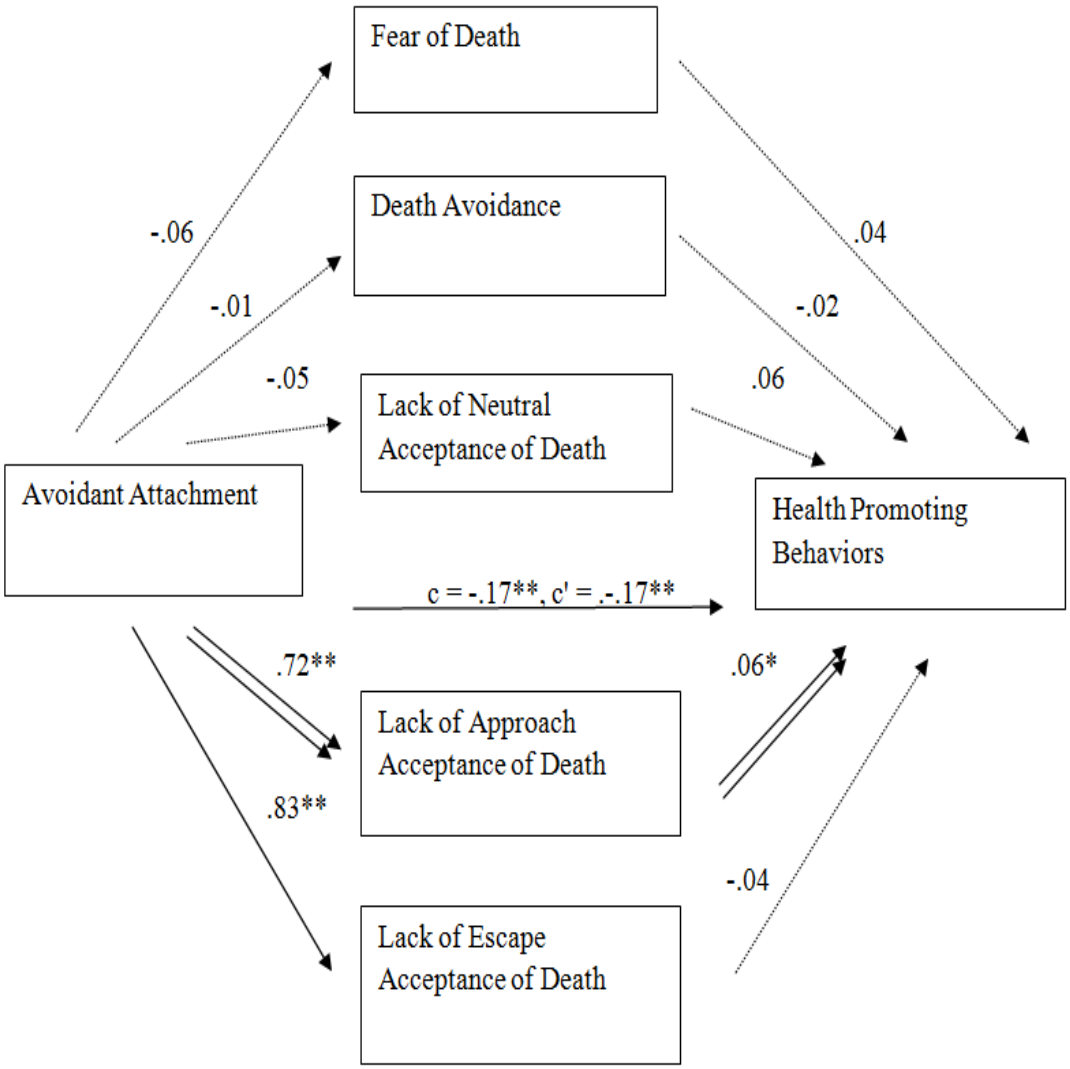

Figure 5. The path model (Model 4) and unstandardized regression coefficients indicating lack of approach acceptance of death as the mediator of the relation between avoidant attachment style and health promoting behaviors in participants who are participating in extreme sport activities

Note 1. * p <.05, ** p <.01
Note 2. Dashed lines show non-significant paths
Note 3. Double lines show mediation

3.2.2 Multiple Mediation Analyses for Participants who do not Engage in Extreme Sport Activities

3.2.2.1 Multiple Mediation Roles of Difficulties in Emotion Regulation Scale Subscales in the Anxious Attachment Style−Health Promoting Behaviors Relation

In order to examine the mediator role of emotion regulation strategies in anxious attachment style−health promoting behaviors relation with participants who do not engage in extreme sport activities, a multiple mediation model with 6 subscales of Difficulties in Emotion Regulation Scale were tested (hypothesized relations are presented as Model 5). Table 21 shows the summary of the results. As can be seen in Figure 6, lack of clarity about emotions mediated the anxious attachment style−health promoting behaviors relation. Increases in anxious attachment style led to increases in lack of clarity about emotions (a = .44, p < .001), which in turn resulted in decreases in health promoting behaviors (b = -.06, p > .05). The direct effect of anxious attachment style on health promoting behaviors was significant (c = -.14, p < .001); however, the total effect of anxious attachment style on health promoting behaviors through all of the mediator variables in participants who do not engage in extreme sport activities was not significant (c' = -.05). The total indirect effect of anxious attachment style on health promoting behaviors through 6 mediators (B = -.09, SE = 03) was significant (bias corrected confidence intervals ranged between -.15 and -.05). Overall, the model was significant [F(7, 194) = 6.79, p < .001] and this multiple mediation model predicted 18 % of the variance in health promoting behaviors from anxious attachment style through 6 different types of difficulties in emotion regulation. Moreover, a bias corrected confidence interval for the indirect effect of lack of clarity about emotions (B = -.03, SE = .02) based on the 1000 bootstrap samples was above zero and significant for anxious attachment style-health promoting behaviors relation (Table 22).

Table 22

The Summary of the Findings for Model 5

Independent Variable	Mediator	Dependent Variable	Mediation	Confidence Interval
Anxious Attachment	Lack of Clarity	Health Promoting Behaviors	Yes	Significant
Anxious Attachment	Lack of Awareness	Health Promoting Behaviors	No	Not Significant
Anxious Attachment	Impulsiveness	Health Promoting Behaviors	No	Not Significant
Anxious Attachment	Nonacceptance of Emotions	Health Promoting Behaviors	No	Not Significant
Anxious Attachment	Lack of Goals	Health Promoting Behaviors	No	Not Significant
Anxious Attachment	Lack of Strategies	Health Promoting Behaviors	No	Not Significant

Table 23

Bootstrap Results for Indirect Effects in Multiple Mediation Model 5

	Unstandardized Coefficients		95% Bias Corrected Confidence Intervals		Standardized Coefficients	
Indirect Effect	B	Standard Error	Lower	Upper	β	Standard Error
Total	-.09*	.03	-.15	-.05	-.09	.03
Lack of Clarity About Emotions	-.03*	-.03	-.07	-.00	-.03	.02

Note. * $p < .05$

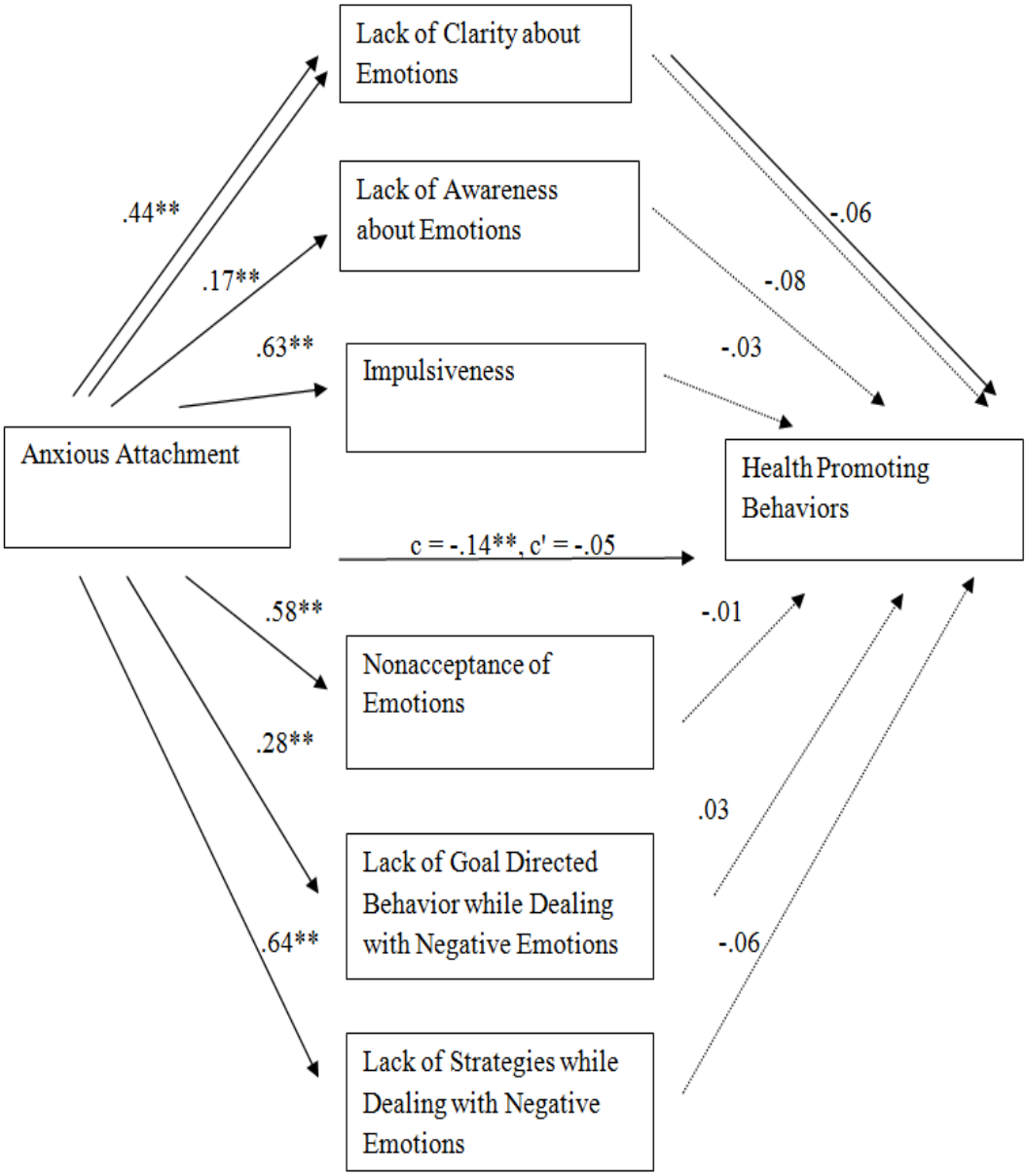

Figure 6. The path model (Model 5) and unstandardized regression coefficients indicating lack of clarity about emotions as the mediator of the relation between anxious attachment style and health promoting behaviors in participants who are not participating in extreme sport activities

Note 1. * p <.05, ** p <.01
Note 2. Dashed lines show non-significant paths
Note 3. Double lines show mediation

3.2.2.2 Multiple Mediation Roles of Death Attitude Profile-Revised Subscales in the Avoidant Attachment Style−Health Promoting Behaviors Relation

A multiple mediation model with the mediator roles of the 5 subscales of the death attitudes in avoidant attachment style−health promoting behaviors relation was examined (hypothesized relations are presented as Model 6). Table 23 shows the summary of the results. As can be seen in Figure 7, increases in avoidant attachment style led to increases in the lack of escape acceptance of death (a = .36, p < .05) , which resulted in decreases in health promoting behaviors (b = -.03, p < .05). Specifically, when avoidant attachment decreased, escape acceptance increased, which in turn increased health promoting behaviors. Both the direct effect of avoidant attachment style on health promoting behaviors (c = -.15, p < 001), and the total effect of avoidant attachment style on health promoting behaviors through all of the mediator variables (c' = -.13, p < .001) were significant. As can be seen in Table 24, the total indirect effect of avoidant attachment style on health promoting behaviors through 5 mediators (B = -.02, SE = .02) was not significant since the bias corrected confidence intervals ranged between -.06 and .01. In general, the model was significant [F(6, 195) = 7.06, p <.001] and this model predicted 19 % of the variance in health promoting behaviors from avoidant attachment style through 5 different types of death attitudes. Furthermore, a bias corrected confidence interval for the indirect effect of lack of escape acceptance of death (B = -.01, SE = .01) based on the 1000 bootstrap samples was above zero for the avoidant attachment style.

Table 24

The Summary of the Findings for Model 6

Independent Variable	Mediator	Dependent Variable	Mediation	Confidence Interval
Avoidant Attachment	Fear of Death	Health Promoting Behaviors	No	Not Significant
Avoidant Attachment	Death Avoidance	Health Promoting Behaviors	No	Not Significant
Avoidant Attachment	Lack of Neutral Acceptance	Health Promoting Behaviors	No	Not Significant
Avoidant Attachment	Lack of Approach Acceptance	Health Promoting Behaviors	No	Not Significant
Avoidant Attachment	Lack of Escape Acceptance	Health Promoting Behaviors	Yes	Significant

Table 25

Bootstrap Results for Indirect Effects in Multiple Mediation Model 6

	Unstandardized Coefficients		95% Bias Corrected Confidence Intervals		Standardized Coefficients	
Indirect Effect	B	Standard Error	Lower	Upper	β	Standard Error
Total	-.02*	.02	-.06	-.01	-.02	.02
Lack of Escape Acceptance of Death	-.01*	.01	-.04	-.00	-.01	.01

Note. * $p < .05$

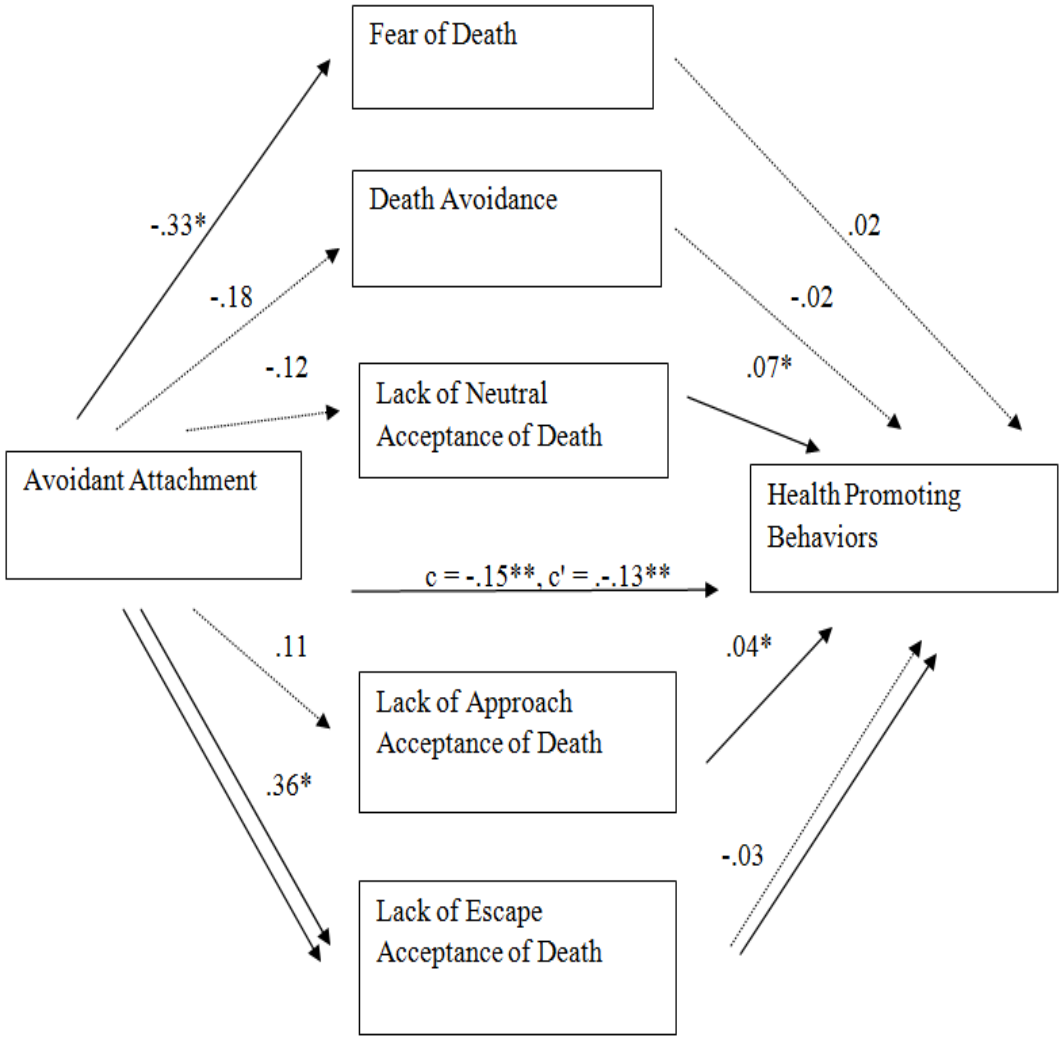

Figure 7. The path model (Model 6) and unstandardized regression coefficients indicating lack of escape acceptance of death as the mediator of the relation between avoidant attachment style and health promoting behaviors in participants who are not participating in extreme sport activities

Note 1. * p <.05, ** p <.01
Note 2. Dashed lines show non-significant paths
Note 3. Double lines show mediation

3.2.2.3 Multiple Mediation Roles of Difficulties in Emotion Regulation Scale Subscales in the Avoidant Attachment Style−Health Promoting Behaviors Relation

A multiple mediation model with the mediator roles of the 6 subscales of the Difficulties in Emotion Regulation Strategies in avoidant attachment style−health promoting behaviors relation was examined (hypothesized relations are presented as Model 7). Table 25 shows the summary of the results and there were not any significant mediators in avoidant attachment style−health promoting behaviors relation.

Table 26

The Summary of the Findings for Model 7

Independent Variable	Mediator	Dependent Variable	Mediation	Confidence Interval
Avoidant Attachment	Lack of Clarity	Health Promoting Behaviors	No	Not Significant
Avoidant Attachment	Lack of Awareness	Health Promoting Behaviors	No	Not Significant
Avoidant Attachment	Impulsiveness	Health Promoting Behaviors	No	Not Significant
Avoidant Attachment	Nonacceptance of Emotions	Health Promoting Behaviors	No	Not Significant
Avoidant Attachment	Lack of Goals	Health Promoting Behaviors	No	Not Significant
Avoidant Attachment	Lack of Strategies	Health Promoting Behaviors	No	Not Significant

3.2.2.4 Multiple Mediation Roles of Death Attitude Profile-Revised Subscales in the Anxious Attachment Style−Health Promoting Behaviors Relation

A multiple mediation model with the mediator roles of the 5 subscales of the Death Attitude Profile-Revised in anxious attachment style−health promoting behaviors relation was examined (hypothesized relations are presented as Model 8). Table 26 shows the summary of the results and there were not any significant mediators in anxious attachment style−health promoting behaviors relation Table 26.

Table 27

The Summary of the Findings for Model 8

Independent Variable	Mediator	Dependent Variable	Mediation	Confidence Interval
Anxious Attachment	Fear of Death	Health Promoting Behaviors	No	Not Significant
Anxious Attachment	Death Avoidance	Health Promoting Behaviors	No	Not Significant
Anxious Attachment	Lack of Neutral Acceptance	Health Promoting Behaviors	No	Not Significant
Anxious Attachment	Lack of Approach Acceptance	Health Promoting Behaviors	No	Not Significant
Anxious Attachment	Lack of Escape Acceptance	Health Promoting Behaviors	No	Not Significant

CHAPTER 4

DISCUSSION

The aim of the current study was to examine the relations among attachment styles, emotion regulation strategies, death attitudes, and their possible effects on health promoting behaviors among those who participate versus do not participate in extreme sport activities. For this purpose, the possible differences among the levels of demographic variables (extreme sport participation, gender, education, income level, marital status, province, psychological health status, and physical health status) in terms of study variables (attachment styles, emotion regulation strategies, death attitudes, and health promoting variables), and correlation coefficients among the study variables were examined. Then, multiple mediation analyses were conducted in order to examine paths among attachment styles, emotion regulation strategies, death attitudes, and health promoting behaviors.

4.1 Differences among the Levels of Demographic Variables in terms of Study Measures

4.1.1 Differences between the Levels of Participation in Extreme Sport Activities in terms of Study Measures. Participants who engage in extreme sport activities had higher levels of fear of death scores than participants who do not engage in extreme sport activities. In this study, the participants of extreme sport group were the ones, who were performing paragliding, rock climbing, deep diving, base jumping, high level mountaineering and/or other extreme activities and purposefully confronting with death, what they may actually afraid of. Therefore, their fear of death or death anxiety scores might be higher than the participants who do not want to engage in extreme sport activities and face the death risk. Some of the extreme sport participants indicated that fear is an essential element for their

survival; in fact they indicated that fear keeps them alive (Brymer & Schweitzer, 2013). Similarly in the literature, some professionals who are frequently exposed to death, such as nurses (Meisenhelder, 1994), firefighters and police officers (Hunt, Letser, & Ashton, 1983), and crisis intervention workers (Neimeyer & Dingemans, 1980), were found to have higher fear of death scores.

Extreme sport participants had lower levels of neutral acceptance of death scores than participants who do not perform extreme sport activities. Neutral acceptance of death is simply accepting death as an unchangeable fact of the end of life, perceiving death without fear or welcome, and trying to do best in the course of life. Hence, death can be a complicated challenge for participants engaging in extreme sport activities. If they had accepted death as an unchangeable fact of life and perceived it with welcome, then they would not want to challenge it by participating in these risky extreme sport activities that may result in death.

Participants who engage in extreme sport activities had higher health promoting behaviors scores than other participants. In the literature, it was reported that mortality salience is associated with higher levels of health promoting behaviors (Taubman-Ben-Ari & Findler, 2005; Bozo, Tunca, & Şimşek, 2009). In a congruent manner, participation in extreme sport activities made mortality perception more salient, which in turn, might resulted in higher levels of health promoting behaviors. Their higher fear of death scores, in addition to lower neutral acceptance of death scores, might be an indication of their investment on this world, rather than after life. This investment necessitates engagement in health promoting behaviors, such as eating responsibly and exercising to live healthier and longer. Although, participation in extreme sports activities is seemingly very risky, to perform them one should be fit and healthy. Thus, they should take extra care of their health. In sum, considering extreme sport activities as health compromising behaviors might be shallow.

4.1.2 Differences between the Levels of Gender in terms of Study Measures.

Females had higher levels of anxious attachment scores than males in the current study. This finding is congruent with the literature suggesting that females are prone to have more anxious attachment style scores than males. Anxious attachment is characterized by worry about partner's reluctance to get close to, worry about partner's affection, experiencing strong urge to get very close to partner, and being anxious while experiencing separations and losses (Fraley & Shaver, 2000). In an evolutionary perspective, females' anxious attachment style serves as a strategy to maximize closeness with their kin and partners (Kirkpatrick, 1998), and also it may be a counter strategy to diminish partner's avoidance (Del Giudice, 2011).

Females had also higher levels of lack of clarity about their emotions, impulse control difficulties while dealing with negative emotions, non-acceptance of emotional responses, and lack of strategies while dealing with negative emotions, all of which are difficulties in regulating emotions. According to Stevens (2014), individuals with higher anxious attachment are aware of their overwhelming emotions, but they have some deficits in emotional clarity and experience difficulty in making sense of their feelings and accepting them. Moreover, anxiously attached individuals, similar to our female participants, have problems in controlling their impulsive emotional reactions (Kobak & Sceery, 1988). Furthermore, without social support anxiously attached individuals cannot set any strategies to overcome their problems (Mikulincer, Shaver, & Pereg, 2003; Mallinckrodt, 2000); and as mentioned above females were consistently found more anxiously attached than males. Thus, the current finding suggesting higher lack of strategies while dealing with negative emotions for females might be explained by their attachment style.

In the current study, males had higher levels of fear of death scores than females. In the literature, there are contradictory results for fear of death scores for gender. While some studies reported higher fear of death for men (Cole, 1978; Depaola, Griffin, Young, & Neimeyer, 2003; Robinson & Wood, 1984), others indicated that women have higher levels of fear of death (Dattel & Neimeyer, 1990; Wong, Reker, & Gesser, 1994). What is more, some studies could not find any gender differences

in terms of fear of death (Thiemann, Quince, Besson, Wood, & Berclay, in press; Mullins & Lopez, 1982). In spite of these contradictory findings in the literature, similar to our findings, a study conducted with a Turkish sample did also find males as having higher death anxiety/fear of death than females (Taşdemir & Gök, 2012). Therefore, it can be suggested that in Turkish culture, males have higher fear of death scores than females. This finding might be explained by the way the women are treated in Turkey. Many Turkish women experience domestic violence and sexual traumas (Beşpınar & Canel Çınarbaş, in press). The lifetime prevalence of physical abuse by spouse was reported as 62 % (Vahip & Doğanavşargil, 2006). What is more, 71.4 % of the Turkish women encounter with psychological, physical or sexual abuse even during their pregnancy (Başbakanlık Aile Araştırma Kurumu, 1995). Being exposed to violence with such a high frequency and/or intensity, women in Turkey may perceive death as a very highly possible event, which may also be an alternative for persistent violence. Thus, Turkish women's fear of death scores appeared to be lower than men's scores.

Parallel to the finding mentioned above, females had higher neutral acceptance of death scores than males in the current study. In Wong, Reker, and Gesser's (1994) study, females were more likely to accept death. This result can be explained by men's avoidance of death thoughts rather than accepting them (Del Giudice, 2011). Moreover, it was reported that individuals who have lower levels of fear of death might accept death as a natural part of life (Wong, Reker, & Gesser, 1994). Similarly, it was reported that people who have lower levels of fear of death have higher levels of death acceptance (Neimeyer, Wittkowski, & Moser, 2004). Thus, females' lower fear of death and higher neutral acceptance of death were parallel to each other and the literature.

4.1.3 Differences among the Levels of Education in terms of Study Measures.

In the current study, it was found that high school graduates have significantly higher anxious attachment style scores than graduate school graduates; however, both high school and graduate school graduates did not differ from university graduates. In Cooper, Shaver, and Collins's (1998) study, anxious adolescents

reported significantly lower grades and educational aspirations, and higher delinquent behaviors and substance use. Hence, anxiously attached individuals are more likely to perform poorly in academic life. In another study conducted in Turkey, elementary and high school graduates reported higher anxious attachment scores than university graduates (Durak-Batıgün, & Büyükşahin, 2008). Although this study did not include graduate level participants, in general, it may be suggested that anxious attachment might be related with lower academic competence.

The current findings suggested that high school graduates had significantly higher levels of impulse control difficulties while dealing with negative emotions (e.g., losing control over behaviors, having difficulty controlling behaviors, becoming out of control, feeling out of control) than graduate school graduates; however, both high school and graduate school graduates did not differ from university graduates. According to the literature, impulsiveness is related with absenteeism in school and academic failure (Öner et al., 2012; Shiner, 2000; Shiner, Masten, & Roberts, 2003). Thus, the participants with elevated levels of impulsiveness might not be able to enter graduate school.

4.1.4 Differences between the Levels of Marital Status in terms of Study Measures. In terms of their attachment styles, single participants were more anxious and avoidant than married participants, in the present study. This finding might be explained by the study of Latty-Mann and Davis (1996). Accordingly, individuals prefer securely attached individuals as their partners rather than anxious or avoidant ones. Thus, it is not surprising that single individuals tend to have insecure attachment styles. Moreover, couples who have insecure attachment styles, i.e., anxious and avoidant attachment styles, tend to have higher numbers of conflict (Cohn, Silver, Cowan, Cowan, & Pearson, 1992), lower levels of trust, commitment, and interdependence (Simpson, 1990), which in turn may result in break up, divorce, or multiple marriages (Ceglian & Gardner, 1999). So, even if they get married, insecurely attached individuals' relationships might last shorter.

4.1.5 Differences between the Levels of Psychological Disorder History in terms of Study Measures. Participants who reported a psychological disorder history had significantly higher anxious and avoidant attachment style scores than participants without psychological disorder history. This finding was in line with the literature. While anxious and avoidant attachment styles were related with several psychological disorders, such as eating disorders (Fonagy et al., 1996), personality disorders (Fonagy et al., 1996), depressive symptoms (Bifulco, Moran, Ball, & Bernazzoni, 2002), anxiety symptoms (Muller, Lemieux, & Sicoli, 2001), secure attachment style was related with psychological well-being (Dieperink, Leskela, Thuras, & Engdahl, 2001).

Between the levels of psychological disorder history, there was a significant difference in terms of lack of clarity about emotions, impulse control difficulties while dealing with negative emotions, non-acceptance of emotional responses, and lack of strategies while dealing with negative emotions. The participants with a history of psychological disorder had more difficulties in regulating their emotions. Similarly, the literature showed that difficulties in emotion regulation strategies are positively associated with several psychological symptoms (American Psychological Association, 1994; Gratz & Roemer, 2004; John & Gross, 2004). In another study conducted in Turkey, similar findings were revealed. Rugancı and Gençöz (2010) found that difficulties in emotion regulation strategies might be signs of several psychological disorders. These consistent findings are only correlational in nature. That is to say, it is not clear whether they suffer from psychological symptoms due to their difficulties in regulating their emotions or vice versa.

Although escape acceptance of death (i.e., death can be perceived as an escape from problems of existence, death is a welcomed alternative for painful and anguished life) was not correlated with psychological well being in the original study of death attitudes (Wong, Reker, & Gesser, 1994), in the current study participants who reported psychological disorder history had lower levels of escape acceptance than the ones without psychological disorder history. This finding is inconsistent with

the literature suggesting that individuals with psychological problems are more likely to commit suicide (Harris & Barraclough, 1997).

4.1.6 Discussion of the Hierarchical Regression Analysis. In the hierarchical regression analysis, first, participants who perform extreme sport activities were found to be engaged in more health promoting behaviors than participants who do not engage in extreme sport activities. As mentioned before, participation in extreme sport activities may make mortality awareness more salient, which in turn, might lead to higher health promoting behaviors (Taubman-Ben-Ari & Findler, 2005; Bozo, Tunca, & Şimşek, 2009). Moreover, the individuals who perform risky activities like extreme sports should take care of their health to enable themselves to perform these activities. Second, after controlling the effects of gender and extreme sport participation, participants with higher levels of anxious and avoidant attachment styles reported lower levels of health promoting behaviors. Individuals with higher leves of anxious attachment style were found to have risks of sexually transmitted diseases, unexpected pregnancies, substance abuse related disorders, and lack of exercise. Avoidantly attached individuals were reported as reluctant to seek medical help for their complaints, since they had difficulties in trusting health care professionals. This insecure attachment style was also found to be related with health comprimising behaviors such as smoking, cocaine use, alcohol use, high calorie intake, and lack of seatbelt use (Ahrens, Ciecharowski, & Katan, 2012; Feeney & Ryan, 1994). Third, after controlling for gender, extreme sport participation and attachment styles, difficulties in awareness about emotions was related with lower levels of health promoting behaviors. If participants were unaware of their actual emotions and needs, they may have difficulties in monitoring their health status, which in turn might affect their health promoting behaviors, too. Fourth, participants with higher levels of neutral acceptance of death, in other words, participants who believe that death is a natural part of life, reported less health promoting behaviors. In the original study of death attitudes, neutral acceptance was positively related with physical well-being (Wong, Reker, & Gesser, 1994). In Turkish culture, individuals were found to have higher levels of

fatalistic attitudes (Kasapoğlu & Ecevit, 2003), which might be related with lower levels of health promoting behaviors, too. Fatalistic individuals do not worry about the things that they perceive being out of their control, which may result in lower levels of risk perception (Şimşekoğlu, Nordfjærn, Zavareh, Hezaveh, Mamdoohi, & Rundmo, 2013). Since neutral acceptance might be interpreted as an attitude of not worrying about the inevitable end of life, it can also be related with fatalism and not taking the responsibility of own health. Fifth, the participants with higher approach acceptance of death attitudes reported less health promoting behaviors. Approach acceptance of death is related with the idea that there will be a happy after life, and this acceptance of death attitude is rooted in religiosity (Wong, Reker, & Gesser, 1994). Fear of death and religious beliefs are contradictory to each other in such a way that, believers tend to cope with their fear of death with the belief of symbolic immortality. If participants believe in symbolic immortality, they may not attend health promoting behaviors to deal with their mortality. Last, the participants with higher escape acceptance of death attitudes engaged in more health promoting behaviors. Individuals with higher levels of escape acceptance perceive the death as the end of existential sufferings and pain (Wong, Reker, & Gesser, 1994). Escape acceptance of death might also be perceived as an escape from physical and psychological sufferings in daily life. Thus, health promoting behaviors can be a good coping mechanism to overcome suffering and pain.

Up to now, we tried to discuss the findings of the preliminary analyses. In the following section, the findings of the main analyses will be discussed.

4.2 The Mediator Role of Difficulties in Emotion Regulation Strategies

4.2.1 The Mediator Role of Difficulties in Emotion Regulation Strategies in Participants who Engage in Extreme Sport Activities. Lack of awareness about emotions and lack of goals while dealing with negative emotions, as two of the non-adaptive emotion regulation strategies, mediated anxious attachment style–health promoting behaviors relation in extreme sport sample.

First, the individuals with higher anxious attachment characteristics were less likely to be aware of their emotions, which in turn, decreased their health promoting behaviors in extreme sport group. Contradictory to this finding, Stevens (2014) indicated that participants with high anxious attachment style characteristics were more aware of their emotions; however, they also had difficulties in clarifying their emotions. In other words, anxiously attached individuals were aware of their emotions, but they struggled in identifying, controlling, and regulating them. Our finding may also be explained by the nature of the sample. Risky behaviors and adrenaline seeking are inseparable parts of extreme sports; and they could be used by extreme sport participants to compensate for their lack of awareness of their emotions. Moreover, these participants may be in such a confused state that (in addition to being unaware of their emotions), they may not being able to monitor their psychological and physical health. Therefore, anxiously attached extreme sport participants' likelihood to perform health promoting behaviors decreases with the mediator role of lack of awareness about their intense emotions.

Second, the individuals with higher anxious attachment style were more likely to lack goals while dealing with negative emotions, which in turn, decreased their health promoting behaviors in extreme sport group. Anxiously attached individuals may stuck into their compelling emotions and preoccupy with them most of the time, they may have difficulties in concentrating, focusing on other things, getting work done, thinking about anything else (all of which are resembling lacking goals while dealing with negative emotions). Similarly, Stevens (2014) indicated that people with higher levels of anxious attachment style are more likely to let their difficult emotions disrupt their goals in daily life; including their health related goals, such as performing health behaviors.

In extreme sport group, only lack of goals while dealing with negative emotions mediated the avoidant attachment style-health promoting behaviors relation. The higher their avoidant attachment characteristics, the more they lacked goals while dealing with negative emotions, which in turn, decreased their health promoting behaviors. In extreme sport group, participants with higher levels of avoidant

attachment might have engaged in these risky activities to regulate their emotions with suppressing their emotions and becoming distant to them. In other words, since they did not face their negative emotions, they experienced difficulties in concentrating or getting work done. With the participation in extreme sports, these individuals might have defined another manageable goal and source of satisfaction in their life. Additionally, parallel with their non-adaptive strategies to cope with their negative emotions and other problems, they might have preferred to use unhealthy behaviors, rather than health promoting behaviors.

4.2.2. The Mediator Role of Difficulties in Emotion Regulation Strategies in Participants who do not Engage in Extreme Sport Activities. Lack of clarity about emotions mediated anxious attachment style-health promoting behaviors relation in participants who do not engage in extreme sport activities. An increase in anxious attachment style was associated with an increase in lack of clarity about emotions, which in turn, decreased their health promoting behaviors. It was indicated that although individuals with anxious attachment style are more aware of their emotions than individuals with avoidant attachment style, they have still problems in clarifying their emotions, an emotion regulation strategy. In other words, anxiously attached individuals are usually aware of their emotions; however, they have problems in clarifying them (Stevens, 2014). Similarly, in the current study, participants with higher levels of anxious attachment had difficulty in identifying their negative emotions. As one of their general characteristics, anxiously attached individuals experience anxiety and rumination in their relationships so extremely that they could not observe, identify or clarify their actual emotions and needs, which in turn, may interfere with their attentiveness to their health condition or health promoting behaviors.

4.3 The Mediator Role of Death Attitudes

4.3.1 The Mediator Role of Death Attitudes in Participants who Engage in Extreme Sport Activities. In extreme sport sample, approach acceptance of death mediated the anxious attachment style–health promoting behaviors relation. An

increase in anxious attachment style led to a decrease in approach acceptance of death, which in turn, increased health promoting behaviors. Approach acceptance of death is related with an attitude of happy after life that can be rooted in religiosity. Since anxiously attached individuals are characterized by feelings of anxiety, worry, and fear in their relationships and problems in regulating these feelings, they may have the same feelings towards their relation with death. It was indicated that fear of death and religious beliefs are negatively associated with each other, because believers may have a symbolic immortality, which helps them to cope with their fear of death (Wong, Reker, & Gesser, 1993). Therefore, it can be suggested that participants with higher levels of anxious attachment might have lower levels of religious beliefs, which in turn is related with lower levels of approach acceptance of death. In other words, since anxiously attached individuals do not believe in symbolic immortality, they experience fear and anxiety in relation to death, which might have directed them to increase their health promoting behaviors to live healthier and longer.

In the same sample, approach acceptance of death did also mediate the avoidant attachment style–health promoting behaviors relation. An increase in avoidant attachment style decreased approach acceptance of death, which in turn, increased health promoting behaviors. Avoidant attachment style is related with lack of feelings of security, proximity, self reliance; and emotional distance and avoidance in their relationships. Hence, these individuals may also avoid thinking about death and afterlife, which are characteristics of individuals with lower approach acceptance of death. To conclude, if an individual avoids the idea of death and afterlife, then s/he needs to make investment into this life through increasing their health promoting behaviors.

4.3.2 The Mediator Role of Death Attitudes in Participants who do not Engage in Extreme Sport Activities. Escape acceptance of death mediated avoidant attachment style–health promoting behaviors relation in participants who do not engage in extreme sport activities. A decrease in avoidant attachment style was associated with an increase in escape acceptance of death, which in turn, increased

health promoting behaviors. In higher levels of escape acceptance of death, individuals suffer from life, and death can be an alternative for them to escape from the problems of existence.

The findings mentioned in the previous paragraph were interesting. The individuals with decreased avoidant attachment style had higher escape acceptance of death; although they were not avoiding death. In fact, since they suffer in life, they see death as an escape from this suffering and pain. Still, these people prefer to confront with their suffering and pain. Since escape acceptance is viewed as an attempt to escape from this physical and psychological pain, health promoting behaviors may constitute a good solution for getting rid of sufferings of daily life for these participants. As Buddha stated "Without health life is not life; it is only a state of languor and suffering–an image of death".

4.4 Strengths and Implications

This study aimed to find the effects of attachment styles on health promoting behaviors with the mediating roles of emotion regulation strategies and death attitudes. This study was a pioneer in providing an insight into health promoting behaviors by testing mediation models including attachment styles, emotion regulation strategies, and death attitudes of individuals as predictor variables. Another novelty of the present study was testing these models in two different samples: individuals do and do not participate in extreme sport activities. The participants who engage in extreme sport activities were selected purposefully, since in health psychology literature they were considered to have high levels of health risk behaviors. However, as mentioned before, this group's health promoting behaviors were found to be higher than the ones' who do not engage in extreme sport activities.

This study included fear of death, death avoidance, and three different death acceptance types in order to enlighten the mediating role of death attitudes in attachment–health promoting behaviors relation in two different participant groups, which is again a novel contribution to Turkish psychology literature. As expected,

these death attitudes had different mediator roles for two different participant groups. While in extreme sport group approach acceptance of death mediated insecure attachment styles-health promoting behaviors relation, in the other group only escape acceptance of death mediated avoidant attachment style-health promoting behaviors relation. In other words, different death attitudes had different roles in shaping extreme vs. non-extreme group individuals' health promoting behaviors.

As another contribution to Turkish psychology literature, we found that insecure attachment styles can be regarded as risk factors for performing health behaviors. Since attachment styles are relatively permanent bonds between the children and their parents/significant others, as a prevention and intervention strategy, the information of insecure attachment styles-health promoting behavior relation can be included in the education programs aimed for especially parents of chronically ill children. Also, certain education programs or campaigns by Ministry of Health to promote positive parenting practices can be developed.

Difficulties in emotion regulation strategies were related with a decrement in health promoting behaviors. Thus, in psychotherapy practices, improvement of effective emotion regulation strategies has a vital role for not only psychological health but also for physical health through facilitating health promoting behaviors. Thus, health psychologists should not ignore working on emotions and their regulation while working with individuals who attend primary, secondary, and tertiary prevention programs.

In the group of participants who do not engage in extreme sport activities, fear of death and neutral acceptance of death were positively related with health promoting behaviors. Thus, as Bozo, Tunca, and Şimşek (2009) suggested, to promote individuals' willingness and motivation to engage in health-promoting behaviors, reminders of death can be used, especially by the campaigns organized by the Ministry of Health. Similarly, in psychotherapy practices, patients' fear of death attitudes and death acceptance styles can be discussed for the development of health promoting behaviors.

As mentioned above, health psychology literature regards extreme sport activities as one of the health risk behaviors. However in this study, participants who engage in extreme sport activities stated more health promoting behaviors than participants who do not engage in these activities. When we consider extreme group participants as athletes, it is actually not surprising that they performed higher levels of health promoting behaviors. Also, these individuals might use these activities as a way of approach strategy to cope with fear of death.

4.5 Limitations and Suggestions for Future Studies

Although further studies are needed, this study provided preliminary findings on the attachment style-health promoting relation with the mediator roles of emotion regulation strategies and death attitudes in participants who do and do not engage in extreme sport activities. Even though individuals with anxious attachment style and avoidant attachment style were examined in this study, individuals with higher levels of both anxious and avoidant attachment, i.e., fearful attachment style, were not examined. Thus, future studies should concentrate on all attachment styles, which are secure, preoccupied, dismissing, and fearful, as proposed by Bartholomew and Horowitz (1991).

In the measurement of the attitudes towards death, participants' anxiety, avoidance or acceptance towards death were measured with self report measures in an explicit way. Some perspectives in psychology literature indicated that conscious reports of death may not be reliable. For instance, terror management theory argued that people adopt different defense mechanisms when they experience death anxiety at different levels of consciousness (Arndt, Greenberg, & Cook, 2002). Therefore, in typical terror management theory experiments, participants briefly write what they think about their own mortality, and then experimenters suppress these mortality thoughts with different study designs in order to reduce conscious thoughts of death and then they collect data via death measures (Arndt, Greenberg, Solomon, Pyszczynski, & Solomon, 1998). Thus, in future studies researchers should also

include unconscious death attitudes using experimental designs, rather than solely collecting data on conscious death attitudes through self report measures.

In this study, the age range of the participants (18-40) corresponded to adulthood period of life; the data were cross-sectional in nature. To observe developmental changes in participants, and to be able to talk about cause and effect relations, future studies are suggested to use longitudinal designs rather than cross-sectional ones.

The present sample included participants engaging in different types of extreme sport activities such as base jumping, cave diving, 40 meter deep dive, kite surfing, high level mountaineering, mountain bicycling, paragliding, rallying, rafting, rock climbing, sky diving, snowboard, and multiple extreme sport activities. However, extreme sport participation may not be a single phenomenon referring to the same characteristics of active participants of extreme sport activities. Therefore, future studies may focus on different types of extreme sport activities to examine the relations investigated in the current study.

4.6 Conclusion

Different non-adaptive emotion regulation strategies mediated insecure attachment styles−health promoting behaviors relations in two groups of the current study. While lack of awareness about emotions and lack of goals while dealing with negative emotions were mediators in extreme sport sample, only lack of clarity about emotions was a mediator in anxious attachment style−health promoting behaviors relation in participants who do not engage in extreme sport activities. For extreme sport sample suffering from lack of emotional awareness, to promote their health promoting behaviors, clinical and health psychologists may attend on and care about their patients' feelings and acknowledge their emotions. For their lack of goal directed behavior while dealing with negative emotions, problem focused coping strategies can be fostered since these individuals have problems in concentration due to their compelling emotions. For participants who do not engage in extreme sport activities, clinical and health psychologists might work on making sense out of patients' feelings.

Similarly, different death attitudes mediated insecure attachment styles−health promoting behaviors relations in two groups. In extreme sport sample, approach acceptance of death mediated insecure attachment styles−health promoting behaviors relation, whereas, in participants who do not engage in extreme sport activities, escape acceptance of death mediated avoidant attachment−health promoting behaviors relation. For extreme sport participants, an attitude of happy after life might have resulted in health compromising behaviors; therefore, the importance of living healthy and longer may be stressed. In participants who do not engage in extreme sport activities, the perception that death is a welcomed alternative for painful life was found to be related with higher health promoting behaviors. Thus, health promoting behaviors can be regarded as a good solution for getting rid of sufferings of this life.

In sum, as Buddha stated 'Health is the greatest gift'. Different groups of individuals may have different paths for health compromising and promoting behaviors. Therefore, it is important to figure out these differences to promote living healthier and longer.

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APPENDICES

APPENDIX A: DEMOGRAPHIC FORM

1. Yaşınız .....

2. Cinsiyetiniz (1)Kadın (2)Erkek

3. Eğitim Durumunuz

(1) İlkokul (2) Ortaokul (3) Lise (4) Üniversite (5) Lisansüstü

4. Gelir Durumunuz/Ailenizin Gelir Durumu

(1) Düşük (2) Orta (3) Yüksek

5. Medeni Durumunuz

(1) Bekar (2) Evli (3) Boşanmış (4) Dul

6. Yaşamınızın çoğunu geçirdiğiniz yer

(1) Büyük şehir (İstanbul, Ankara, İzmir gibi) (2) Şehir (3) Kasaba (4) Köy

7. Mesleğiniz .....

8. Üniversite öğrencisi iseniz; bölümünüz .....sınıfınız.....

9. Herhangi bir extrem (uç) spor yapıyor musunuz? (1) Evet (2) Hayır

10. Cevabınız EVET ise aşağıdakilerden hangisidir?

(1) Paraşütle yüksekten atlama (2) Mağara dalıcılığı(3) 40 m sualtı dalışı
(4) Buz tırmanışı(5) Uçurtma sörfü (6) Dağ tırmanışı(7) Yamaç paraşütü
(8) Ralli (9) Rafting (10) Kaya tırmanışı (11) Motokros
(12) Hava dalışı (13) Uçurum atlayışı (14) Diğer .....

11. Herhangi bir psikolojik rahatsızlık geçirdiniz mi? (1) Evet (2) Hayır

Cevabınız EVET ise ne tür bir rahatsızlık yaşadığınızı belirtiniz.....

12. Herhangi bir fiziksel rahatsızlık geçirdiniz mi? (1) Evet (2) Hayır

Cevabınız EVET ise ne tür bir rahatsızlık yaşadığınızı belirtiniz .....

APPENDIX B: EXPERIENCES IN CLOSE RELATIONSHIPS-REVISED

Aşağıda verilen cümlelere ne ölçüde katıldığınızı **eşinizle olan ilişkinizi göz önünde bulundurarak cevaplayınız**. Her maddenin evliliğinizdeki duygu ve düşüncelerinizi ne oranda yansıttığını karşılarındaki 5 aralıklı cetvel üzerinde ilgili rakamı yuvarlak içine alarak belirtiniz. Eğer eşinizi kaybettiyseniz veya eşinizden ayrı yaşıyorsanız, aşağıdaki maddeleri **bir ilişki içinde bulunduğunuzu varsayarak cevaplayınız.** 1----------2----------3----------4----------5 Hiç katılmıyorum / Biraz katılmıyorum / Kararsızım/ fikrim yok / Biraz katılıyorum / Tamamen katılıyorum **ÖNEMLİ NOT:** Aşağıdaki cümlelerin bazılarında "yakın olmak" veya "yakınlaşmak" ifadeleri geçmektedir. Bu ifadelerle kastedilen eşinizle duygusal yakınlık kurmak, düşüncelerinizi veya başınızdan geçenleri eşinize açmak, eşinize sarılmak ve benzeri davranışlardır. Lütfen ilgili soruları bu tanıma göre cevaplayınız.	**Hiç Katılmıyorum**	**Biraz Katılmıyorum**	**Kararsızım**	**Biraz Katılıyorum**	**Tamamen Katılıyorum**
1. Eşimin sevgisini kaybetmekten korkarım.	1	2	3	4	5
2. Gerçekte ne hissettiğimi eşime göstermemeyi tercih ederim.	1	2	3	4	5
3. Sıklıkla, eşimin artık benimle olmak istemediği korkusuna kapılırım.	1	2	3	4	5
4. Özel duygu ve düşüncelerimi eşimle paylaşmak konusunda kendimi rahat hissederim.	1	2	3	4	5
5. Sıklıkla, eşimin beni gerçekten sevmediği kaygısına kapılırım.	1	2	3	4	5
6. Eşime güvenip dayanmak konusunda kendimi rahat bırakmakta zorlanırım.	1	2	3	4	5
7. Eşimin beni, benim onu önemsediğim kadar önemsemediğinden endişe duyarım.	1	2	3	4	5
8. Eşime yakın olma konusunda çok rahatımdır.	1	2	3	4	5

9. Sıklıkla, eşimin bana duyduğu hislerin benim ona duyduğum hisler kadar güçlü olmasını isterim.	1	2	3	4	5
10.Eşime açılma konusunda kendimi rahat hissetmem.	1	2	3	4	5
11.İlişkilerimi kafama çok takarım.	1	2	3	4	5
12.Eşime fazla yakın olmamayı tercih ederim.	1	2	3	4	5
13.Benden uzakta olduğunda, eşimin başka birine ilgi duyabileceği korkusuna kapılırım.	1	2	3	4	5
14.Eşim benimle çok yakın olmak istediğinde rahatsızlık duyarım.	1	2	3	4	5
15.Eşime duygularımı gösterdiğimde, onun benim için aynı şeyleri hissetmeyeceğinden korkarım.	1	2	3	4	5
16.Eşimle kolayca yakınlaşabilirim.	1	2	3	4	5
17.Eşimin beni terkedeceğinden pek endişe duymam.	1	2	3	4	5
18.Eşimle yakınlaşmak bana zor gelmez.	1	2	3	4	5
19.Eşim kendimden şüphe etmeme neden olur.	1	2	3	4	5
20.Genellikle, eşimle sorunlarımı ve kaygılarımı tartışırım.	1	2	3	4	5
21.Terk edilmekten pek korkmam.	1	2	3	4	5
22.Zor zamanlarımda, eşimden yardım istemek bana iyi gelir.	1	2	3	4	5
23.Eşimin, bana benim istediğim kadar yakınlaşmak istemediğini düşünürüm.	1	2	3	4	5
24.Eşime hemen hemen her şeyi anlatırım.	1	2	3	4	5
25.Eşimin bazen bana olan duygularını sebepsiz yere değiştirdiğini hissederim.	1	2	3	4	5
26.Başımdan geçenleri eşimle konuşurum.	1	2	3	4	5
27.Çok yakın olma arzum bazen insanları korkutup uzaklaştırır.	1	2	3	4	5
28.Eşim benimle çok yakınlaştığında gergin hissederim.	1	2	3	4	5
29.Eşim beni yakından tanırsa, “gerçek ben”i sevmeyeceğinden korkarım.	1	2	3	4	5
30.Eşime güvenip dayanmak konusunda rahatımdır.	1	2	3	4	5

31.Eşimden ihtiyaç duyduğum şefkat ve desteği görememek beni öfkelendirir.	1	2	3	4	5
32.Eşime güvenip dayanmak benim için kolaydır.	1	2	3	4	5
33.Başka insanlara denk olamamaktan endişe duyarım	1	2	3	4	5
34.Eşime şefkat göstermek benim için kolaydır.	1	2	3	4	5
35.Eşim beni sadece kızgın olduğumda önemser.	1	2	3	4	5
36.Eşim beni ve ihtiyaçlarımı gerçekten anlar.	1	2	3	4	5

APPENDIX C: DIFFICULTIES IN EMOTION REGULATION STRATEGIES

Aşağıda insanların duygularını kontrol etmekte kullandıkları bazı yöntemler verilmiştir. Lütfen her durumu dikkatlice okuyunuz ve her birinin sizin için ne kadar doğru olduğunu içtenlikle değerlendiriniz. Değerlendirmenizi uygun cevap önündeki yuvarlak üzerine çarpı (X) koyarak işaretleyiniz.

1. Ne hissettiğim konusunda netimdir.
○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

2. Ne hissettiğimi dikkate alırım.
○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

3. Duygularım bana dayanılmaz ve kontrolsüz gelir.
○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

4. Ne hissettiğim konusunda net bir fikrim vardır.
○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

5. Duygularıma bir anlam vermekte zorlanırım.
○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

6. Ne hissettiğime dikkat ederim.
○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

7. Ne hissettiğimi tam olarak bilirim.
○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

8. Ne hissettiğimi önemserim.
○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

9. Ne hissettiğim konusunda karmaşa yaşarım.
○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

10. Kendimi kötü hissettiğimde, bu duygularımı kabul ederim.
○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

11. Kendimi kötü hissettiğimde, böyle hissettiğim için kendime kızarım.
○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

12. Kendimi kötü hissettiğimde, böyle hissettiğim için utanırım.
○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

13. Kendimi kötü hissettiğimde, işlerimi yapmakta zorlanırım.
○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

14. Kendimi kötü hissettiğimde, kontrolümü kaybederim.

O Neredeyse Hiçbir zaman	O Bazen	O Yaklaşık Yarı yarıya	O Çoğu zaman	O Neredeyse Her zaman

15. Kendimi kötü hissettiğimde, uzun süre böyle kalacağıma inanırım.

O Neredeyse Hiçbir zaman	O Bazen	O Yaklaşık Yarı yarıya	O Çoğu zaman	O Neredeyse Her zaman

16. Kendimi kötü hissettiğimde, sonuç olarak yoğun depresif duygular içinde olacağıma inanırım.

O Neredeyse Hiçbir zaman	O Bazen	O Yaklaşık Yarı yarıya	O Çoğu zaman	O Neredeyse Her zaman

17. Kendimi kötü hissettiğimde, duygularımın yerinde ve önemli olduğuna inanırım.

O Neredeyse Hiçbir zaman	O Bazen	O Yaklaşık Yarı yarıya	O Çoğu zaman	O Neredeyse Her zaman

18. Kendimi kötü hissettiğimde, başka şeylere odaklanmakta zorlanırım.

O Neredeyse Hiçbir zaman	O Bazen	O Yaklaşık Yarı yarıya	O Çoğu zaman	O Neredeyse Her zaman

19. Kendimi kötü hissettiğimde, kendimi kontrolden çıkmış hissederim.

O Neredeyse Hiçbir zaman	O Bazen	O Yaklaşık Yarı yarıya	O Çoğu zaman	O Neredeyse Her zaman

20. Kendimi kötü hissettiğimde, halen işlerimi sürdürebilirim.

O Neredeyse Hiçbir zaman	O Bazen	O Yaklaşık Yarı yarıya	O Çoğu zaman	O Neredeyse Her zaman

21. Kendimi kötü hissettiğimde, bu duygumdan dolayı kendimden utanırım.

O Neredeyse Hiçbir zaman	O Bazen	O Yaklaşık Yarı yarıya	O Çoğu zaman	O Neredeyse Her zaman

22. Kendimi kötü hissettiğimde, eninde sonunda kendimi daha iyi hissetmenin bir yolunu bulacağımı bilirim.

O Neredeyse Hiçbir zaman	O Bazen	O Yaklaşık Yarı yarıya	O Çoğu zaman	O Neredeyse Her zaman

23. Kendimi kötü hissettiğimde, zayıf biri olduğum duygusuna kapılırım.

O Neredeyse Hiçbir zaman	O Bazen	O Yaklaşık Yarı yarıya	O Çoğu zaman	O Neredeyse Her zaman

24. Kendimi kötü hissettiğimde, davranışlarımı kontrol altında tutabileceğimi hissederim.

O Neredeyse Hiçbir zaman	O Bazen	O Yaklaşık Yarı yarıya	O Çoğu zaman	O Neredeyse Her zaman

25. Kendimi kötü hissettiğimde, böyle hissettiğim için suçluluk duyarım.

O Neredeyse Hiçbir zaman	O Bazen	O Yaklaşık Yarı yarıya	O Çoğu zaman	O Neredeyse Her zaman

26. Kendimi kötü hissettiğimde, konsantre olmakta zorlanırım.

O Neredeyse Hiçbir zaman	O Bazen	O Yaklaşık Yarı yarıya	O Çoğu zaman	O Neredeyse Her zaman

27. Kendimi kötü hissettiğimde, davranışlarımı kontrol etmekte zorlanırım.

○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

28. Kendimi kötü hissettiğimde, daha iyi hissetmem için yapacağım hiç bir şey olmadığına inanırım.

○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

29. Kendimi kötü hissettiğimde, böyle hissettiğim için kendimden rahatsız olurum.

○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

30. Kendimi kötü hissettiğimde, kendim için çok fazla endişelenmeye başlarım.

○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

31. Kendimi kötü hissettiğimde, kendimi bu duyguya bırakmaktan başka yapabileceğim birşey olmadığına inanırım.

○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

32. Kendimi kötü hissettiğimde, davranışlarım üzerindeki kontrolümü kaybederim.

○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

33. Kendimi kötü hissettiğimde, başka bir şey düşünmekte zorlanırım.

○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

34. Kendimi kötü hissettiğimde, duygumun gerçekte ne olduğunu anlamak için zaman ayırırım.

○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

35. Kendimi kötü hissettiğimde, kendimi daha iyi hissetmem uzun zaman alır.

○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

36. Kendimi kötü hissettiğimde, duygularım dayanılmaz olur.

○ Neredeyse Hiçbir zaman ○ Bazen ○ Yaklaşık Yarı yarıya ○ Çoğu zaman ○ Neredeyse Her zaman

APPENDIX D: DEATH ATTITUDE PROFILE-REVISED

Bu soru formu ölüm hakkında farklı tutumlara ilişkin çeşitli ifadeler içermektedir. Her bir ifadeyi dikkatle okuyarak katılma ya da katılmama yönündeki kararınızı yandaki 7 dereceli ölçek üzerinde belirtiniz. Örneğin bir madde yer alan "Ölüm bir arkadaştır" ifadesine ne kadar katılıp ya da katılmadığınızı sıralanan seçenekler içerisinden size uygun olanı (X) işaretleyiniz. Ölçeğin "tamamen katılıyorum" yani 7'den dan "kesinlikle katılmıyorum"a yani 1'e doğru ilerlediğine dikkat ediniz. Ancak kararsızlık kategorisini mümkün olduğunca az işaretlemeye çalışınız. Lütfen hiçbir cümleyi atlamamaya ve tek bir seçeneği işaretleyerek değerlendirmeye özen gösteriniz. İfadeler birbiri ile aynı görülebilir fakat her biri küçük de olsa bazı farklılıklar içermektedir.

	7	6	5	4	3	2	1
1.Ölüm şüphesiz acı bir deneyimdir.							
2.Kendi ölme ihtimalim bende kaygı yaratır.							
3.Ne olursa olsun ölümü düşünmekten kaçınırım.							
4.Öldükten sonra cennete gideceğime inanıyorum.							
5.Ölüm tüm sıkıntılarıma son verecektir.							
6. Ölüm doğal, inkar edilemez ve kaçınılmaz bir olay olarak görülmelidir.							
7. Ölümle yok oluş beni huzursuz ediyor.							
8. Ölüm, sonsuz memnuniyet verici bir yere giriştir.							
9. Ölüm, bu berbat dünyadan kaçışı sağlar.							
10. Ölüm düşüncesi her aklıma geldiğinde kafamdan uzaklaştırmaya çalışırım.							
11. Ölüm, acı ve ızdıraptan kurtuluştur.							
12.Sürekli ölümü düşünmemeye çalışırım.							

13. Cennetin bu dünyadan daha iyi bir yer olduğuna inanıyorum.							
14. Ölüm hayatın doğal bir parçasıdır.							
15. Ölüm tanrıya kavuşma ve ebedi bir huzurdur.							
16. Ölüm yeni ve harika bir hayatı vaad eder.							
17. Ölümden ne korkarım ne de onu beklerim.							
18. Yoğun bir ölüm korkum var.							
19. Ölüm hakkında düşünmekten tamamen kaçınırım.							
20. Ölümden sonra hayat konusu beni fazlasıyla rahatsız eder.							
21. Ölümün herşeyin sonu olacağı anlamına gelmesi gerçeğini bilmek beni korkutur.							
22. Öldükten sonra sevdiklerimle bir araya gelmeyi bekliyorum.							
23. Ölümü dünyevi ızdıraptan kurtuluş olarak görürüm.							
24. Ölüm, basit bir anlatımla yaşam sürecinin bir parçasıdır.							
25. Ölümü sonsuz ve kutsal bir yere geçiş olarak görürüm.							
26. Ölüm konusuna yönelik bir şey yapmamaya çalışırım.							
27. Ölüm ruha harika bir özgürlük sağlar.							
28. Ölüm ile yüzleşmemde bana rahatlık veren tek şey ölümden sonraki hayata olan inancımdır.							
29. Ölümü bu dünyanın yükünden kurtuluş olarak görürüm.							
30. Ölüm, ne iyi ne de kötüdür.							
31. Ölümden sonraki hayatı özlemle bekliyorum.							
32. Ölümden sonra ne olacağını bilmemenin yarattığı belirsizlik beni kaygılandırıyor.							

APPENDIX E: HEALTH PROMOTING LIFESTYLE PROFILE-REVISED II

SAĞLIKLI YAŞAM DAVRANIŞLARI ÖLÇEĞİ

Bu anket şu andaki yaşam şekliniz ve kişisel alışkanlıklarınızla ilgili cümlelerden oluşmaktadır. Lütfen her bir soruyu doğru bir şekilde cevaplandırınız ve tüm maddeleri cevaplandırmaya özen gösteriniz. Gerçekleştirdiğiniz davranışların hangi yoğunlukta olduğunu belirtmek için 1 ile 4 arasındaki ölçekten size uygun olanı işaretleyiniz.

1= Hiçbir zaman, **2**= Bazen, **3**= Çoğu zaman, **4**= Her zaman

		Hiçbir zaman	Bazen	Çoğu zaman	Her zaman
1	Sorunlarımı ve endişelerimi bana yakın insanlarla paylaşırım	1	2	3	4
2	Az yağlı, doymuş yağ oranı ve kolestrol oranı düşük besinler tercih ederim.	1	2	3	4
3	Kendimde olağandışı bir belirti ya da sempton gördüğümde doktora yada sağlık uzmanına başvururum.	1	2	3	4
4	Düzenli olarak spor yaparım.	1	2	3	4
5	Yeteri kadar uyurum	1	2	3	4
6	Olumlu yönde değiştiğimi ve geliştiğimi hissediyorum.	1	2	3	4
7	Diğer insanlar başarılarından dolayı rahatlıkla överim.	1	2	3	4
8	Şeker ve şekerli yiyeceklerin tüketimini kısarım.	1	2	3	4
9	Sağlıklı yaşam hakkında okur ya da tv programları izlerim.	1	2	3	4
10	Haftada en az 3 kere 20 ya da daha fazla dakika güce dayalı egzersiz yaparım (tempolu yürüyüş, bisiklet, aerobik gibi...)	1	2	3	4
11	Hergün rahatlama ve gevşeme egzersizlerine vakit ayırırım.	1	2	3	4
12	Hayatımın bir amacı olduğuna inanıyorum.	1	2	3	4
13	Insanlarla anlamlı ve tatmin edici ilişkilerim vardır.	1	2	3	4
14	Hergün toplamda 6-11 porsiyon (500-1000 gram) ekmek, tahıl, pirinç ya da makarna tüketirim.	1	2	3	4
15	Söylediklerini anlamadığımda doktoruma sorular sorarım.	1	2	3	4
16	Hafif ile orta zorlukta fiziksel aktivite yaparım (Örneğin haftada 5 gün veya daha fazla 30-40 dakikalık yürüyüşler).	1	2	3	4
17	Hayatımda değiştiremeyeceğim şeyleri kabullenirim.	1	2	3	4

		Hiçbir zaman	Bazen	Çoğu zaman	Her zaman
18	Geleceğe umutla bakarım.	1	2	3	4
19	Yakın arkadaşlarımla vakit geçiririm.	1	2	3	4
20	Hergün 2-4 adet meyve yerim.	1	2	3	4
21	Doktorumun tavsiyesi hakkında şüphem varsa ikinci bir uzman görüşü alırım.	1	2	3	4
22	Boş zamanlarımda eğlenceli (yüzme, dans, bisiklet gibi) fiziksel aktivitelerde bulunurum.	1	2	3	4
23	Uyku zamanı güzel düşüncelere konsantre olurum.	1	2	3	4
24	Kendimden hoşnut ve huzurluyum.	1	2	3	4
25	İlgimi sevgimi ve yakınlığımı başkalarına kolaylıkla gösterir	1	2	3	4
26	Hergün 1-3 tabak sebze yerim.	1	2	3	4
27	Sağlığımla ilgili merak ettiklerimi doktorlarla konuşurum.	1	2	3	4
28	Haftada en az 3 kez esneme egzersizleri yaparım.	1	2	3	4
29	Stresimi kontrol etmek için özel yöntemler kullanırım.	1	2	3	4
30	Hayatımdaki uzun vadeli planları gerçekleştirmek için çalışır	1	2	3	4
31	Önemsediğim insanlara yakınlık gösterir ve onlardanda yakınlık görürüm.	1	2	3	4
32	Hergün toplamda yarım ile bir kilo arasında süt, yoğurt veya peynir tüketirim.	1	2	3	4
33	Vucudumda tehlike göstergesi olabilecek fiziksel değişiklikle farkedebilmek için ayda en az 1 kere vucudumu incelerim.	1	2	3	4
34	Günlük aktivitelirim sırasında egzersiz yaparım (asansöre binmek yerine merdiven çıkmak, öğle tatilinde yürümek, arabamı gideceğim yerden uzağa park edip yürümek gibi...).	1	2	3	4
35	İş ve eğlenceye dengeli vakit ayırırım.	1	2	3	4
36	Hergünü ilginç ve ilgi çekici bulurum.	1	2	3	4
37	Duygusal yakınlık ihtiyaçlarımı karşılamanın yollarını bulurum.	1	2	3	4
38	Hergün sadece 2-3 tabak (150-225 gram) et, tavuk, balık, kuru fasulye, yumurta ve fındık fıstık yerim.	1	2	3	4
39	Kendime daha nasıl iyi bakabileceğim konusunda doktorumdan bilgi isterim.	1	2	3	4

		Hiçbir zaman	Bazen	Çoğu zaman	Her zaman
40	Spor yaparken nabzımı ölçerim.	1	2	3	4
41	Hergün 15- 20 dakika gevşeme egzersizleri ya da meditasyon yaparım.	1	2	3	4
42	Hayatımda benim için nelerin önemli olduğunun farkındayım	1	2	3	4
43	Beni önemseyen insanlardan destek alırım.	1	2	3	4
44	Paketli yiyeceklerin üzerindeki besin, yağ ve sodyum oranlarını öğrenmek için etiketlerini okurum.	1	2	3	4
45	Kişisel sağlık bakımı ile ilgili eğitici programlara katılırım.	1	2	3	4
46	Egzersiz yaparken hedeflediğim nabza ulaşırım.	1	2	3	4
47	Yorulmamak için gün içindeki hızımı ayarlarım.	1	2	3	4
48	Benden daha yüce bir varlığa bağlı olduğumu hissediyorum.	1	2	3	4
49	Başkalarıyla olan anlaşmazlıklarımı, tartışarak veya uzlaşarak çözerim.	1	2	3	4
50	Kahvaltı ederim.	1	2	3	4
51	Gerekli olduğunda öğüt veye danışmanlık almaya çalışırım.	1	2	3	4
52	Yeni deneyimlere ve beni geliştirecek şeylere açığımdır.	1	2	3	4

APPENDIX F: CURRICULUM VITAE

ECE (TATHAN) BEKAROĞLU

Date of Birth: 08.10.1987

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Educational Background:

2010−2015 Ph.D. after Bachelor's Degree, Middle East Technical University (METU), Institute of Social Sciences, Clinical Psychology Ph.D. Program

2005−2010 B.S., Middle East Technical University (METU), Department of Psychology

Degrees and Honors:

Middle East Technical University, Department of Psychology, High Honor Student, 2006−2010

Turkish Psychological Association, 'Research Competition for Young Psychologists', 1st Research, 2010

The Scientific and Technological Research Council of Turkey, BİDEB 2211, Graduate Scholarship Program, 2010−2015

Internships and Work Experience:

04/2014−present: Middle East Technical University, Research Assistant

10/2012−04/2014: Gazi University, Research Assistant

09/2011−09/2015: Middle East Technical University, Ayna Clinical Psychology Unit, Clinical Psychologist

01/2012−05/2012: Ankalife Kadın Sağlığı ve Tüp Bebek Merkezi, Clinical Psychologist Intern

08/2011: Ankara Muharebe ve Bilgi Sistemleri Destek Komutanlığı Psikolojik Danışma Merkezi, Psychologist

02/2011−06/2011: Ankara Numune Eğitim ve Araştırma Hastanesi I. Psikiyatri Kliniği, Psychologist Intern

08/2009: Ankara Gülhane Askeri Tıp Akademisi (GATA) Ruh ve Sinir Hastalıkları Anabilim Dalı Başkanlığı Yetişkin Servisi, Psychologist Intern

07/2008−09/2008: Gazi Üniversitesi Tıp Fakültesi Psikiyatri Anabilim Dalı, Psychologist Intern

Publications:

Tathan, E. (2014). Winnicott'ın nesne ilişkileri kuramı ile somatoform bozuklukların incelenmesi: Ağrı bozukluğu vakası. *Ayna Klinik Psikoloji Dergisi, 1*(3), 17−28.

Bozo, Ö., Tathan, E., & Yılmaz, T. (2014). Does perceived social support buffer the negative effects of Type C personality on quality of life of breast cancer patients? *Social Indicators Research,* 119(2), 791−801. doi: 10.1007/s11205-013-0503-8.

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Conference Presentations:

Önel-Kızıl, T., Demirbaş, H., Baştuğ, G., Kırıcı, S., Tathan, E., Kasmer, N., & Başkak, B. (2013). A Scale for the Assessment of Hyperfocusing in Attention Deficit and Hyperactivity Disorder, 26th European College of Neuropsychopharmacology.

Gençöz, F., Topcu, M., & Tathan, E. (2012). Kişilik, Başa Çıkma Yolları ve Duygular ile Film Seçimleri Arasındaki İlişki, 17. Ulusal Psikoloji Kongresi Özet Kitabı, 151.

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Yılmaz, T., Tathan, E., & Bozo, Ö. (2010). C Tipi Kişiliğin Meme Kanseri Hastalarının Yaşam Kaliteleri Üzerine Etkisi: Algılanan Sosyal Desteğin Biçimleyici Rolü, 16. Ulusal Psikoloji Kongresi Kongre Özet Kitabı, 49—50.

Baştürk, Ö., Tathan, E., Tekin, C., & Yılmaz, T. (2009). Üniversite Öğrencilerinde Mükemmeliyetçiliğin Ölçülmesi: Nasıl Ölçek Geliştirilir?, 14. Ulusal Psikoloji Öğrencileri Kongresi Kongre Bildiri Özetleri Kitabı, 38—39.

Association Memberships:

2010-present: Turkish Psychological Association, Membership

APPENDIX G: TURKISH SUMMARY

BÖLÜM 1

GİRİŞ

Geçmişte, ölümün temel sebebi tüberküloz, ishal ve verem gibi enfeksiyon rahatsızlıkları olmasına rağmen, 1900'lerin başlarından itibaren, sebep kalp rahatsızlıkları, kanser ve diyabet gibi kronik rahatsızlıklar olmaya başladı (Brannon ve Feist, 2007). Günümüzde, tüm dünyada ölüm oranlarının %60'ının sebebi kalp rahatsızlıkları, kanser, kronik solunum rahatsızlıkları, diyabet ve felç gibi kronik rahatsızlıklardır (World Health Organization, 2015). Kronik rahatsızlıklar sağlıksız yaşam biçimleri ve davranışları ile güçlü bir şekilde ilişkili olduğu için, kişiler kronik rahatsızlıklardan korunmak için sağlık davranışlarını artırabilirler.

1.1 Sağlık Davranışları

Sağlık davranışları, kişinin farklı çevresel koşullara entegre olabilmesi için iyilik ve sağlıklı olma halini devam ettirerek, gerçek insan potansiyeline ulaşabilme amacıyla yaptığı aktivitelerdir (Pender, Murdaugh, ve Parsons, 2006). Sağlık davranışları kendini gerçekleştirme, sağlık sorumluluğu, egzersiz, iyi beslenme, kişiler arası destek ve stres yönetimi gibi çok boyutlu bir yapıya sahiptir (Walker, 1987). Bazı sağlık davranışları düzenli sağlık kontrolü, yılda bir diş temizliği yaptırma, dişleri günde iki kez fırçalama, vitamin ve mineral destekleri alma, düzenli olarak kahvaltı yapma, günde üç öğün yemek yeme, egzersiz yapma ve iyi öz bakıma sahip olmayı içerir (Scharfe ve Eldredge, 2001). Koroner kalp hastalığı ölümün başlıca sebeplerinden biridir ve sigara içme, aktif olmayan yaşam biçimi ve sağlıksız

beslenme ile ilişkilidir. Koroner kalp hastalığının risklerini azaltabilmek için, kişiler sigara içmeyi bırakabilir, sağlıklı ve düşük kolestrollü gıdalarla beslenebilir, düzenli olarak egzersiz yapabilir ve gerektiğinde medikal tedavi alabilirler. Bu yüzden daha önce de bahsedildiği gibi, sağlık davranışlarında bulunarak kendimizi kronik rahatsızlıklardan koruyabiliriz.

Her ne kadar sağlık davranışlarında bulunma konusunda bir artış olsa da, kişilerin sağlık davranışlarında ve sağlığa riskli davranışlarda bulunma durumlarında değişiklikler vardır (Fardy ve ark., 1995). Sağlığa riskli olan davranışlar, yara ve hastalık riskini artıran kişisel davranışlar olarak tanımlanır (Steptoe ve Wardle, 2004). Sağlığa riskli davranışlar sigara içme, alkol tüketme, yasal olmayan ilaçlar ve uyuşturucular kullanma, emniyet kemeri takmadan araç kullanma, fast food tüketme, aşırı kilolu veya aşırı zayıf olmayı içerir (Scharfe ve Eldredge, 2001). Kişilik özellikleri sağlık davranışlarında ve sağlığa riskli davranışlarda merkezi bir role sahip olduğu için, araştırmacılar farklı gruplarda çeşitli psikolojik değişkenleri çalışarak bu davranışların çeşitliliğini belirlemeye çalışmışlardır.

1.2 Bağlanma Stilleri

Sağlık davranışları ile ilişkili bulunan bir psikolojik değişken kişilerin bağlanma stilleridir. Bağlanma, çocuk ile bakım veren kişi arasındaki sürekli ve kalıcı bir bağ olarak tanımlanmıştır. Bu yüzden, çocuk özellikle de stresli zamanlarda bakım veren kişinin yakınlığını arar (Thompson, 2002). Bowlby'e göre, bütün bebekler kendilerine bakım veren figür ile yakınlık ve seçici bir bağ kurmaya yatkındır (1958, 1969, 1973, 1980). Ainsworth ve çalışma arkadaşları, 12-18 aylık çocukların birincil bağlanma figürlerinden ayrıldığında yaptıklarını gözlemleyebilmek için 'Yabancı Durum Deneyi'ni geliştirmişlerdir. Bu deneyde çocuk kendisine yabancı olan araştırmacı ile aynı odada kalır ve bir süre sonra birincil bağlanma figürü bulundukları odaya gelir (Ainsworth & Bell, 1970). Bu süreçten sonra, araştırmacılar çocukları güvenli, kaygılı ve kaçıngan olarak üç kategoriye ayırdılar. Bağlanma figürü odada olmadığında güvenli çocuk etrafı keşfetmeye çalışmış ve araştırmacı ile iletişim kurmuştur ayrıca bağlanma figürü içeri girdiğinde ona

mutluluğunu göstermiş ve yaşadıklarını paylaşmaya çalışmıştır. Ancak, kaygılı bağlanan çocuklar kaygılanmış, araştırmacı ile kısıtlı bir iletişim kurmuş, çevreyi keşfetmek istememiş ayrıca bağlanma figürü yanına geldiğinde rahatlayamamıştır. Bunun yanı sıra kaçıngan bağlanan çocuklar, birincil bağlanma figüründen ayrıldıklarında etkilenmemişler, araştırmacı ile iletişim kurmamışlar ve bağlanma figürü geri döndüğünde ilgi göstermemişlerdir.

Bağlanma stillerinin yaşam boyu sabit olması Hazan ve Shaver (1987) tarafından çalışılmıştır. Kişilerin romantik ilişkilerdeki bağlanma stillerinin çocukluktaki bağlanma stilleri ile sabit olduğunu belirtmişlerdir. Çocuklara benzer olarak, yetişkinler stresli zamanlarında duygularını regüle edebilmek, destek ve ilgi alabilmek için yeni bağlanma figürü olan partnerlerini aramaktadırlar.

Literatürde, romantik ilişkisi olan güvenli bağlanan kişilerin sağlık davranışlarında bulunduğu ve semptomlarını hakkında konuştuğu, ancak güvensiz bağlanan kişilerin daha fazla sağlığa riskli davranışlarda bulunduğu gözlemlenmiştir (Pietromonaco, Uchino, ve Schetter, 2013; Savada, Busseri, Molnar, Perrier, ve DeCourville, 2009; Scharfe ve Eldredge, 2001). Örneğin kaygılı bağlanan kişilerin semptomlarını oldukça sık belirttikleri ve sağlık hizmetlerini kullanma oranlarının diğer bağlanmalara göre daha fazla olduğu rapor edilmiştir. Bu kişilerin cinsel ilişki ile bulaşan hastalıklara, beklenmeyen gebeliklere, madde kullanımı ile ilişkili rahatsızlıklara yatkın oldukları ve daha az spor yaptıkları belirtilmiştir. Öte yandan, kaçıngan bağlanan kişilerin profesyonel sağlık hizmeti sağlayanlara güvenmedikleri için, şikayetleri olsa da sağlık yardımı almaktan uzak durdukları; bu yüzden de hastane randevularını kaçırdıkları ve belirtilen tedavilere uymadıkları söylenmiştir. Kaçıngan bağlanan kişiler, ayrıca sigara kullanma, kokain kullanma, aşırı alkol kullanımı, yüksek kalorili beslenme ve emniyet kemeri kullanmama gibi sağlığa riskli davranışlar sergilemektedirler (Ahrens, Ciecharowski, Katan, 2012; Feeney ve Ryan, 1994). Kısaca, çocuk ile bakım veren kişi arasında gelişen bağlanma, kişilerin sağlık davranışları ile ilişkili bulunmuştur.

1.3 Duygu Regülasyonu

Kişilerin duygu regülasyon stratejilerinin de sağlık davranışları ile ilişkili olduğu bulunmuştur. Duygu regülasyonu, duyguların sıklığı, yoğunluğu ve süresi ile ilgili olarak kişisel farklılıklar olarak tanımlanır (Oatley, Keltner, ve Jenkins, 2006). Gross'a göre (2002), duygu regülasyonu, duygusal deneyimlerin sıklığını, yoğunluğunu ve süresini regüle edebilmek için duygusal reaksiyonları değiştirebilme ve bunlarla baş etme stratejileri anlamına gelir. Gratz ve Roemer (2004) duygu regülasyonu zorluklarını bazı yapılar ile belirtmişlerdir: duyguların net olmaması, duyguları anlamama ve farkında olmama, zorlu duygularla karşılaşınca davranışı kontrol etmede dürtüsel olma, olumsuz duyguları kabul etmeme, duyguları regüle edebilme için sağlıklı stratejileri az kullanma ve olumsuz duyguları yaşarken amaçlara ulaşmada güçlük yaşama.

Pennebaker (1993, 1995) duyguların bastırılmasının, stresi ve ruminatif düşünceleri artırdığını ve kümülatif stres ve ruminatif düşüncenin, stresle ilişkili rahatsızlıklara yatkınlığa sebep olduğunu bulmuştur. Bu durumda olumlu duygusal işlevsellik sadece duygusal sıkıntıların yok olmasını sağlamaz aynı zamanda çevrenin taleplerini karşılamamızı sağlayarak fiziksel sağlığımızı olumlu yönde etkiler. Literatürde, duygularını sözel olarak ya da yazıyla ifade etmek gibi duygusal olarak kendini açığa vurmanın sağlık üzerinde olumlu etkileri olduğu bulunmuştur (Consedine, Magai, & Bonanno, 2002; Appleton & Kubzansky, 2014). Özellikle, ilk defa kalp krizi geçirmiş hastaların, duygularını yazıya döktüklerinde ilaca daha az ihtiyaç duydukları, düşük tansiyon, daha az kardiyolojik semptom deneyimledikleri ve daha az doktor randevusu aldıkları gözlemlenmiştir (Willmott, Harris, Gellaitry, Cooper, & Horne, 2011). Duygu regülasyonu stratejileri ve kardiyolojik rahatsızlıklar gibi, kanserin de aleksitimi olarak bilinen bir duygu regülasyonu zorluğu ile ilişkili olduğu bilinmektedir (Temoshok, 1987).

Duygu regülasyonu stratejileri ve bağlanma arasındaki ilişki incelendiğinde, güvenli bağlanan kişilerin olumsuz duygularını bastırmadıkları, bunun yerine duygularının farkına varma, problem çözme, sosyal destek arama ve çökkünlük göstermeden

zorlayan anıları hatırlayabilme gibi aktif duygu regülasyon stratejileri kullandıkları belirtilmiştir (Mikulincer & Orbach, 1995). Kaçıngan bağlanan kişilerde duygular bastırıldığı için (özellikle korku, kızgınlık, utanç, suçluluk, üzüntü gibi tehdit ve kırılganlık ile ilişkili duygular), onlarla baş etmek yerine, zorlayan duygular, olaylar ve hatıralardan kaçındıkları dile getirilmiştir (Mikulincer, Shaver, & Pereg, 2003; Shaver & Mikulincer, 2002). Kaygılı bağlanan kişilerin ise yaşadıkları kaygı ve stresi, yaşadıkları olaylar hakkında ruminasyon yaparak, duygu odaklı baş etme stratejileri kullanarak, ayrılma sinyallerine karşı aşırı hassas olarak ve başkalarının desteği olmadan problemlerinin üstesinden gelemeyeceklerini düşünerek, duygularını regüle etmeye çalıştıkları söylenmiştir (Mikulincer, Shaver, & Pereg, 2003; Shaver & Mikulincer, 2002).

Özetle, etkili duygu regülasyon stratejilerinin sağlıklı beslenme ve fiziksel aktiviteye olumlu etkileri olduğu ancak duygu regülasyonundaki zorlukların yaşanan semptomu tanıyamama, sağlık problemleri hakkında konuşurken sorun yaşama, sosyal destek almama, sağlık taramaları yaptırmama ve tedaviye uymama konusunda olumsuz etkileri olduğu belirtilmiştir. Bağlanma stillerine göre ise, güvenli bağlanan kişilerin sağlıklı duygu regülasyon stratejileri kullandıkları ancak güvensiz bağlanan kişilerin adaptif olmayan duygu regülasyonu stratejileri kullandıkları açıklanmıştır.

1.4 Ölüm Tutumu

Ölüm araştırmaları alanında en çok çalışılan konulardan biri evrensel bir kavram olan ölüm korkusu ya da ölüm kaygısıdır. Varoluşçu bakış açısına göre, kişiler hayatlarında bir anlam bulmaya çalışırlar ve ölüm bu anlam bulma çabasına bir engeldir; ancak kişinin hayatına bir anlam bulması ölüm korkusunu azaltır (Frankl, 2009). Literatürde, ölüm korkusunun sebepleri kendiliği kaybetme, ölümün bilinmez yapısı, acı çekmeden korkma, geride kalan aile üyelerine ilişkin kaygılar, ilişkileri düzeltmek için olanakları kaybetme ve ölüme karşı hissedilen yetersizliktir (Feifel & Branscomb, 1973; Fry, 1990; Wass, Berardo, & Neimeyer, 1988). Ölümden sonra yaşama inananların ve inançsız olanların, din konusunda net

olmayanlara göre daha az ölüm korkusu yaşadıkları belirtilmiştir (Wong, Reker, & Gesser, 1993). Bunun yanı sıra, kişiler ölüm korkusunu azaltabilmek için, ölüm hakkında düşünmek ve konuşmaktan vazgeçebilirler (Wong, Reker, & Gesser, 1993). Bu sebeple, ölümden kaçınma, ölümle ilgili düşünceleri bilinç düzeyinden uzaklaştırmak için kullanılan bir savunma mekanizmasıdır.

Ölüm korkusu, ölümden kaçınma ve ölümü kabul birbirleriyle ilişkili kavramlardır, birbirlerinin zıttı değildir, bir harmoni içinde birlikte var olurlar (Feifel, 1990). Ölümü kabul, kaçınılmaz ve reddedilmez olan yaşamın sonuna psikolojik bir hazırlıktır (Kübler-Ross, 1969, 1981). Wong, Reker ve Gesser'in (1993) çalışmasına göre üç farklı ölümü kabul tarzı vardır. Nötr kabul, ölümü yaşamın sonundaki değiştirilemez bir gerçeklik olarak görme, ölümü ne korku ne de bir memnuniyetle karşılama ve yaşam süresince elinden gelenin en iyisini yapabilmektir. Yaklaşan kabul, kökeni dinde olan, ölümden sonra mutlu bir hayatın olacağına inanmaktır. Dindar kişilerin ölümden sonraki hayata inandıkları ve diğer kişilere göre daha fazla yaklaşan kabul sergiledikleri bulunmuştur. Kaçış kabulü ise ölümü acı çekilen bir hayattan kaçış ve bir seçenek olarak görmektir. Eğer bir kişi hayatında acı çekiyorsa, ölüm varoluşun problemlerinden kaçışa yardımcı olabilir.

Kişilerin ölüm tutumlarının fiziksel sağlığın iyileştirilmesi ve sağlık geliştirici davranışların gerçekleştirilmesi ile ilgili olduğu belirtilmiştir. Ölümlü olmanın farkındalığı kişinin fiziksel sağlığını iyileştirmeye motive edebilir (Vail ve ark, 2012). Benzer şekilde kişiler sağlık geliştirme davranışlarının ölüm riskini azalttığını fark ederlerse, bu davranışları gerçekleştirme ihtimalleri artar (Knight & Elfenbein, 1996).

Bağlanma stillerinin kişilerin ölüm tutumları ile ilişkili olduğu dile getirilmiştir. Örneğin, güvenli bağlanan kişilerin, kaygılı ve kaçıngan bağlanan kişilere göre daha az ölüm korkusu deneyimledikleri gözlemlenmiştir (Mikulincer ve ark., 1990). Mikulincer ve Florian'ın (2000) başka bir çalışmasında ise, kaçıngan bağlanmış kişilerin diğer bağlanma stillerine sahip kişilere göre daha az ölüm korkusu deneyimledikleri belirtilmiştir. Bu kişiler bastırma ve inkar gibi savunma

mekanizmalarını daha sık kullandıkları için ölüm korkusunun ifadesi azalıyor olabilir.

Özetle, ölümü kabul fiziksel sağlığın iyileştirilmesi, tıbbi tedavilere uyulması, egzersiz ve sigara içmeme ile ilişkili bulunmuştur (Arndt, Schimel, & Goldenberg, 2003; Arndt ve ark., 2011; Martin & Salovey, 1996). Fakat ölüm korkusu ya da ölüm kaygısının sağlık davranışlarını olumsuz olarak etkilediği belirtilmiştir (Knight & Elfenbeim, 1996). Bağlanma stillerine göre, güvenli bağlanan kişiler daha az ölüm korkusu deneyimlemektedirler. Kaygılı kişiler ise bastırma ve inkar gibi savunma mekanizmalarını kullandıklarında daha az seviyede ölüm korkusu rapor edebilirler.

1.5 Ekstrem Sporlar

Tehlikeli ya da ekstrem sporlar yapan kişiler sağlık psikolojisi literatürüne göre sağlığa riskli davranışlarda bulunmaktadırlar (Willig, 2008). Ekstrem sporlar, bir hatanın ya da yanlış bir davranışın ölüm ya da sakatlık ile sonuçlandığı aktivitelerdir (Brymer, 2005). Bazı ekstrem spor aktiviteleri yamaç paraşütü, uçaktan atlama, yüksek seviye dağ tırmanışı, 40 metre su altı dalışı, mağara dalışı, buz tırmanışı, uçurtma sörfü, ralli, rafting, kaya tırmanışı, hava dalışı ve rüzgar sörfüdür (Celsi, Rose, & Leigh, 1993).

Geleneksel bakış açısına göre, ekstrem sporlara katılım risk alma ve adrenalin arayışı ile ilişkilidir. Katılımcılar risk almaları ve ölüm arzuları sebebiyle psikolojik bir patoloji sergiliyor olarak belirtilmiştir (Brymer & Oades, 2009). Ancak, diğer çalışmalarda ekstrem spor yapanların doğa ile olumlu ilişkileri olduğu ve bu aktiviteler sayesinde doğayla bir hissettikleri (Brymer, Downey, & Gray, 2009), cesaretli oldukları ve ölüm korkuları ile yüzleştikleri (Brymer & Oades, 2009) söylenmiştir.

Ekstrem spor yapanlar ve bağlanma stilleri ile ilgili bir literatür bulunmamasına rağmen, stresli spor aktivitelerine katılanların bu aktivitelerdeki zorluk ve

belirsizliklerle kendi bağlanma sistemleri ile baş ettikleri gözlemlenmiştir (Forrest, 2008).

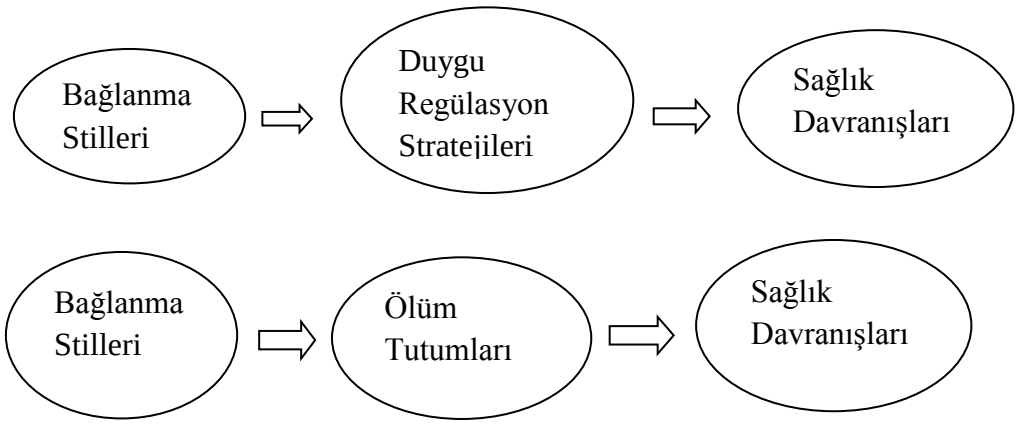
Duygu regülasyonu stratejileri açısından ise, duygularını tanımlama ve sağlıklı bir şekilde ifade etme yerine zorluklar yaşadıkları ifade edilmiştir (Woodman ve ark., 2008). Brymer ve Schweitzer ise (2013), ekstrem spor katılımcılarının genel popülasyona göre daha az kaygılı olduklarını, yaşadıkları zorlu duygularla kaçınarak değil yüzleşerek baş ettiklerini söylemiştir. Duygusal istikrar açısından riskli spor yapan kişilerin yapmayanlara göre daha istikrarlı oldukları, sakin ve dengede kalabildikleri bulunmuştur (Kajtna, Tusak, Baric, & Burnic, 2004).

Ekstrem sporlarda ölüm bir ihtimaldir ancak çoğu katılımcı en kötü senaryo yerine an'a odaklandıklarını belirtmişlerdir (Willig, 2008). Brymer ve Schweitzer (2013) ekstrem spor katılımcılarının, ölümün doğasını ve kaçınılmaz oluşunu kabul ettiklerini ifade etmişlerdir. Ancak çoğu çalışmada ölüme maruz kalınan mesleklerde diğer mesleklere göre daha yüksek seviyede ölüm korkusu ya da ölüm kaygısı olduğu belirtilmiştir, örneğin hemşireler (Meisenhelder, 1994), polis ve itfaiyeciler (Hunt, Lester, & Ashton, 1983), intihar hattı çalışanları (Neimeyer & Dingemans, 1980).

Kısacası, sağlık psikolojisi literatüründe ekstrem sporla uğraşmak sağlığa ilişkin risk içerdiği için sağlıklı bir davranış olarak değil psikolojik bir patoloji olarak görülebilir. Ancak yakın zamanlardaki çalışmalarda bu spor katılımcılarının doğayla daha barışık oldukları, cesur ve duygularıyla yüzleşen kişiler oldukları belirtilmiştir. Duygu regülasyonu açısından duygularını tanımlama ve ifade etme konusunda zorluklar yaşadıkları, korku ve kaygı gibi duygularla baş ederken etkili yollar kullanamadıkları söylenmiştir. Bu grubun ölüm tutumları, ölüm korkusu ve ölüm kabulü açısından literatürde birbiriyle çelişen sonuçlar bulunmuştur.

1.6 Çalışma

Bu çalışmanın amacı bağlanma stilleri, duygu regülasyon stratejileri, ölüm tutumları ve bunların olası etkilerinin sağlık davranışları ile ilişkilerini, ekstrem spor yapan ve yapmayan katılımcılarda araştırmaktır.



Figür 1. Çalışmanın Önerilen Modeli
Not. Her iki model de ekstrem spor yapan ve yapmayan katılımcılarda test edilmiştir

1.7 Araştırma Soruları ve Hipotezler

1. Ekstrem spor yapan ve yapmayan katılımcılarda bağlanma stilleri, duygu regülasyon stratejileri, ölüm tutumları ve sağlık davranışları arasında anlamlı ilişkiler var mıdır?

2. Duygu regülasyon stratejileri ve ölüm tutumları, bağlanma stilleri ve sağlık davranışları arasındaki ilişkiye aracılık ediyor mudur?

2.a. Ekstrem spor yapan katılımcılarda, duygu regülasyon stratejilerinin alt ölçeklerinin bağlanma stilleri ve sağlık davranışları arasındaki ilişkiye aracılık etmesi hipotez edilmiştir.

2.b. Ekstrem spor yapmayan katılımcılarda, duygu regülasyon stratejilerinin alt ölçeklerinin bağlanma stilleri ve sağlık davranışları arasındaki ilişkiye aracılık etmesi hipotez edilmiştir.

2.c. Ekstrem spor yapan katılımcılarda, ölüm tutumları alt ölçeklerinin bağlanma stilleri ve sağlık davranışları arasındaki ilişkiye aracılık etmesi hipotez edilmiştir.

2.d. Ekstrem spor yapmayan katılımcılarda, ölüm tutumları alt ölçeklerinin bağlanma stilleri ve sağlık davranışları arasındaki ilişkiye aracılık etmesi hipotez edilmiştir.

BÖLÜM 2

YÖNTEM

2.1 Katılımcılar

Bu çalışma ekstrem spor yapan 109 katılımcı ile ekstrem spor yapmayan 202 katılımcıdan oluşmaktadır. Türkiye'nin farklı şehirlerinde yaşamakta olan katılımcılara "Qualtrics: Online Survey Software & Insight Platform" adı verilen online veri toplama sistemi ile ulaşılmıştır.

Ekstrem spor yapan katılımcılar farklı türde sporlarla ilgilenmektedir (paraşütle yüksekten atlama, mağara dalışı, 40 metre derin dalış, uçurtma sörfü, yüksek seviyede dağcılık, dağ bisitleti, yamaç paraşütü, ralli, rafting, kaya tırmanışı, hava dalışı, snowboard gibi).

2.2 Ölçüm Araçları

2.2.1 Demografik Bilgi Formu. Bu form katılımcının yaşı, cinsiyeti, medeni durumu, çalışma durumu, sosyo-ekonomik seviyesi, eğitim seviyesi, yaşadığı yer, fiziksel sağlık geçmişi, psikolojik sağlık geçmişi ve ekstrem sporlara katılımı ile ilgili soruları içerir.

2.2.2 Bağlanma. "Yakın İlişkilerde Yaşantılar Envanteri-II" bağlanma boyutlarını ölçmek amacıyla kullanılmıştır. Fraley, Waller ve Brennan (2000) tarafından geliştirilen ölçek 18 kaygı alt boyutu, 18 kaçınma alt boyutu olmak üzere toplamda 36 maddeden oluşmaktadır. 5'li Likert ölçeği kullanılmaktadır ve 1 (hiç katılmıyorum) ile 5 (tamamen katılıyorum) arasında değişmektedir. Türkçe'ye Selçuk, Günaydın, Sümer ve Uysal (2005) tarafından adapte edilmiştir. Bu

çalışmada güvenirlik katsayısı kaygı alt boyutu için .91, kaçınma alt boyutu için .92 olarak belirlenmiştir.

2.2.3 Duygu Regülasyonu. Gratz ve Roemer (2004) tarafından geliştirilen "Duygu Regülasyon Zorluğu Ölçeği" kullanılmıştır. Duyguların net olmaması, duyguları anlamama ve farkında olmama, zorlu duygularla karşılaşınca davranışı kontrol etmede dürtüsel olma, olumsuz duyguları kabul etmeme, duyguları regüle edebilmek için sağlıklı stratejileri az kullanma ve olumsuz duyguları yaşarken amaçlara ulaşmada güçlük yaşama olmak üzere 6 alt boyuttan oluşmaktadır. 36 maddeden oluşan ölçek, 5'li Likert tipidir ve yanıtlar 1 (Neredeyse hiçbir zaman) ile 5 (Neredeyse her zaman) arasında değişmektedir. Ölçek Türkçe'ye Rugancı ve Gençöz (2010) tarafından adapte edilmiştir, bu çalışmada güvenirlik katsayısı ölçeğin alt boyutlarında .67 ile .93 arasında değişmektedir.

2.2.4 Ölüme Karşı Tutumlar. Wong, Reker ve Gesser (1994) tarafından geliştirilen "Ölüme İlişkin Tutumlar Envanteri-Yeniden Düzenlenmiş" katılımcıların ölüm tutumlarını ölçmek amacıyla kullanılmıştır. Ölçek 32 maddeden ve 7'li Likert tipinden oluşmaktadır, yanıtlar 1 (Kesinlikle katılmıyorum) ile 7 (Tamamen katılıyorum) arasında değişmektedir. Ölüm korkusu, ölümden kaçınma, ölümü nötr kabul, ölüme yaklaşan kabul ve ölüme kaçış kabulü olmak üzere 5 alt boyuttan oluşmaktadır. Ölçeğin Türkçe adaptasyonu Çevik ve Kav (2013) tarafından yapılmıştır. Bu çalışmada ölçeğin alt boyutlarının güvenirlik katsayısı .69 ile .94 arasında değişmektedir.

2.2.5 Sağlık Davranışları. Walker, Sechrist ve Pender (1987) tarafından geliştirilen Sağlıklı Yaşam Davranışları Ölçeği katılımcıların sağlık davranışı seviyelerini ölçmek amacıyla kullanılmıştır. Türkçe'ye Bozo, Tunca ve Şimşek (2009) tarafından adapte edilen ölçek 6 alt boyuttan ve 52 maddeden oluşmaktadır. 4'lü Likert tipi olan ölçeğin yanıtları 1 (Hiçbir zaman) ile 4 (Her zaman) arasında değişmektedir. Çalışmada toplam değer dikkate alınmış ve güvenirlik katsayısı .92 olarak bulunmuştur.

2.3 Prosedür

Orta Doğu Teknik Üniversitesi'nin Etik Kurulu'ndan onay alındıktan sonra, çalışmanın ölçekleri "Qualtrics" adı verilen online veri toplama sistemine aktarılmıştır. Her katılımcıdan bilgilendirilmiş onam alınmıştır, katılımcılar çalışmanın amacı hakkında bilgilendirilmişlerdir. Çalışmadan istedikleri zaman ayrılabilecekleri konusunda garanti verilmiştir. Ekstrem spor yapmayan katılımcıların verileri Orta Doğu Teknik Üniversitesi'nden, online veri davetiyesi yollanarak toplanmıştır. Ölçek sosyal ağlarda da duyurulmuştur. Türkiye'nin farklı şehirlerindeki çeşitli spor klüplerinde olan ekstrem spor yapan katılımcılarına online veri sistemi duyurusu ile ulaşılmıştır. Ölçeklerin doldurulması yaklaşık olarak 25 dakika sürmüştür. Ölçeklerin doldurulmasının ardından katılımcılar çalışmanın amacı ile ilgili daha detaylı olarak bilgilendirilmiş ve olası soruları için araştırmacının iletişim bilgileri verilmiştir. Veri toplama süreci Ekim 2014'den Mart 2015'e kadar sürmüştür. Ön analizlerin ardından, Hayes'in (2013) çoklu aracı değişken analizi çalışmanın hipotezlerini test etmek için kullanılmıştır.

BÖLÜM 3

SONUÇ VE TARTIŞMA

3.1 Çalışma Değişkenlerine Göre Demografik Değişkenlerin Seviyeleri Arasındaki Farklılıklar

3.1.1 Çalışma Değişkenlerine Göre Ekstrem Spor Katılımı Seviyeleri Arasındaki Farklılıklar.

Ekstrem spor yapan katılımcılar yapmayanlara göre daha yüksek seviyede ölüm korkusu yaşadıklarını belirtmişlerdir. Bu çalışmada, ekstrem spor katılımcıları, aslında korkma ihtimali yaşadıkları ölüme bilinçli olarak meydan okumaktadırlar. Bu sebeple, onların ölüm korkusu ya da ölüm kaygısı değerlendirmelerinin bu gibi aktivitelere katılmayan ve ölüm riskiyle yüzleşmeyen kişilere göre yüksek olması muhtemeldir. Bazı ekstrem spor katılımcıları, korkunun yaşamlarında önemli bir yere sahip olduğunu hatta bu duygunun onları canlı tuttuğunu belirtmişlerdir (Brymer & Schweitzer, 2013). Benzer şekilde, literatürde ölümle sürekli yüzleşen bazı meslek çalışanlarının örneğin hemşirelerin (Meisenhelder, 1994), itfaiyecilerin ve polislerin (Hunt, Lester, & Ashton, 1983) ve kriz müdahale çalışanlarının (Neimeyer & Dingemans, 1980) daha yüksek ölüm korkusu yaşadıkları belirtilmiştir.

Ekstrem spor katılımcılarının bu sporları yapmayan katılımcılara göre daha az seviyede ölümü nötr kabul sergiledikleri bulunmuştur. Ölümü nötr kabul, ölümü yaşamın sonunun değişmeyen bir gerçeği olarak kabul etmek, ölümü ne korkuyla ne de coşkuyla beklemek ve yaşarken en iyisini yapabilmek olarak tanımlanmıştır. Bu yüzden, ölüm ekstrem spor yapan katılımcılar için karmaşık bir meydan okuma olabilir. Bu kişiler eğer ölümü değişmeyen bir gerçek olarak kabul etselerdi, belki de sonucu ölüm olabilecek riskli ekstrem sporlarda bulunmazlardı.

Ekstrem sporlar yapan katılımcılar, yapmayan katılımcılara göre daha fazla seviyede sağlık davranışı rapor etmişlerdir. Literatürde, yüksek seviyede ölümlülük algısının daha fazla sağlık davranışında bulunma ile ilişkili bulunduğu belirtilmiştir (Taubman-Ben-Ari & Findler, 2005; Bozo, Tunca, & Şimşek, 2009). Paralel bir şekilde, ekstrem sporlara katılım ölümlülük algısını artırır bu da daha fazla sağlık davranışında bulunma ile ilişkili olabilir. Hem yüksek seviyede ölüm korkuları hem de düşük seviyede ölümü nötr kabulü oluşları onların ölümden sonraki yaşam yerine şimdiki hayatlarına daha çok yatırım yaptıkları anlamına gelebilir. Ekstrem sporlara katılım oldukça riskli olsa da, bu sporları yapabilmek için kişinin sağlıklı ve fit olması gerekir. Bu sebeple de sağlık davranışlarına fazlaca önem veriyor olabilirler. Özetle, ekstrem sporlarda bulunmanın sağlığa zararlı olduğunu algısı sığ bir yaklaşım olabilir.

3.1.2 Çalışma Değişkenlerine Göre Cinsiyetin Seviyeleri Arasındaki Farklılıklar. Bu çalışmada kadınların erkeklere göre daha fazla kaygılı bağlanma sergiledikleri bulunmuştur. Bu çalışma literatürdeki, kadınların erkeklere göre daha fazla kaygılı bağlanma stiline sahip oldukları bilgisi ile tutarlıdır. Kaygılı bağlanma partnerinin kişiye yakınlaşmak istememe korkusu, partnerin duygularına dair endişe, partnerine yakın olmaya ilişkin güçlü bir arzu ve ayrılıkla kayıplarda kaygı deneyimleme ile karakterizedir (Fraley & Shaver, 2000). Evrimsel bir perspektife göre, kadınların kaygılı bağlanma stili akrabaları ve partnerleri ile olan yakınlığını maksimum seviyeye çıkarmak amacına hizmet eder (Kirkpatrick, 1998) ve bu stil partnerin kaçıngan durumuna karşı bir karşı strateji olabilir (Del Giudice, 2011).

Kadınlar duyguları regüle etmede; duyguların net olmaması, zorlu duygularla karşılaşınca davranışı kontrol etmede dürtüsel olma, olumsuz duyguları kabul etmeme ve duyguları regüle edebilmek için sağlıklı stratejileri az kullanma alt boyutlarında erkeklerden daha fazla zorluk yaşadıklarını belirtmişlerdir. Stevens'a göre (2014), yüksek seviyede kaygılı bağlanma sergileyen kişiler onları zorlayan duyguların farkındadırlar ancak bu duygulara netlik kazandırmada ve bu duyguları anlamlandırıp kabul etmede zorluk yaşarlar. Ayrıca, kaygılı bağlanan kişiler, bu çalışmadaki kadın katılımcılar gibi, dürtüsel olan duygusal reaksiyonlarını kontrol

etmede problem yaşarlar (Kobak & Sceery, 1988). Bunun yanı sıra, kaygılı bağlanan kişiler sosyal destek olmadan problemlerini aşabilmek için stratejiler belirleyemezler (Mikulincer, Shaver, & Pereg, 2003; Mallinckrodt, 2000). Bu sebeple, kadınların duygularını regüle edebilmek için sağlıklı stratejileri daha az kullanmaları, kaygılı bağlanma stilleri ile açıklanabilir.

Bu çalışmada, erkekler kadınlara göre daha fazla ölüm korkusu rapor etmişlerdir. Literatürde, cinsiyete göre ölüm korkusu hakkında birbiriyle çelişen sonuçlar vardır. Bazı çalışmalar erkeklerin daha fazla ölüm korkusu yaşadıklarını belirtirken (Cole, 1978; Depaola, Griffin, Young, & Neimeyer, 2003; Robinson & Wood, 1984), diğer çalışmalar kadınların daha fazla ölüm korkusu yaşadıklarını ifade etmiştir (Dattel & Neimeyer, 1990; Wong, Reker, & Gesser, 1994). Ayrıca, bazı çalışmalar ölüm korkusu açısından cinsiyetler arası fark bulamamıştır (Thiemann, Quince, Besson, Wood, & Berclay, basımda; Mullins & Lopez, 1982). Literatürdeki bu çelişkili sonuçlara rağmen, bu çalışmanın sonuçları ile tutarlı olarak Türkiye örnekleminde yapılan bir çalışmada daha erkekler kadınlara göre daha fazla ölüm korkusu belirtmişlerdir (Taşdemir & Gök, 2012). Bu sebeple, Türk kültüründe erkeklerin kadınlara göre daha fazla ölüm korkusu yaşadıkları dile getirilebilir. Bu sonuç, Türkiye'de kadınların maruz kaldıkları davranışlar ile açıklanabilir. Türkiye'de birçok kadın aile içi şiddet ve cinsel travmalar deneyimlemektedir (Beşpınar ve Canel-Çınarbaş, basımda). Kadınların %62'si hayatlarının bir döneminde eşlerinden fiziksel şiddet gördüklerini belirtmişlerdir (Vahip ve Doğanavşargil, 2006). Dahası, Türk kadınlarının % 71.4'ü hamilelik dönemlerinde psikolojik, fiziksel ya da cinsel tacize maruz kaldıklarını söylemişlerdir (Başbakanlık Aile Araştırma Kurumu, 1995). Bu gibi şiddet çeşitlerine uzun süre ve sıklıkla maruz kalan kadın, Türkiye'de ölümün oldukça olası olduğunu düşünüyor ve ölümü süregelen bir şiddete alternatif olarak düşünüyor olabilir. Bu sebeple, Türkiye'deki kadınların ölüm korkusu değerleri erkeklere göre daha az gibi görünmektedir.

Bahsedilen sonuçlarla paralel olarak, bu çalışmada kadınların ölümün nötr kabulü değerleri erkeklere göre daha yüksektir. Wong, Reker ve Gesser'in (1994)

çalışmasında, kadınların erkeklere göre ölümü daha fazla kabul ettikleri bulunmuştur. Bu sonuç, erkeklerin ölüm fikirlerini kabul etmek yerine kaçınmaları ile açıklanabilir (Del Giudice, 2011). Ayrıca, ölüm korkusunu daha az yaşayanların ölümü hayatın doğal bir parçası olarak kabul ettikleri belirtilmiştir (Wong, Gesser, & Reker, 1994). Benzer şekilde, ölüm korkusunu daha az yaşayan kişiler daha fazla ölümü nötr olarak kabul etmektedirler (Neimeyer, Wittkowski, & Moser, 2004). Bu durumda, bu çalışmadaki kadınların yüksek ölümü nötr kabulleri ile ölüm korkusunu daha az yaşamaları birbirleriyle ve literatürle paraleldir.

3.1.3 Çalışma Değişkenlerine Göre Eğitimin Seviyeleri Arasındaki Farklılıklar. Bu çalışmada, lise mezunlarının lisans sonrası eğitim mezunlarına göre daha fazla kaygılı bağlanma sergiledikleri ancak üniversite mezunlarının her iki mezun grubundan farklılaşmadığı görülmüştür. Cooper, Shaver ve Collins'in (1998) çalışmasında, kaygılı ergenlerin daha düşük notlar aldıkları, eğitime ilişkin arzularının daha az olduğu, daha fazla kriminal davranışlarda bulundukları ve madde kullandıkları belirlenmiştir. Bu sebeple, kaygılı bağlanan kişilerin akademik yaşamlarında daha kötü bir tablo çizmeleri muhtemeldir. Türkiye'de yapılmış bir başka çalışmada, ortaokul ve lise mezunlarının, üniversite mezunlarına göre daha fazla kaygılı bağlanma gösterdikleri bulunmuştur (Durak-Batıgün & Büyükşahin, 2008). Bu çalışma lisans sonrası katılımcıları içermemiş olsa da, kaygılı bağlanmanın düşük seviyedeki akademik başarı ile ilişkili olduğu belirtilebilir.

Lise mezunlarının lisans sonrası eğitim mezunlarına göre zorlu duygularla karşılaşınca davranışı kontrol etmede daha fazla dürtüsel oldukları (örneğin davranışları üzerindeki kontrolü kaybetme, davranışlarını kontrol ederken zorluk yaşama, kontrolden çıkma, kontrolden çıkmış hissetme) ancak üniversite mezunlarının bu iki mezun grubundan farklılaşmadığı gözlemlenmiştir. Literatüre göre, dürtüsellik okula devam etmeme ile güçlü bir şekilde ilişkilidir (Öner ve ark., 2012; Shiner, 2000; Shiner, Masten, & Roberts, 2003). Bu sebeple, yüksek seviyede dürtüsellik sergileyen katılımcılar belki de lisans ve sonrası eğitim kurumlarına girememektedirler.

3.1.4 Çalışma Değişkenlerine Göre Medeni Durum Seviyeleri Arasındaki Farklılıklar. Bağlanma stillerine göre, bekar katılımcılar evli katılımcılara göre daha fazla kaygılı ve kaçıngan bağlanma stiline sahiptir. Bu sonuç Latty-Mann ve Davis'in (1996) çalışması ile açıklanabilir. Buna göre, kişiler güvenli bağlanma stiline sahip olan kişileri, kaygılı veya kaçıngan bağlananlara göre tercih etmektedirler. Bu yüzden, bekar kişilerin daha fazla güvensiz bağlanma stiline sahip olmaları şaşırtıcı değildir. Bunun yanı sıra, güvensiz bağlanan kişilerin (kaygılı ya da kaçıngan gibi) daha fazla kavga ettikleri (Cohn, Silver, Cowan, Cowan, & Pearson, 1992), daha az güven ve bağlılık duydukları (Simpson, 1990) ve sonucunda da ayrıldıkları, boşandıkları ya da birden fazla evlilik yaptıkları (Ceglian & Gardner, 1999) belirtilmiştir. Yani, evlenseler de güvensiz bağlanan kişilerin ilişkileri daha kısa sürebilir.

3.1.5 Çalışma Değişkenlerine Göre Psikolojik Rahatsızlık Tarihçesinin Seviyeleri Arasındaki Farklılıklar. Psikolojik rahatsızlık tarihçesi olan katılımcıların, bu tarihçesi olmayanlara göre daha fazla kaygılı ve kaçıngan bağlanma sergiledikleri bulunmuştur. Bu sonuç literatürle uyumludur. Kaygılı ve kaçıngan bağlanma yeme bozuklukları (Fonagy ve ark., 1996), kişilik bozuklukları (Fonagy ve ark., 1996), depresif semptomlar (Bifulco, Moran, Ball, ve Bernazzoni, 2002), kaygı bozuklukları (Muller, Lemieux, & Sicoli, 2001) ile ilişkiliyken, güvenli bağlanma psikolojik iyilik hali ile (Dieperink, Lesleka, Thuras, & Engdahl, 2001) ile ilişkili bulunmuştur.

Psikolojik rahatsızlık tarihçesinin seviyeleri arasında, duyguların net olmaması, zorlu duygularla karşılaşınca davranışı kontrol etmede dürtüsel olma, olumsuz duyguları kabul etmeme ve duyguları regüle edebilmek için sağlıklı stratejileri daha az kullanma alt boyutları arasında anlamlı fark bulunmuştur. Psikolojik rahatsızlık tarihçesi olan kişilerin duygularını regüle etmede daha çok zorlandıkları gözlemlenmiştir. Benzer şekilde, literatürde duyguları regüle etmede zorluk yaşamanın çeşitli psikolojik semptomlarla olumlu olarak ilişkili olduğu belirtilmiştir (American Psychological Association, 1994; Gratz & Roemer, 2004; John & Gross, 2004). Türkiye'de yapılmış bir başka çalışmada da benzer sonuçlar elde edilmiştir.

Rugancı ve Gençöz (2010) duygu regülasyon zorluklarının çeşitli psikoljik rahatsızlıkların işaretleri olabileceğini belirtmişlerdir. Bu tutarlı sonuçlar doğası gereği korelasyoneldir. Yani, psikolojik rahatsızlıkların duygu regülasyon zorluklarından mı kaynaklandığı ya da duygu regülasyon zorluklarının psikolojik rahatsızlıklardan mı kaynaklandığı belirtilemez.

Ölüme kaçış kabulü (ölümün varoluş problemlerinden bir kaçış olarak algılanması, ölümün acı dolu hayat yerine hoş karşılanan bir alternatif olması) orijinal ölüm tutumu çalışmasında psikolojik iyilik hali ile ilişkili bulunmamıştır (Wong, Reker, & Gesser, 1994) ancak bu çalışmada psikolojik rahatsızlık tarihçesi olan kişiler olmayanlara göre daha az ölüme kaçış kabulü belirtmişlerdir. Bu sonuç psikolojik rahatsızlık yaşayan kişilerin intihar etmeye eğilimleri olduğu sonucu ile tutarlı değildir (Harris & Barraclough, 1997).

Bu noktaya kadar ön analiz sonuçları verilmiş ve tartışılmıştır. Bu noktadan sonra, ana analiz sonuçları verilip tartışılacaktır.

3.2 Duygu Regülasyonu Zorluklarının Aracı Değişken Rolü

3.2.1 Duygu Regülasyonu Zorluklarının Ekstrem Spor Yapan Katılımcılarda Aracı Değişken Rolü.

Duyguları anlamama/farkında olmama ve olumsuz duyguları yaşarken amaçlara ulaşmada güçlük yaşama değişkenleri, kaygılı bağlanma−sağlık davranışları ilişkisinde ekstrem spor yapan katılımcılarda aracı değişkenler olmuştur.

İlk olarak, yüksek seviyede kaygılı bağlananlar duygularını anlama ve farkında olma konusunda daha çok zorluk yaşamaktadırlar, bu da ekstrem spor yapan grupta sağlık davranışlarının azalmasına sebep olmaktadır. Bu sonuçlar örneklemin doğasından kaynaklanıyor olabilir. Riskli davranışlar ve adrenalin arayışı ekstrem sporların ayrılmaz parçalarıdır ve bunlar katılımcıların duygularını anlamama/farkında olmama zorlukları ile baş edebilmek için kullandıkları yöntemler olabilir. Ayrıca, ekstrem spor katılımcıları kaygılı bağlanmaları sebebiyle öyle karmaşık bir durumda olabilirler ki (duyguların farkında olmamaya ek olarak)

fiziksel ve psikolojik sağlıklarını kontrol edemiyor olabilirler. Sonuç olarak, kaygılı bağlanmış ekstrem spor katılımcılarının sağlık davranışlarının düşük olması, duyguları anlamama/farkında olmama alt ölçeğinin aracı rolüyle açıklanabilir.

İkinci olarak, kaygılı bağlanmış kişiler olumsuz duyguları yaşarken amaçlarına ulaşmada güçlük yaşamaktadırlar, bu da sağlık davranışlarında düşüşe sebep olmaktadır. Kaygılı bağlanmış kişiler kendilerini zorlayan duygulara saplanabildikleri ve yoğun bir uğraş verdikleri için, konsantre olma, başka şeylere odaklanma, işlerini bitirme ve başka şeyler düşünme konularında (hepsi olumsuz duyguları yaşarken amaçlarına ulaşmada güçlük çekenlerin özellikleri) zorlanmaktadırlar. Benzer şekilde, Stevens (2014) kaygılı bağlanan kişilerin zorlu duygularının hayatlarındaki amaçlarını mahvetmesine daha çok izin verdiklerini belirtmiştir, bu amaçlar sağlıkla ilgili olabilir örneğin sağlık geliştirici davranışlarla ilgili hedeflere de zarar verebilir.

Ekstrem spor grubunda, olumsuz duyguları yaşarken amaçlara ulaşmada güçlük yaşama, kaçıngan bağlanma−sağlık davranışları ilişkisine aracılık etmiştir. Kaygılı bağlanma özellikleri arttıkça, daha fazla olumsuz duyguları yaşarken amaca ulaşmada güçlük yaşamaktadırlar, bu da sağlık davranışlarını azaltmaktadır. Ekstrem spor grubunda, kaçıngan bağlanan kişiler riskli spor aktivitelerine duygularını regüle etme amacıyla (örneğin duygularını bastırma ve zorlu duygulardan uzaklaşma gibi) katılıyor olabilirler. Bir başka deyişle, olumsuz duygularıyla yüzleşmedikleri, aksine kaçındıkları için, konsantre olmakta ve işlerini tamamlamada zorluk yaşıyor olabilirler. Ekstrem sporlara katılarak, hayatlarında başarabilecekleri bir hedef belirliyor ve bundan keyif alıyor olabilirler. Ayrıca, olumsuz duygularla ve problemlerle baş etmedeki adaptif olmayan stratejilerine paralel olarak, sağlıksız davranışları sağlık davranışlarını tercih ediyor olabilirler.

3.2.1 Duygu Regülasyonu Zorluklarının Ekstrem Spor Yapmayan Katılımcılarda Aracı Değişken Rolü.

Duyguların net olmaması, kaygılı bağlanma−sağlık davranışları ilişkisinin ekstrem spor yapmayan katılımcılarda aracı değişkeni olarak bulunmuştur. Kaygılı bağlanma arttıkça, duyguların net olmaması

artmaktadır bu durum da sağlık davranışlarını azaltmaktadır. Kaygılı bağlanan kişilerin kaçıngan bağlanan kişilere göre daha fazla duygularının farkında olduğu ancak hala duyguları konusunda net olamadıkları dile getirilmiştir (Stevens, 2014). Benzer şekilde, bu çalışmada da kaygılı bağlanan kişilerin ilişkilerinde yoğun kaygı ve ruminasyon yaşadıkları için, gerçek duygularını ve ihtiyaçlarını gözlemleyemedikleri, tanımlayamadıkları ve netlik sağlayamadıkları, bu durumun da sağlık davranışlarına olan özenlerini etkilediği söylenebilir.

3.3 Ölüm Tutumlarının Aracı Değişken Rolü

3.3.1 Ölüm Tutumlarının Ekstrem Spor Yapan Katılımcılarda Aracı Değişken Rolü.

Ekstrem spor grubunda, ölüme yaklaşan kabul, kaygılı bağlanma − sağlık davranışları ilişkisinde aracı değişken olarak belirlenmiştir. Kaygılı bağlanma arttıkça, ölüme yaklaşan kabul azalmakta bu durum da sağlık davranışlarında artışa sebep olmaktadır. Ölüme yaklaşan kabul, temeli dini inançta yer alan, ölümden sonraki mutlu bir hayata inanmaya işaret eder. Kaygılı bağlanan kişiler, kaygı, endişe ve korku duygularını yoğun olarak deneyimledikleri ve regüle etmekte zorlandıkları için, benzer duyguları ölüme karşı da hissediyor olabilirler. Ölüm korkusu ve dini inançların birbirleriyle olumsuz ilişkili oldukları, çünkü inançlı kişilerin sembolik bir ölümsüzlüğe inandıkları için ölüm korkusuyla baş edebildikleri dile getirilmiştir (Wong, Reker, & Gesser, 1994). Bu sebeple, kaygılı kişiler daha az inançlı olabilir bu da daha az seviyede ölüme yaklaşan kabul sergilemelerine sebep olabilir. Bir başka deyişle, kaygılı kişiler sembolik bir ölümsüzlüğe inanmadıkları için, ölümle ilişkili olarak korku ve kaygı yaşıyor, bu durum da onları daha uzun ve sağlıklı yaşamak için daha fazla sağlık davranışlarına yönlendiriyor olabilir.

Aynı örneklemde, ölüme yaklaşan kabul, kaçıngan bağlanma−sağlık davranışları ilişkisine de aracılık etmiştir. Kaçıngan bağlanma arttıkça, ölüme yaklaşan kabul azalmakta bu durum da sağlık davranışlarının artmasına sebep olmaktadır. Kaçıngan bağlanma stili güven duyma ve yakınlık gibi durumların olmayışı, ilişkilerde duygusal uzaklık ve kaçınma ile tanımlanmaktadır. Bu sebeple, bu kişiler

ölüm ve sonrası konusunda da düşünmekten kaçınıyor olabilirler, bu durum da ölüme yaklaşan kabulün azalması ile ilişkilidir. Özetlemek gerekirse, eğer kişi ölüm ve sonrası hakkında düşünmekten kaçınıyorsa, o kişi sağlık davranışlarını artırarak bu dünyaya yatırım yapmaya çalışıyor olabilir.

3.3.2 Ölüm Tutumlarının Ekstrem Spor Yapmayan Katılımcılarda Aracı Değişken Rolü. Ölüme kaçış kabulü, kaçıngan bağlanma−sağlık geliştirici davranışlar arasındaki ilişkiye, ekstrem spor yapmayan katılımcılarda aracılık etmiştir. Kaygılı bağlanma azaldıkça, ölüme kaçış kabulü artmakta bu da sağlık geliştirici davranışları artırmaktadır. Ölüme kaçış kabulünde kişi yaşantısında zorluklar yaşamakta ve acı çekmektedir, bu sebeple ölüm varoluş problemlerinden kaçınmak için bir alternatif haline gelmektedir. Bu aracı değişkenin rolü oldukça ilgi çekicidir. Daha az kaçıngan bağlanma sergileyen kişiler daha fazla ölüme kaçış kabulü sergilemektedirler ancak aslında ölümden kaçınmamaktadırlar. Aslında, bu dünyada zorluklar yaşadıkları için, ölümü bir kaçış olarak görmektedirler. Yine de, bu kişiler kendi yaşadıkları zorluklar ve deneyimledikleri acılar ile yüzleşmektedirler. Ölüme kaçış kabulü, fiziksel ve psikolojik acıdan kaçınma olduğu için, sağlık davranışları günlük yaşamın acılarından kaçınmak için iyi bir çözüm olabilir.

3.4 Çalışmanın Güçlü Yönleri ve Çıkarımları

Bu çalışmanın amacı bağlanma stillerinin sağlık davranışları üzerindeki etkisini, duygu regülasyon stratejileri ve ölüm tutumlarının aracı rolüyle belirlemekti. Bu çalışma belirtilen değişkenlerin ilişkilerinin çoklu aracı değişken analizi kullanarak belirlenmesi açısından ilk olma özelliğini taşır. Bir diğer yenilik ise bu ilişkilerin iki farklı örneklem grubunda, ekstrem spor yapan ve ekstrem spor yapmayan kişilerde test edilmesidir. Ekstrem spor yapan katılımcılar bu çalışma için özellikle seçilmiştir, çünkü sağlık psikolojisi literatürü bu spor türlerini yüksek seviyede sağlığa riskli davranış olarak ele almıştır. Ancak daha önce de bahsedildiği gibi, ekstrem spor katılımcılarının bu sporları yapmayanlara göre daha fazla sağlık davranışında bulundukları belirlenmiştir.

Bu çalışma ölüm korkusu, ölüm kaygısı ve üç farklı ölüm kabulü tutumlarının, bağlanma stilleri − sağlık davranışları arasındaki ilişkideki aracı rollerini iki farklı örneklemde test etmesi açısından da Türkiye psikoloji literatüründe bir ilktir. Beklendiği gibi, farklı ölüm tutumları iki grupta aracı değişken olmuştur. Ekstrem spor yapan katılımcılarda, ölüme yaklaşan kabul güvensiz bağlanma stilleri − sağlık davranışları ilişkisine aracılık ederken, ekstrem spor yapmayan katılımcılarda ölüme kaçış kabulü güvensiz bağlanma stilleri − sağlık davranışları ilişkisine aracılık etmiştir. Bir başka deyişle, farklı ölüm tutumları ekstrem spor yapan katılımcılar ve yapmayan katılımcıların sağlık davranışlarını şekillendirmiştir.

Bu çalışmanın bir diğer katkısı da, güvensiz bağlanma stillerinin sağlık davranışlarını uygulamada bir risk faktörü olarak bulunmasıdır. Bağlanma stilleri, çocuk ve ebeveyn/bakım veren kişi arasındaki kalıcı bir bağdır, bu sebeple bir önlem ve müdahale stratejisi olarak, güvensiz bağlanma stillerinin sağlık davranışlarına olan olumsuz etkisi, özellikle çocukları kronik hastalıklar yaşayan ebeveynlere bir eğitim programında açıklanabilir. Ayrıca, Sağlık Bakanlığı tarafından olumlu ebeveynlik uygulamaları, eğitim programları ve kampanyalar desteklenebilir.

Duygu regülasyonunda yaşanan zorluklar, sağlık davranışlarında azalma ile ilişkili çıkmıştır. Bu sebeple, psikoterapi uygulamalarında, etkin duygu regülasyon stratejilerinin sadece psikolojik sağlık için değil aynı zamanda sağlık geliştirici davranışlar aracılığıyla fiziksel sağlık için de hayati bir öneme sahip olduğu bilgisi kullanılmalıdır. Bu sebeple, sağlık psikologları da birincil, ikincil ve üçüncül önlem programlarında, duygularla ve duygu regülasyonlarıyla ilgili çalışmayı göz ardı etmemelidirler.

Ekstrem spor yapan katılımcılarda, ölüm korkusu ve ölümü nötr kabul, sağlık davranışları ile olumlu olarak ilişkili bulunmuştur. Bozo, Tunca ve Şimşek'in (2009) çalışmasında, ölüm korkusunun sağlık davranışları ile olumlu bir ilişkide olduğu belirlenmiştir. Bu sebeple kişilerin sağlık davranışlarını artırmada, ölüm hatırlatıcıları kullanılabilir. Bu bilgi Sağlık Bakanlığı tarafından organize edilen

kampanyalarda da yer alabilir. Benzer şekilde, psikoterapi uygulamalarında, danışanların ölüm korkuları ve ölümü kabul tutumları sağlık davranışları açısından ele alınabilir.

3.5 Sınırlılıklar ve Gelecek Çalışmalar İçin Öneriler

Bu çalışmada güvensiz bağlanma stillerinden kaygılı ve kaçıngan bağlanma çalışılmıştır ancak gelecek çalışmalarda Bartholomew ve Horowitz (1991) tarafından önerilen güvenli, saplantılı, kayıtsız ve korkulu bağlanma stilleri çalışılabilir.

Kişilerin ölüm tutumlarını belirlemek amacıyla, onların özbildirimleri kullanılmıştır. Ancak psikoloji literatüründe ölüme ilişkin bilinçli değerlendirmelerin güvenilir olamayabileceği söylenmiştir. Örneğin, Terör Yönetme Teorisi'ne göre kişiler bilincin farklı boyutlarında ölüm ve ölüm korkusuyla baş etmek için farklı savunma mekanizmaları kullanırlar (Arndt, Greenberg, & Cook, 2002). Bu sebeple, tipik bir Terör Yönetme Teorisi deneyinde, katılımcılara öncelikle kendi ölümleri ile ilgili neler düşündükleri yazmaları istenir, ardından araştırmacı bilinçli ölüm düşüncelerini bastıracak farklı bir deney düzeni kurgulayarak ölümle ilgili tutumlara ilişkin bilinçdışı veriyi toplarlar (Arndt, Greenberg, Solomon, Pyszczynski, & Solomon, 1998). Bu sebeple, gelecek çalışmalarda araştırmacılar bilinçdışı ölüm tutumlarına ilişkin bilgi toplayabilecekleri deney yöntemleri kullanabilirler.

Bu çalışmada, katılımcıların yaşları yetişkinlik dönemini kapsamaktadır ve veriler tek bir zamanda kesitsel olarak toplanmıştır. Gelişimsel değişimleri görebilmek ve sebep−sonuç ilişkisinden bahsedebilmek için, gelecek çalışmalar boylamsal çalışmaları kullanabilir.

Bu çalışma tüm ekstrem sporları kapsamıştır ancak gelecek çalışmalar belirli ekstrem spor katılımcılarını kapsayarak değişkenlerin ilişkilerini ele alabilir.

3.6 Sonuç

Budha'nın belirttiği gibi 'Sağlık en büyük hediyedir'. Farklı katılımcı gruplarının sağlık davranışlarına ve sağlığa riskli davranışlara giden farklı yolları olabilir. Bu yüzden, daha sağlıklı ve uzun bir süre yaşayabilmek için bu farklılıkları belirlemek oldukça önemlidir.

APPENDIX H: TEZ FOTOKOPİSİ İZİN FORMU

ENSTİTÜ

Fen Bilimleri Enstitüsü [ ]

Sosyal Bilimler Enstitüsü [x]

Uygulamalı Matematik Enstitüsü [ ]

Enformatik Enstitüsü [ ]

Deniz Bilimleri Enstitüsü [ ]

YAZARIN

Soyadı : Bekaroğlu
Adı : Ece
Bölümü : Psikoloji

TEZİN ADI (İngilizce) : The Relations among Attachment Styles, Emotion Regulation Strategies, Death Attitudes, and Health Promoting Behaviors: Extreme Sports Participants vs. Non-Participants

TEZİN TÜRÜ : Yüksek Lisans [ ] Doktora [x]

1. Tezimin tamamından kaynak gösterilmek şartıyla fotokopi alınabilir. [ ]
2. Tezimin içindekiler sayfası, özet, indeks sayfalarından ve/veya bir bölümünden kaynak gösterilmek şartıyla fotokopi alınabilir. [x]
3. Tezimden bir (1) yıl süreyle fotokopi alınamaz. [ ]

TEZİN KÜTÜPHANEYE TESLİM TARİHİ: