Maternal Negative Affectivity and Child-feeding:
Results from the Norwegian Mother and Child Cohort Study.

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ABSTRACT

In this thesis, I explore the influence of maternal Negative Affectivity on child diet and the mechanisms that mediate this influence. For this purposed I used data from a nation-wide birth cohort study of between 15 000 and 30 000 mother-child dyads.

The main findings of this study were that the children of mothers with a high level of Negative Affectivity to a lesser extent are breastfed during the first 6 months of their life, and have a diet of poorer nutritional value at the age of 18 months and 3 years. Moreover, it is suggested in this thesis a causal link between high levels of Negative Affectivity, external Parental Locus of Control (i.e. believing not to have control over the child), and control-oriented child-feeding practices of pressuring the child to eat and restricting the child's food intake. Indeed, external Parental Locus of Control was the most important mechanism, entirely mediating the effect of Negative Affectivity on child feeding practices. What is more, external Parental Locus of Control partially explained the association between the two child-feeding practices. This implicates that believing not to have control over the child, can be viewed as a common etiological factor for control-oriented child feeding.

Child feeding practices showed different associations with child diet. Pressuring the child to eat was associated with a diet of poorer nutritional value. Restricting the child's food intake, in contrast, was associated with a diet of preferable nutritional value.

These findings are important for the understanding of early child-feeding and risk factors for an obesogenic child diet, particularly because belief systems such as Parental Locus of Control are accessible for interventions. Moreover, awareness of these relationships may have clinical relevance for health personnel giving guidance on child-feeding.

LIST OF PAPERS

Paper I

Ystrom, E., Niegel, S., Klepp, K.-I., & Vollrath, M. E. (2008). The impact of maternal negative affectivity and general self-efficacy on breast-feeding: The Norwegian Mother and Child Cohort Study. *Journal of Pediatrics*, 152, 68-72.

Paper II

Ystrom, E., Niegel, S., & Vollrath, M. E. The impact of maternal negative affectivity on dietary patterns of 18-month-old children in the Norwegian Mother and Child Cohort Study. *Maternal and Child Nutrition*, (in press).

Paper III

Ystrom, E., Barker, M., & Vollrath, M. E. The impact of mothers' negative affectivity, parental locus of control and child-feeding practices on dietary patterns of 3-year old children. The Norwegian Mother and Child Cohort Study. (submitted).

INTRODUCTION

Child Diet

Breast milk promotes sensory and cognitive development, and protects the infant against infectious and chronic diseases (Mortensen, Michaelsen, Sanders, & Reinisch, 2002). Full breastfeeding reduces infant mortality due to common childhood illnesses such as diarrhea or pneumonia and promotes a quicker recovery during illness (Paricio Talayero et al., 2006). The beneficial effects of breastfeeding have been found in resource-poor and in affluent societies (Kramer et al., 2001). Moreover, breastfeeding is also associated with reduced risk of the sudden infant death syndrome (Ford et al., 1993) and risk of inflammatory bowel disease in adults (Klement, Cohen, Boxman, Joseph, & Reif, 2004).

In addition, breastfeeding has in meta-studies been associated with a long term reduced risk of atopic disease (Friedman & Zeiger, 2005), type I and type II diabetes mellitus (Norris & Scott, 1996; Owen, Martin, Whincup, Smith, & Cook, 2006), particular forms of childhood cancer (Martin, Gunnell, Owen, & Smith, 2005), and later weight gain and obesity (Armstrong, Reilly, & Child Health Information Team, 2002; Dewey, 2003; Owen et al., 2005). The positive and negative effects found in the meta-studies of the health outcomes were in general small after adjusting for confounding variables, and there were indications of possible publication bias. Despite this, the authors advocated the continuance of breastfeeding recommendation.

Currently, the World Health Organization (WHO) recommends as a general policy exclusive breastfeeding during the first 6 months of life, with the caveat that infants must be managed individually in the case of insufficient growth (Kramer & Kakuma, 2002).

In recent years there have been an explosive growth of childhood obesity in the western world (Wang & Lobstein, 2006). Intake of fat and refined sugar have been suggested to be partly responsible for this development of obesity in children (Ludwig, Peterson, & Gortmaker, 2001; Foreyt & Poston, II, 2002). A frequent intake of sweet foods high in added sugar could lower the overall nutritional value of the diet. In recent years several research groups have studied patterns of early childhood diet from infancy to preschool age in the Western world using exploratory statistical techniques (North & Emmett, 2000; Northstone & Emmett, 2005). The number of factors utilized range from three to four, but with two major factors when examining the scree plots: An unhealthy diet (sometimes called “*junk*”-diet) rich

in sugar and fat and a wholesome diet (sometimes called “*healthy*”-, “*health conscious*”-, and “*traditional*”-diets rich in fiber, vitamins and minerals).

Covariates of Child Diet

Sustaining breastfeeding for 6 months can be difficult. There are a number of known risk factors that can impede the establishment and sustaining of breastfeeding. Among medical variables, cesarean section and preterm birth are known risk factors (Chapman & Perez-Escamilla, 1999). Mothers’ low level of education, low socioeconomic status, maternal smoking, child in daycare, and early return to work may impede breastfeeding. (Millar & Littlepage, 1970; Lande et al., 2003; Ong, Yap, Li, & Choo, 2005; Cooper, Murray, & Stein, 1993; Wagner et al., 2006). Older mothers and those with several children tend to sustain breastfeeding for longer periods (Venancio & Monteiro, 2006; Wagner & Wagner, 1999; Wagner et al., 2006).

The person with the greatest influence on a child’s diet is often the mother, and the mother’s characteristics in turn, influence her choices. Being young, having lower education attainment, being a smoker, being overweight, and having more than one child increase the likelihood that a mother feeds her child fewer foods from the wholesome pattern and more from the unhealthy pattern (North & Emmett, 2000; Northstone & Emmett, 2005).

Maternal Psychological Dispositions and Child-feeding

General Self-efficacy

A determinant of health behavior that has received a lot of attention is *Self-efficacy*, the belief in one’s capabilities to cope successfully with future challenges (Bandura, 1977). The original notion of Albert Bandura, the “father” of Self-efficacy, was that efficacy beliefs will fluctuate depending on the situation or skills required and therefore should be operationalized into discrete domains (Bandura, 1997). For the current investigation however, a general trait construct was used: *General Self-efficacy*. General Self-efficacy is the belief in one’s capabilities to cope successfully with a variety of challenging situations (Luszczynska, Scholz, & Schwarzer, 2005). A high level of General Self-efficacy both improves the goal settings, such as the intention to perform the recommended act of full breastfeeding, but also leads to more persistence in following the goal. General Self-efficacy has been found to be positively associated with active coping with pain ($r=.33$ corrected for attenuation), with

domain specific optimistic self-beliefs such as nutrition Self-efficacy ($r=.27$ corrected for attenuation), and inversely associated with depressive symptoms ($r=-.45$ corrected for attenuation) (Luszczynska et al., 2005).

Until recently the investigations of Self-efficacy and breastfeeding focused on a situation discrete form of Self-efficacy: *breastfeeding Self-efficacy* (Dennis, 1999). Breastfeeding Self-efficacy is associated with longer breastfeeding duration (Dennis & Faux, 1999; Blyth et al., 2002; Blyth et al., 2004). Dennis (1999) suggested that breastfeeding Self-efficacy was due to both previous personal experience, such as having sufficient milk production, or vicarious breastfeeding experience, verbal persuasion from others, and positive emotional states.

Negative Affectivity

Personality is defined as stable dispositions to think, feel, and behave in consistent ways across situations and time. As personality traits are determinants of behavior, they also affect health-related behaviors. One trait with known effects on health behaviors is *Negative Affectivity*, a broad trait construct describing the tendency to frequently experience negative emotions, such as anxiousness, depressiveness, and irritability, and to have a negative view of oneself (Watson & Clark, 1984). Negative Affectivity has been found to be essentially equivalent to the *Neuroticism* factor, also often called *Emotional Stability*, in the much applied five factor model of personality (John & Srivastava, 1999; Clark & Watson, 1999). To make the overview of findings on the different labels of Neuroticism also known as Emotional Stability also known as Negative Affectivity more readable, will findings from the literature listed in the following text be reported as findings on Negative Affectivity.

Negative Affectivity and Coping

Coping is the way individuals manage stressful situations (Bolger, 1990). Persons with high levels of Negative Affectivity use dysfunctional strategies to cope with stress. It is a consistent finding in the literature that a high level of Negative Affectivity is associated with passive and inefficient coping strategies; persons with high levels of Negative Affectivity use to a greater extent self-blame, emotional-focused coping, and escape-avoidance and to a lesser extent problem-focused coping, support seeking, and positive reappraisal (McCrae & Costa, 1986; Smith, Pope, Rhodewalt, & Poulton, 1989; Bolger, 1990; Watson & Hubbard, 1996; Vollrath, Torgersen, & Alnaes, 1998; Vollrath, 2001).

Negative Affectivity might seem like a highly undesirable trait; it implicates not taking on life. This might not be the case. While one is taking on life it is fortunate to survive; one thing any living person has in common with his or her ancestors is that they survived the dangers of life long enough to become an ancestor. Vigilance, behavioral inhibition and avoidance facilitate survival under threatening situations. In the same manner facilitates affects of fear, distress, and modest self-esteem the motivation to keep out threatening situations even before physically getting in those situations. Anger aids a person to defend his or her resources when threatened. Any person completely lacking these characteristics would expose her or himself to potentially mortal threats.

Mood, Anxiousness, Negative Affectivity and Breastfeeding

The question whether there is a link between maternal mood, anxiety, and breastfeeding has been discussed in the literature. In several cross-sectional studies during the last decades breastfeeding puerperal women been found to have more positive life events, and lower depression, anxiety and anger scores than formula feeders (Berg-Cross, Berg-Cross, & McGeehan, 1979; Modhal & Newton, 1979; Weisenfeld, 1985; Virden, 1988; Cooper et al., 1993; Heck & Decastro, 1993; Galler, Harrison, Biggs, Ramsey, & Forde, 1999; Mezzacappa, Guethlein, Vaz, & Bagiella, 2000; Henderson, Evans, Straton, Priest, & Hagan, 2003; Groer, 2005; Dunn, Davies, McCleary, Edwards, & Gaboury, 2006; Sisk, Lovelady, Dillard, & Gruber, 2006).

In a recent study, post-partum anxiety was related to less breastfeeding confidence but not to breastfeeding knowledge (Britton, 2007). This might imply that the coping due to Negative Affectivity is not related to the potential success of breastfeeding due to actual knowledge, but hampers the follow through. Although performed at a time when the societal view on breastfeeding was different, the conclusion in a pioneering study (1959) describing hospitalized women the first week after birth was that those women who selected breastfeeding rather than bottle feeding were more anxious than those who chose bottle feeding. Moreover, those women who subsequently succeeded with their chosen breastfeeding were more calm than those who failed (Call, 1959). Furthermore, in a study done at about the same time, breastfeeding woman were found to emphasize exchange of positive affection with other people (Brown, Chase, & Winson, 1961; Newton & Newton, 1967). This indicates that initial selection of breastfeeding rather than bottle feeding could be

influenced by extraversion/Positive Affectivity (Clark & Watson, 1999) related factors, while follow through of breastfeeding is related to Negative Affectivity.

But so far, the picture is not entirely clear. In a study conducted in the late sixties, the authors concluded that both election and duration of breastfeeding was related to less Negative Affectivity measured postnatally (Cornell, 1969). In a study applying Raymond Cattell's 16 Personality Factors it was found that mothers practicing unrestricted breastfeeding (continuously feeding at the child's will) were more suspicious (factor L), more extroverted (factor F), and more open to change (factor Q1) than those who practiced bottle feeding (Chamberlain, 1976). There were no differences on factors semantically at the core of Negative Affectivity.

Wagner and colleagues (1999, 2006) applied in two separate studies the five factor model (FFM) of personality (John & Srivastava, 1999) to investigate personality differences between those who initiated breastfeeding versus those who initiated bottle feeding during their hospitalization 24-96 hours postpartum (Wagner & Wagner, 1999; Wagner et al., 2006). In the first study, published in 1999, 100 mothers completed the full Revised NEO Personality Inventory (NEO-PI-R), which measures 30 facets of the FFM of personality (John & Srivastava, 1999). Women who had chosen to initiate breastfeeding had higher scores on facets of extraversion, openness to experience, agreeableness, and one facet of conscientiousness. Mothers who had chosen bottle feeding had higher scores on only one facet; the angry hostility facet of Neuroticism. The construct of anger and hostility are semantically within the domain of Negative Affectivity. In the second study by Wagner et al. (2006), 86 mothers completed the short version of the NEO-PI-R. Mothers who had chosen to initiate breastfeeding were also in this study more extraverted, open to experience, and agreeable. The effect of agreeableness turned redundant when all the five factors in the five factor model predicted breastfeeding in a multiple regression analysis.

While different sub facets of the traits extraversion and openness to experience (John & Srivastava, 1999) might be related to initiation of breastfeeding, there is in sum quite extensive evidence that Negative Affectivity is to some extent related to both election and especially sustainment of breastfeeding. What is more, since the assessment of Negative Affectivity was done postpartum, one cannot conclude on whether ineffective coping due to Negative Affectivity hampers breastfeeding or whether breastfeeding failure increases the level of Negative Affectivity.

A mother's decision to breastfeed depends on her situation. The situation of a person can influence the measurement of Negative Affectivity. Earlier studies on maternal mood and breastfeeding have only rarely adjusted the results according to the mother's current demographic situation and physical condition.

The role of oxytocin.

It is well known the public that a sudden shock can stop livestock from producing milk. Case studies of women who have suffered stressing situations document that they have had abrupt cessation of lactation shortly afterwards (Ruvalcaba, 1987). The let down reflex, which starts the secretion of milk, is controlled by the hormone oxytocin. Oxytocin secretion has been found to be inversely associated with trait anxiety and guilt (Uvnäs-Moberg, Widström, Nissen, & Björvell, 1990; Nissen, Gustavsson, Widström, & Uvnäs-Moberg, 1998). Given that milk secretion is related to stress (Dewey, 2001; Tu, Lupien, & Walker, 2005), and persons with high levels of Negative Affectivity have dysfunctional stress coping strategies, it is plausible that the disposition of Negative Affectivity would act as a risk factor for to a greater extent being influenced by neonatal stressors.

Negative Affectivity, Parental Locus of Control and Child-feeding

Meal times can be emotive for both mother and child. Children often prefer foods with a high fat and sugar content (Hill, 2002). Mothers know that their children should not have too many of such foods. Every parent is familiar with the frustration of trying to feed a child food they are refusing to eat. Such a situation is wearing for most people. Emotionally unstable mothers might be imagined to experience less control over the child (Lovejoy, Verda, & Hays, 1997) and respond more inconsistently than most (Metsapelto & Pulkkinen, 2003).

Mothers characterized by levels of Negative Affectivity believe that the behavior and development of their child is not contingent on their parenting, but largely determined by forces external to their parenting such as child temperament and chance (Lovejoy et al., 1997). This belief is described as Parental Locus of Control. Parents who have this belief have been found to compensate by using an authoritarian general parenting style with excessive control (Janssens, 1994). Furthermore, parents with higher levels of Negative Affectivity have also been found to have poor parental control, both exhibiting authoritarian parenting with

excessive control and permissive parenting with insufficient control (Metsapelto & Pulkkinen, 2003).

In the study of child diet there has been a focus on maternal child-feeding practices. A commonly used measure for studying child-feeding practices is the Child-feeding Questionnaire (CFQ) (Birch et al., 2001). It is a descriptive approach focusing on parental beliefs and practices related to child's obesity proneness. Of the seven factors in the CFQ, the control oriented factors pressure to eat, i.e. pressuring the child to eat more, and restriction, i.e. keeping attractive foods away from the child, have been given attention in relation to obesogenic diet in children.

Both general parenting styles involving poor parental control and the control-oriented child-feeding practices pressuring a child to eat and restricting a child's food intake, have been found to be predictive of the child consuming a less 'wholesome' diet, i.e. comprising vegetables and fruit, and a more 'unhealthy' diet, comprising sugary and fatty foods (Fisher & Birch, 1999b; Fisher & Birch, 1999a; Fisher, Mitchell, Smiciklas-Wright, & Birch, 2002; Birch, McPhee, Shoba, Pirok, & Steinberg, 1987; Patrick, Nicklas, Hughes, & Morales, 2005; De Bourdeaudhuij, 1997; Golan, 2006; Brown, Ogden, Voegle, & Gibson, 2008).

Deficits of previous studies

The two main weaknesses in the previous studies of maternal mood, anxiety, and personality in relation to breastfeeding were firstly the predominant use of cross-sectional design, secondly small sample sizes which might have led to a type II error (not finding a true effect).

A major weakness of the previous studies on child dietary patterns was the consistent use of the product-moment correlation matrix. In doing this, one firstly assumes that all the dietary components have equal variance; secondly, and more gravely that the causal factors forming the dietary pattern monotonously influence the intake frequency of all dietary components. This is quite an optimistic assumption. It makes more sense to approach the problem using the polychoric correlation matrix, since it is based on the assumption that the dietary variable observed is only an indicator of an underlying true normally distributed food intake variable and that the thresholds of this underlying variable determine the frequency of each separate dietary component observed.

Previous studies on predictors of breastfeeding behavior, child-feeding, or dietary patterns have by and large not used proper missing data techniques.

RESEARCH OBJECTIVES

Paper I

To investigate the effect of Negative Affectivity and General Self-efficacy on breastfeeding status at six months while controlling for other known risk factors.

Paper II

To test if mothers high in Negative Affectivity will be less efficient in feeding their child a wholesome diet and less efficient in not feeding an unhealthy diet. This effect will be tested over and beyond known maternal demographic and physical risk factors for unhealthy child eating.

Paper III

Hypothesis 1

The two child dietary patterns of ‘wholesome’ and ‘unhealthy’ diet found in this sample of children 18 months after birth will be re-identified when the children are three years of age.

Hypothesis 2

Since Negative Affectivity relates to external Parental Locus of Control, and the former both relate to excessive control, hypothesis two is that mothers with high levels of Negative Affectivity are more likely to pressure the child to eat and restrict the child’s food intake, but that the effect of this personality trait will be mediated through the beliefs of external Parental Locus of Control.

Hypothesis 3

Higher levels of Negative Affectivity in the mother and external Parental Locus of Control will predict more ‘unhealthy’ and less ‘wholesome’ dietary patterns, because mothers will be more likely to use the two forms of control-oriented child-feeding practices of pressuring the child to eat and restricting the child’s food.

Hypothesis 4

Since it is possible that control-oriented child-feeding practices have an effect on diet in addition to that exerted by mother's personality and general parenting factors, pressuring the child to eat and restricting the child's food intake will have an independent negative effect on the child's 'wholesome' dietary pattern and positive effect on the 'unhealthy' dietary pattern.

MATERIALS AND METHODS

The Norwegian Mother and Child Cohort Study

The data collection was conducted as a part of the *Norwegian Mother and Child Cohort Study* (MoBa) at the Norwegian Institute of Public Health. The study was launched in 1999 with the aim of studying a wide range of demographic, physical, genetic, and mental health exposure variables and outcomes in mothers and children (Magnus et al., 2006). The study will reach its goal of recruiting 100 000 pregnancies within the end of 2008. There are no exclusion criteria, and all maternity units in Norway with more than 100 births annually are included. Mothers are recruited for the study when they undergo their first prenatal ultrasound examination at 17 to 18 weeks gestation. The participation rate in MoBa is 42.7%. Mothers fill out questionnaires at 17 weeks gestation and 6 months, 18 months, and 3 years after childbirth. Response rates at 17 weeks gestation are 95%, 87% at 6 months after birth, 77% at 18 months, and 62% at 3 years (Magnus et al., 2006; Magnus, 2007). For the current study the *Medical Birth Registry of Norway* (MBRN), containing information about all births in Norway (Irgens, 2000) and information from the questionnaires administered at the five assessment points were used.

Sample

Paper I

Paper I included 34 083 single birth mothers returned the questionnaires at the 17th and 30th week of gestation and 6 months postpartum. The sample was restricted to singletons. The number of cases excluded because of missing data was 6330, and missing information was distributed as follows: maternal age: 1; gestational age of infant: 68; breast milk milk: 2213; Negative Affectivity and General Self-efficacy: 2257; education: 659; maternal smoking: 1005; external daycare: 131. The final sample comprised 27 753 mothers.

Paper II

At the time that paper II was conducted, questionnaires from 28,242 participating mothers with a child that had reached 18 months of age were available. Because of missing data 1.5% (n=479) of the participants were excluded from the analyses. The final sample consisted of 27 763 mothers. The lower fraction of missing cases in paper II and forward was

due to an increasing awareness during the study of the selection biases that can be produced by list wise deletion of missing cases.

Paper III

When paper III was written, questionnaires from 15,103 participating mothers with a child that had reached 3 year of age were available. Because of missing data, 6.5% (n=981) of the participants were excluded. The final sample therefore included 14,122 mothers.

Measures

Demographical and Physical Characteristics

Information regarding cesarean section, primiparity, and duration of gestation (based on ultrasound) was retrieved from the MBRN. Maternal self-reports were used as a secondary source where an entry in the MBRN was missing. Mothers completed questionnaires about age, smoking, education, income, marital status (currently single mother or cohabitating/married), current body mass index (BMI), and whether the infant was in daycare. Postpartum maternal smoking was defined as smoking 1 or more cigarettes per day since labor. Preterm birth was defined in accordance with the 10th revision of the *International Classification of Diseases* (World Health Organization, 2004) as birth before gestation week 37. Level of education and income were measured during pregnancy. Education was defined as number of years of education including college and university studies. To scale income, relative income was defined largely in line with the definition of relative poverty used by the Organization for Economic Cooperation and Development: median income earned by mother and father during pregnancy as 0 and intervals of $\pm 50\%$ of the median as ± 1 .

Psychometric Measures

Paper I

Negative Affectivity.

To measured maternal Negative Affectivity, short versions of the *Hopkins Symptom Checklist*, the SCL-5 were administred (Tambs & Moum, 1993) at the 17th week of gestation, and the SCL-8 administered at 30th week of gestation (Strand, Dalgard, Tambs, & Rognerud,

2003; Tambs, 2004). The SCL is a self-administered instrument designed to measure psychological distress, particularly anxiousness and depressiveness (Strand et al., 2003). A typical item of the SCL is “*Worrying too much about things*”. The response categories range from 1 to 4 (*not bothered, a little bit bothered, quite much bothered and very much bothered*). The SCL-5 and SCL-8 demonstrated internal consistencies of $\alpha=.78$ and $\alpha=.82$, respectively. Although the SCL is designed to measure distress, it has been documented that it can substitute for measures of Negative Affectivity, particular when assessed repeatedly (Watson & Clark, 1984). Therefore, the SCL-5 at gestation week 17 and the SCL-8 at gestation week 30 were pooled across the time points and computed a mean score. The temporal stability of the SCL-5 and the SCL-8 was adequate ($r=.57$; r corrected for attenuation $=.71$).

General Self-efficacy.

To measure General Self-efficacy at gestation week 30 it was used a 5-item version of the 10-item *General Self-efficacy Scale* (Luszczynska et al., 2005). A typical item is, “*I always manage to solve difficult problems if I try hard enough.*” Response categories are *incorrect* (1), *partly correct* (2), *almost correct* (3), *completely correct* (4). The internal consistency of the General Self-efficacy scale was above adequate at $\alpha=.83$.

General Self-efficacy Scale correlated $-.23$ with SCL-8 at gestation week 30, which corresponds to a correlation of $-.28$ corrected for attenuation.

Paper II and III

Negative Affectivity.

The measurement models for Negative Affectivity were equal in paper II and III. The difference was that in paper II the measurement points at 30th week of gestation, 6 months postpartum, and 18 months postpartum were utilized; while in paper III the measurement points at 6 months, 18 months and 3 years postpartum were used.

A measure of mother’s Negative Affectivity from several short scales in the questionnaires was compiled. The 8-item short version of the Hopkins Symptom Checklist (SCL) was used to assess the Anxiousness-Depressiveness component of Negative Affectivity (Strand et al., 2003; Tambs, 2004). To measured the anger component of Negative Affectivity, a 3-item short version of the Anger subscale of the Differential Emotions Scale was used (Izard, Libero, Putnam, & Haynes, 1993), and the Self-Esteem component of

Negative Affectivity assessed using a 4-item short version of the Rosenberg Self-Esteem scale (Rosenberg, 1989). By subsuming these short scales into one, a measure of Negative Affectivity with stronger psychometric characteristics was constructed. These components of Negative Affectivity include both time-invariant, dispositional variance and time-specific variance, which reflects a mother's state at the time when she filled out the questionnaire. To subtract the time-invariant dispositional factor, a latent variable across the three assessments was constructed (for details, see the statistics section).

The factor of Negative Affectivity used in paper II and III correlated .92 (without measurement error) with the Neuroticism/Emotional Stability factor in the International Personality Item Pool five factor personality inventory (Gow, Whiteman, Pattie, & Deary, 2005). This validation was done by utilizing the male partner sample of MoBa, which both included the International Personality Item Pool inventory and the measures of Negative Affectivity.

Parental Locus of Control.

The degree of external versus internal Parental Locus of Control was assessed at 3 years after childbirth using 5 items (item number 1, 5, 21, 41, and 44) from the Parental Locus of Control Scale (Campis, Lyman, & Prentice-Dunn, 1986). The Parental Locus of Control scale is a measure of the extent to which parents experience that the behavior of their child is controlled by their internal parenting skills or other events external to their parenting. A high score on the Parental Locus of Control scale indicates an internal Parental Locus of Control, a low score indicates a more external Parental Locus of Control.

Child-feeding practices.

Two forms of control oriented child-feeding practices, restriction of food intake by the mother and pressure to eat from the mother, were measured at 3 years after childbirth using the Restriction and Pressure to Eat subscales of the Child-feeding Questionnaire (Birch et al., 2001). The Child-feeding Questionnaire is a tool for assessing parents' perceptions, beliefs, attitudes, and practices regarding child-feeding relevant to the development of obesity. A typical question from the pressure to eat subscale is "*My child should always eat all of the food on her plate*", and a typical question from the restriction subscale is "*I have to be sure that my child does not eat too many sweets (candy, ice cream, cake or pastries)*". The respondents are asked to 'agree' or 'disagree' with each statement on a 5 point scale.

Paper I

Breastfeeding.

Mothers reported on breastfeeding and bottle feeding sixth month after birth, with detailed reporting for each preceding month. At this time the mothers also reported on feeding of a variety of solid foods; for each food item, they indicated how often, and starting when, the food had been introduced to the infant.

The categorization of breastfeeding was done largely in accordance with the WHO definitions (World Health Organization, 1991), which defines predominant breastfeeding as the case when the infant's predominant source of nutrition has been breast milk. Except for fruit juice and sugar-water, the infant must not have received any other nutrition than breast milk (World Health Organization, 1991). Based on feeding status at 6 months after birth, mothers in our study were classified in 3 feeding groups: *predominant breastfeeding*, *mixed breastfeeding*, and *bottle feeding*. Predominant breastfeeding was breastfeeding without any supplements of formula milk or solid food. Mixed breastfeeding was continued breastfeeding at 6 months, supplemented by milk or solids. Bottle feeding was feeding formula milk by bottle, with possible supplements of solids and no current but possible previous breastfeeding. Although the current WHO recommendation is for exclusive breastfeeding, the current study allowed only predominant breastfeeding to be defined as a category, which is less restrictive. The reason for this is that no information on fluids other than formula the infant might have received up to 6 months postpartum was attainable.

Paper II and III

Child diet.

Information on the current diet was collected through a maternal reported food frequency questionnaire. The food frequency questionnaires consisted of 36 dietary items at 18 months and 37 items at 3 years, and were on types of foods and drinks such as dairy products, cereal based porridge, and fruit juice. Response categories at 18 months ranged from "never" to "5 or more times a day" for drinks and from "never" to "3 or more times a day" for foods. Response categories at 3 years ranged from "never or less than 1 serving per

week” to “*4 or more servings per day*” for foods and drinks, and “*once per month or less*” to “*5 or more times per week*” for dinner foods.

Statistical methods

There was a continuous progression of both awareness of methodological implications and know how throughout the time period of the study. A classical test theory approach was used in paper I. The progression here was an increasing awareness of biases due to list wise deletion. Multiple imputation was therefore sought out in paper I.

In paper II and III, both the measurement and regression models were transferred into Structural Equation Modeling. The reason for this move was that the confidence intervals would be adjusted for the level of uncertainty due to missing data, measurement error could be removed, unidimensional constructs derived from Confirmatory Factor Analysis used, and mediation models applied.

Paper I

Independent t-tests were conducted to compare mothers excluded from the sample with those included in the analyses on the parametric variables. To compare the excluded with the included group on the dichotomous variables, Chi-square tests with correction for continuity were conducted. To investigate whether the missing data on the personality variables were random, estimates based on multiple imputation with estimates without imputation were compared. As the estimates were similar, we refrained from imputing missing data. A multinomial logistic regression model was done to get the odds ratio of mixed breastfeeding and bottle feeding, contrasted with predominant breastfeeding. The scales on Negative Affectivity and General Self-efficacy were modeled as predictors, adjusted for age, cesarean section, external daycare, primiparity, preterm birth, maternal smoking, and years of education. Variables were entered simultaneously in the multinomial logistic regression. An alpha level of .05 was used across the analyses.

Paper II and III

Independent t-tests were conducted with the continuous variables and chi-square tests with the categorical variables to compare the characteristics of the mothers included in the analysis and those excluded because of missing data. To perform exploratory factor analysis

(EFA), the confirmatory factor analyses (CFA), and the structural equation modeling, Mplus 5.1 was used (Muthén & Muthén, 2007; Muthén & Muthén, 2008).

Negative Affectivity and Parental Locus of Control

CFA was used for ordinal data with polychoric correlations to construct the Negative Affectivity components of Anxiousness-Depressiveness, Anger, and Self-Esteem (Flora & Curran, 2004).

The longitudinal modeling of a time-invariant latent variable of Negative Affectivity was done in accordance with the general framework for latent growth curve analyses with latent indicators based on categorical data described by Bollen & Curran (Bollen, 2006). Since the aim was to correct personality for time-specific stress, a time-invariant slope was not modeled, but an intercept-only model was used.

To secure syntactically equal measurement, the thresholds of the response categories within each item, the scaling of each item, and the factor structure of each scale was forced to be equal across time points. As a first step, the three Negative Affectivity components at each time point were combined into a latent variable of time-specific Negative Affectivity. Secondly, the factor loadings of the Negative Affectivity measure were forced to be equal across time. In the last step, a cross-time Negative Affectivity latent variable was constructed by setting the factor loadings equal across time. This procedure secured that the time-specific individual deviations were cancelled from the Negative Affectivity variable. The score therefore constitutes the individual characteristic across time.

A CFA for ordinal data of the items from the Parental Locus of Control scale was done to produce a variable of Parental Locus of Control. The items loaded freely on a factor with variance set to 1. Since the Parental Locus of Control scale can be divided into sub-dimensions, the items which were from the same sub-dimension were allowed to correlate in the CFA.

Child-feeding practices

To construct the two variables on child-feeding practices, 'Restriction' and 'Pressure to Eat', CFA for ordinal data with polychoric correlations was used. The items loaded freely on a factor with variance set to 1. To account for the internal dependencies between the items from the 'Restriction' scale combined in parcels by Birch, et al. (2001), the residual variance of the indicators within each item parcel were allowed to be correlated.

Dietary patterns

To identify the dietary pattern factor from the rated dietary items, a polychoric correlation coefficient matrix was produced from the frequency with which each child was reported to eat each food a month. This correlation matrix was then subject to EFA. This is a technique for assessing the factor structure of data measured on an ordinal scale. The scree plot was analyzed, and two dietary pattern factors were identified. In this evaluation, the fewest number of factors that could explain the most multivariate covariance was sought. Varimax rotation was used in paper II, while geomin oblique rotation was used in paper III (Browne, 2001).

Structural equation modeling

The EFA of child diet, the CFA's of the psychometric measures and the medical and demographic variables was included in a final structural equation model and jointly estimated. Negative Affectivity, the demographic, and the physical variables were defined as independent variables and the two dietary patterns predicted as uncorrelated dependent variables in a multivariate linear regression using structural equation modeling.

When the analyses in paper II were conducted it was not technically possible to include an EFA within structural equation modeling. Therefore, EFA was conducted, and then replicated using the factor loadings in a CFA within the structural equation model. The world of applied statistics fortunately moves forward, so when the work on paper III was done; it was now possible with Mplus version 5.1 to do an EFA within structural equation modeling. When this new option became available in May 2008, paper II was in revision. Therefore the structural equation model for paper II with the new option in Mplus 5.1 was executed. The results were close to identical. Therefore, the model of paper II, then already submitted to the journal, was not changed.

Robust weighted least-squares estimation (robust WLS) was chosen to identify the model (Flora & Curran, 2004; Muthén & Muthén, 2007), since CFA using polychoric correlations has proven to be robust to the non-normal distribution typical for behavioral data. Using robust WLS in Mplus 5.1 with covariates included in the model prohibited the estimation of confidence intervals of the standardized.

As a part of the final structural equation model, missing data for dependent variables as a function of the covariates in the model was estimated, and missing data on continuous

independent variables with the information from continuous covariates was imputed using the expectation-maximization algorithm. Furthermore, cases with missing data on the categorical independent variables from the analyses were excluded. The *root mean square error of approximation* (RMSEA) was interpreted to evaluate model fit to the data. A point-value on the RMSEA below .06 is considered necessary for a good fit, and the upper rim of the confidence interval of RMSEA below .08 for an adequate fit (Hu & Bentler, 1998). Using robust WLS, it was not possible to calculate a confidence interval for the RMSEA.

Test of Mediation

A mediator is the generative mechanism that the independent influences the dependent variable through (Baron & Kenny, 1986). Baron & Kenny (1986) specifies four specific steps as the sine qua non of mediation. The independent and dependent variable have to be associated. Secondly, the independent variable has to be related to the mediator. Thirdly, the mediator has to be related to the independent variable. Lastly, the relationship between the independent variable and the dependent variable has to evanesce or be weakened. Complete mediation is achieved when the association between the independent variable vanishes when controlling for the mediator, partial mediation when the association is weakened. Although not a specific criterion for mediation, if there is not an interaction effect between the mediator and the independent variable in relation to the dependent variable there is no possibility for a competing moderator approach.

Baron & Kenny (1986) envisages a continuum on the last criterion. Furthermore they state that when the association between the independent and the dependent variable is fully accounted for by the mediator, hence is reduced to zero, “*we have a strong evidence for a single, dominant mediator. If the residual path is not zero, this indicates the operation of multiple mediating factors.*” (p 1176).

MAIN FINDINGS

Paper I

The objective of this study was to examine the extent to which maternal personality traits of Negative Affectivity and General Self-efficacy measured during pregnancy predict breastfeeding status at the sixth month postpartum. The adjusting variables maternal smoking, primiparity and cesarean section had a large effect in their own rights on both mixed breastfeeding and bottle feeding compared to predominant breastfeeding. The direction of these associations accords with previous findings and points out the importance of these characteristics (Lande et al., 2003; Chapman & Perez-Escamilla, 1999).

Negative Affectivity increased the odds for both mixed breastfeeding (*Odds ratio (OR)* 1.16; *95% Confidence interval (95% CI)* 1.03 – 1.32) and bottle feeding (*OR* 1.32; *95% CI* 1.14 - 1.53) compared to predominant breastfeeding. General Self-efficacy lowered the odds of bottle feeding (*OR* 0.90; *95% CI* 0.84 – 0.97) but not mixed breastfeeding (*OR* 0.98; *95% CI* 0.92 - 1.04) compared to predominant breastfeeding.

Paper II

The principal finding of this investigation was that mothers with high levels of Negative Affectivity were more likely to feed their children an unhealthy diet (*standardized beta (b)* 0.09; *95% CI* 0.07, 0.10), which is a diet rich in sugar and fat. At the same time, mothers high in Negative Affectivity were neither more nor less likely to feed their child a wholesome diet (*b* -0.00; *95% CI* -0.02, 0.02), i.e., a diet rich in fibre, vitamins, and minerals. This effect persisted over and beyond earlier found socio-demographic risk factors.

The maternal socio-demographic characteristics were important in several respects, and replicate to large extent earlier findings in pre-school aged children. In terms of effect size the number of children was by far the most important predictor, with more than one-third standard deviation increase (β 0.37; *95% CI* 0.35 – 0.39) of unhealthy diet per child. Maternal daily smoking was also a substantial risk factor for feeding the child a less wholesome (β -.19; *95% CI* -0.24 – -0.15) as well as a more unhealthy diet (β 0.19; *95% CI* 0.15 – 0.23).

These findings are novel in several respects. No previous study has explored the potential relation between mothers' personality characteristics and infant dietary patterns. Beyond that, the findings fit nicely with the findings reported in paper I showing that mothers high in Negative Affectivity were more likely to terminate breastfeeding before the end of the

recommended period of 6 months. Taken together, this suggests that mothers high in Negative Affectivity show a tendency to feed their child in a less than optimal way.

Paper III

The key findings of this study were as follows: First, the two child dietary patterns identified in the MoBa-sample at 18 months after birth were corroborated by being identified again at 3 years. Furthermore, they were to a great extent empirically independent of each other: Significantly correlated at $-.10$; non-significant residual correlation at $.04$.

Second, mothers with high levels of Negative Affectivity were more inclined to use restriction of diet or to pressure the child to eat, and these behaviors were fully mediated through external Parental Locus of Control (figure 1). Moreover, external Parental Locus of Control explained a part of the association between Pressure to Eat and Restriction ($\chi^2 16.61, 1\ df$); the reason mothers who pressure the child to eat is likely to also restrict child food intake is their external Parental Locus of Control.

Third, those mothers high in Negative Affectivity and with an external Parental Locus of Control, were more likely to have children with a less ‘wholesome’ and more ‘unhealthy’ diet (figure 1). Moreover these effects were partly mediated by the restriction of the child’s food intake or pressuring the child to eat.

Fourth, in accordance with the hypotheses, mothers who pressured the child to eat tended not to have children with ‘wholesome’ diets and were more likely to have children with more ‘unhealthy’ diets (figure 1). Contrary to the hypotheses, mothers who restricted their children’s food intake tended to have children with more ‘wholesome’ diets and less ‘unhealthy’ diets (figure 1). The effects of child-feeding practices were largely independent of Negative Affectivity and Parental Locus of Control. The effect of Parental Locus of Control on child-feeding and the effects of Parental Locus of Control and child-feeding on dietary patterns were over and beyond the effect of demographic and physical risk factors adjusted for in the model.

Relationships between the demographic and physical variables and children’s diets were in general small, but the in accordance with the general pattern of findings in Paper II and earlier studies on 3-year-old children (North & Emmett, 2000). Maternal smoking ($\beta 0.22$) and the mother being at home ($\beta 0.34$) were substantially sized risk factors for unhealthy eating in 3-year-old children.

FIGURE 1. Structural equation model on influences of maternal Negative Affectivity and external Parental Locus of Control on maternal feeding practices and child diet.

* Residual correlation coefficient, $p < 0.01$.

† Standardized regression coefficient, $p < 0.01$.

‡ Standardized regression coefficient adjusted for physical and medical variables (results from adjusting variables in table 3), $p < 0.01$.

DISCUSSION

Interpretation of the Findings

Maternal Affectivity, Coping, Beliefs and Breastfeeding

Psychological variables, and particularly personality, have rarely been considered as predictors of breastfeeding. It was shown through the data that the stable personality traits Negative Affectivity and General Self-efficacy, assessed during pregnancy, predict the duration of breastfeeding. This finding is particularly important, because a design where breastfeeding is not present at Time 1 excludes the possibility of reverse causation, which is not the case for most of the earlier studies (Wagner & Wagner, 1999). From those previous studies it could not be concluded with certainty whether depressiveness or anxiousness or low Self-efficacy were predictors or consequences of difficulties with breastfeeding. Still, the possibility that failure to breastfeed could influence *sequential* levels of Negative Affectivity is held open.

Negative Affectivity and Breastfeeding

Several mechanisms might function as mediators of the relationship between Negative Affectivity and less breastfeeding. For example, it is well established that Negative Affectivity is closely linked to stress vulnerability, emotional reactivity, passive coping, and health-related worries (Vollrath, 2001; Friedman, 2000; Oswald et al., 2006). Persons high in Negative Affectivity are prone to give up on their goals when confronted with obstacles (Vollrath et al., 1998). Translated to breastfeeding, this could mean that mothers high in Negative Affectivity could be prone to give up breastfeeding early, if breastfeeding the infant proves difficult. Moreover, persons high in Negative Affectivity are more vigilant with regard to perceiving bodily symptoms (Friedman, 2000). Maternal anxiety has been inversely related to breastfeeding confidence, but not to breastfeeding knowledge (Britton, 2007). Earlier studies have found that mothers who discontinue breastfeeding reported worries that their infant was not receiving enough nutrition (Wagner & Wagner, 1999). This worry, more than a lack of knowledge on breastfeeding performance, could be a reason why mothers high in NA begin to supplement with solids or formula earlier than other mothers. Finally, maternal stress has been associated with reduced release of oxytocin and impaired lactogenesis (Dewey,

2001). As high Negative Affectivity increases vulnerability to stress, reduced release of oxytocin could be a consequence.

In the MoBa data almost all the women have at some time during the first week tried to breastfeed their child. This means that almost none of the women in MoBa chose to not initiate breastfeeding at all and go for bottle feeding instead. Previous studies, done in a time and at a place where bottle feeding was more common, investigated differences between those who initially chose to either breastfeed or bottle feed. In 1959, Call found that those who initially decided to solely bottle feed were the least anxious; yet of those who actually put the baby to the breast, it seemed to be the calmer mothers who were most likely to continue. There is therefore little room to interpret such an effect today, since society plausibly has gone from sanctioning bottle feeding to strongly sanctioning breastfeeding. It is possible that the schism where women choose to either breastfeed or bottle feed is to a great extent gone, and that the latter effect described by Call (1959) where women try and fail due to Negative Affectivity is expanded. Moreover, in Wagner and colleagues study (2006) mothers who initiated breastfeeding were found to be more extraverted and open to experience. It seems that such a study of the relation between positive affectivity/extraversion and breastfeeding initiation would be difficult to in Norway when virtually all Norwegian women to some degree initiate breastfeeding during their first week after delivery.

General Self-efficacy and Breastfeeding

General Self-efficacy, in contrast to Negative Affectivity, is particularly predictive of continuing health-promoting behavior also in the face of obstacles. Therefore, it is not surprising that high scores on the General Self-efficacy scale were found in the predominant breastfeeding group. The findings are therefore in accordance with prior research (Blyth et al., 2002; Blyth et al., 2004) and show that high General Self-efficacy predicts the sustaining of breastfeeding beyond the effect of Negative Affectivity. This can be explained by the fact that General Self-efficacy is construed as an action-related trait that shows its effect even when negative emotions may be present.

A recently published British study corroborates the finding of paper I on Self-efficacy and breastfeeding. The authors found that General Self-efficacy measured antenatally predicted perseverance of breastfeeding from zero to four months postpartum. Furthermore, they found that Breastfeeding Self-efficacy was substantially associated with breastfeeding continuation beyond the effect of General Self-efficacy (Bailey, Clark, & Shepherd, 2008).

This finding emphasizes that although General Self-efficacy is applicable in predicting a range of health behaviors, it does not fully cover the range of situation specific coping beliefs.

General Self-efficacy is not conceptually based on unrealistic optimism; it is optimistic beliefs based on various coping experiences (Schwarzer, 1992). In principle multiparas could have more optimistic beliefs about their ability to cope with breastfeeding due to their previous success, or be less optimistic about their ability to cope due to previous failure. Secondly have older age groups been found to have higher levels of General Self-efficacy (Bailey et al., 2008). The results presented in paper I was without these possible confounding effects, since the effect of General Self-efficacy was adjusted for parity and maternal age.

Earlier Findings on Control-oriented Feeding and Child Diet

To date findings relating control-oriented feeding practices to quality of children's diet have been contradictory. On the one hand, control-oriented feeding practices have been associated with increased preference and intake of an 'unhealthy' diet in children of various ages (Fisher & Birch, 1999b; Fisher & Birch, 1999a; Birch et al., 1987; Fisher et al., 2002). On the other hand, parenting characterized by insufficient control has also been associated with intake of an 'unhealthy' and a less 'wholesome' diet in children of various ages (Golan, 2006; De Bourdeaudhuij, 1997). Commonly used scales on feeding-specific parenting practices measure the degree of control over child-eating reported by the parent, whereas scales on general parenting styles measure what the parent believes is essential to do to be in control of their child. An important aspect that lies outside the domain of knowledge with respect to these measures of both feeding specific parental practices and general parenting styles is to what extent the parent finds that her actions are effective in controlling the child, or whether she believes that the child is controlled by factors external to her.

The Art of Defeatism: Negative Affectivity, Parental Control Beliefs and Child-feeding

I interpret the findings on Negative Affectivity, External Parental Locus of Control, child-feeding and diet to be interrelated in the following manner:

Those mothers characterized by high levels of Negative Affectivity tend to have an external Parental Locus of Control (Lovejoy et al., 1997). I interpret this to be because of their ineffective coping skills (Vollrath, 2001). Because they feel they can't control the child's eating behavior they are more likely to compensate by enforcing pressure on the child to eat

or to restrict the child's food intake. Moreover, the mother's external Parental Locus of Control may have a detrimental effect on the child's diet, because the mother will be less able to cope with the child's demand for sweet and fatty foods and less able to assure that the child eats a wholesome diet. Lastly, mothers with an external Parental Locus of Control are less likely to believe that the child is capable of internal self regulation in the feeding situation; therefore it makes sense to exert control.

The finding that pressuring a child to eat is associated with a less 'wholesome' diet and a more 'unhealthy' diet is in line with earlier findings (Brown et al., 2008; Fisher et al., 2002). The reason is that the children who are pressured to eat wholesome foods tend to build an aversion towards those foods (Fisher et al., 2002). Another control-oriented feeding practice that has been associated with a preference for and intake of an 'unhealthy' diet is restriction (Fisher & Birch, 1999b; Fisher & Birch, 1999a). This finding was not replicated, but on the contrary, it was found that restriction was associated with a more 'wholesome' diet and a less 'unhealthy' diet.

The finding that external Parental Locus of Control partially explained the association between Pressure to Eat and Restriction is a novel finding. These two child-feeding practices have in another study, together with the practice of monitoring, been subsumed under a common factor (Birch & Fisher, 2000). This study implicates that if Pressure to Eat and Restriction is constructed as caused by one common factor, the factor could be confounded with the parent's belief of being efficiently in control.

While Pressure to Eat has been described as an overt form of child-feeding, hence perceivable to the child, Restriction has on the other hand been described as a covert form of child-feeding (Ogden, Reynolds, & Smith, 2006). While the overt form has been related to more unhealthy snacking and less fruit and vegetable intakes, other have found the covert form to relate to the opposite (Brown et al., 2008). It could be that when a mother attempts to restrict her child's food intake, it is less obvious than pressuring the child to eat, and therefore the child does not react negatively to what the mother is trying to achieve.

Methodological considerations

Reliability

Reliability is consistency of measurement. Imagine doing an interview study on being for or against the European Union. To be sure whether one has tapped into a persons true

standing, one asks him or her 100 times “are you for or against the European Union?”. Assuming that the fluctuations in answers are due to random influences such as noise atmospheric changes, they will cancel each other out, and the person’s score will to a greater extent reflect his or her true standing. Since humans remember that they have just been asked that very same question, and this would possibly influence their true score; to conform with the assumptions of Classical Test Theory one would have to brainwash the respondents after each question (Lord & Novick, 1968) (pp 29-30). Although the implicated demands of entirely conforming to classical test theory are serious enough for quantitative psychology, reliability was tested in the current study using several approaches.

In paper I an internal consistency reliability coefficient, also known as Cronbach’s alpha, was calculated for the SCL-5, SCL-8, and General Self-efficacy scale. The alphas were .78, .82, and .83 respectively. The reliability coefficient indicates the share of true variance in a measure. The Cronbach’s alpha is an expression of the average split-half correlation and is an indication of how *well* the measure measures one single uni-dimensional factor; given that the measure actually measures only one single factor. For the purpose of paper I, the measures all had acceptable internal consistencies.

The pooling of measures over time done in Paper I could be thought of as a second form of reliability testing: Test-retest reliability. The correlation between the SCL-5 at week 17 and SCL-8 at week 30 was .57. Beyond this being a below adequate score, there are several problems in using this form of reliability. First, if a correlation between two measures is to be seen as an expression of reliability, the true score must have perfect stability. It could be that the true level of Negative Affectivity changed during the 3.5 months between measurement points. Second, to interpret the pooling of SCL-5 and SCL-8 as an attempt to investigate reliability, the measures should have been identical. They were not; SCL-8 has 3 items more than SCL-5.

The concept of reliability differs somewhat between classical test theory and latent variables. Reliability within latent variables is the squared correlation of a measure and its latent variable (Bollen, 1989). The factor loadings for Negative Affectivity were adequate; even when taking in consideration that the current study used a measurement model with second order factors across time. The factor loadings for Parental Locus of Control and child-feeding practices varied more, but were in general adequate.

Construct Validity

Negative Affectivity

The psychometrical derivation of the theoretical implications of a concept is construct validation (Cronbach & Meehl, 1955). To establish construct validity there should be convergence over different methods and discriminability in relation to other constructs (Campbell & Fiske, 1959). Although arguably a limit which should be set in specific relation to each nomological connection, a rule of thumb for deciding on discriminant validity between measures, is that they should not correlate above .80 without measurement error (John & Benet-Martinez, 2000). In paper II and III an approximation of Negative Affectivity was attempted by converging measures of anxiousness/depressiveness, anger, and low self-esteem, which have content semantically defined within Negative Affectivity; (Watson & Clark, 1984). Watson, Clark et al. concludes that the facets of Negative Affectivity have convergent and discriminant validity (Watson et al., 1995)). So was the case in the current study; anxiousness/depressiveness correlated .59 with anger and .61 with low self-esteem, and anger .53 with low self-esteem (from time point at 18 months postpartum; all correlations reported concerning validity are without measurement error). So far, so good. In the introduction it was stated that Negative Affectivity and Neuroticism/Emotional Stability from the five factor model are not discriminable with a correlation reported in the literature of .83 (Clark & Watson, 1999). So after the measure of Negative Affectivity was compiled for this study it was correlated with a measure of Neuroticism/Emotional Stability, utilizing the sample of fathers in MoBa. The correlation was at .92. This implies that the semantical aim for Negative Affectivity was by all means good, but that it possibly was set a little bit too high and towards Neuroticism/Emotional Stability.

The Nomological Relationship Between Negative Affectivity, General Self-efficacy, and Parental Locus of Control

General Self-efficacy does not conform to Bandura's conceptualization of context discrete self-efficacies. General Self-efficacy has no clear cut status as a trait, but is perhaps better conceptualized as a lower order trait. In the five factor model, Self-efficacy is regarded as a facet of the trait *Conscientiousness* (sometimes called *C1 - Competence*) (John & Srivastava, 1999). Although advocates of Self-efficacy as a prime factor would claim that low Self-efficacy is proneness to failure and therefore states of Negative Affect (Bandura, 1997),

it is here claimed that General Self-efficacy is not within the semantical heart of Negative Affectivity. There is discriminant validity between the two measures, with a correlation corrected for attenuation of $-.28$ (Negative Affectivity as measured in Paper I).

In their examination of convergent and discriminant validity of parental efficacy Lovejoy et al. concludes that measures of parental efficacy might reflect distress rather than specific beliefs about parenting. Their conclusion is flawed. First, the mean correlation between Negative Affectivity and Parental Locus of Control is at $.64$ corrected for attenuation; hence sharing 41% variance. The measures of the two concepts correlated $.55$ (30% shared variance) in the current study. This supports, as opposed to the conclusion by Lovejoy et al., discriminant validity. Second, content overlap in the range of psychological questionnaire measurement taken in consideration; measures of Negative Affectivity taps internal states of affects, while measures of parental efficacy taps specific beliefs in a specific parent-child relationship.

Short Scales

Several short form versions of scales were used in the current study. The SCL-5, SCL-8, and the Rosenberg Self-esteem scale were all shortened using stepwise regression; sequentially picking out those items who explain the most variance in the full version score (Tambs & Moum, 1993; Tambs, 2004). The SCL-5 and SCL-8 explain 84% and 89% of the SCL-25 respectively, and the 4-item version of Rosenberg Self-esteem scale explains 90% of the variance in the full 10-item scale (all *not* corrected for measurement error) (Tambs, 2004). The 5-items on General-self efficacy were selected by selecting the items with highest factor loadings.

These two approaches to short-form creation have their differences. While with the regression approach one seeks to make a short form of a *scale*, with the factor analysis approach one seeks to find the best indicators of measuring a *construct*. Since a scale formed by subsuming several questions can have multiple dimensions, one risk, by using the regression approach, to select items representing small sub-dimensions within a scale (e.g. panic attacks). This possibly makes sense when operating on operationalistic terms (i.e. representing a *scale*), but not when seeking construct validity (i.e. finding the best psychometric approach to a concept). It is my opinion that the uni-dimensional factor analytic approach makes by far more sense, if one believes that the responses on the items are actually *due* to (in a causal sense) a characteristic within the responding.

This problem has been remedied in paper II and III by using factor analysis on the regression derived short-forms.

The Content Validity of the Parental Locus of Control Measure

The items used to measure Parental Locus of Control was sampled neither by regression nor factor analysis. The items were selected for the MoBa study on face value. The measure of Parental Locus of Control can be applied both as divided in to sub factors defined by Campis et al. (1986) or subsumed into one scale of internal versus external Parental Locus of Control. On one hand the items were not selected with any sound statistical method, on the other were they selected to best semantically reflect Parental Locus of Control. Still there is uncertainty whether all aspects of Parental Locus of Control are covered well enough.

Strengths of the Study

First, a major strength of this study is that it is a population based cohort study where nearly all members of the population are invited. This makes to some extent the prevalence findings, but especially the association based findings generalizable to the Norwegian population.

Second, earlier studies on psychological determinants of breastfeeding have largely been done post partum. In using measures of the respondents psychological characteristics before the investigated behavior has been initiated strengthens the findings.

This is to the best of knowledge the second study to use polychoric correlations as a basis for studying dietary patterns (Togo, Heitmann, Sorensen, & Osler, 2003) and the first study to apply this methodology on child data. The assumption is that there are several normally distributed etiological factors influencing diet. It does not make sense that the actual frequency in different specific nutritional intakes should be the same. The use of polychoric correlations, where one assumes that the observed association to be caused by normally distributed latent variables follows this assumption to a greater extent than utilizing the much used product-moment correlation matrix in studying dietary patterns.

By using measures of Negative Affectivity across several time points, time specific stress other biases are attenuated.

The definition of data as ordinals (ordered categories) rather than intervals and including this within a latent variable framework does conform syntactically with the notion

of persons having inner characteristics which is manifested in specific responses contingent on their respective level of that characteristic.

12 Shades of Brown: Limitations of the Study

When generalizing the findings, several limitations must be kept in mind.

1. The SCL used to operationalize Negative Affectivity in paper I is less sensitive to normal variations in personality traits and shows a skewed distribution of scores. As a result, the effect sizes might have been either overestimated or underestimated.
2. In paper I Negative Affectivity was operationalized only through anxiousness and depressiveness. It can be argued, however, that Negative Affectivity includes other emotions and affects as well, such as anger, guilt and low self-esteem. At the same time, the measurement models from paper II and III showed that the SCL was a very good proxy of Negative Affectivity.
3. A further limitation in the previous vein is that in paper I a mean score across the items was used, while in paper II and III factor analysis was used. Within a composite score there could be several dimensions influencing the outcome differentially; within a factor score there can be only one dimension, making the association less ambiguous.
4. The full range of personality traits that is relevant in the context of health-behaviors was not assessed. However, space restrictions in the questionnaires did not allow for a full personality assessment questionnaire.
5. Persons with a high level of Negative Affectivity have more health complaints. This could pull the maternal report on child diet in a negativistic direction.
6. The range and numbers of indicators for the dietary patterns was limited, but it could be argued that children under three years of age have a limited diet and it was sought to find only a modest dietary pattern.
7. Although the same size or larger than several known risk factors, the effect size of Negative Affectivity on the unhealthy eating was small. Still, child diet has probably a wide range of etiological factors, so a very large effect size from only one maternal personality trait was not expected.
8. Unlike in the study of dietary patterns in this sample at 18 months after birth, marital status and age were not controlled for parity. Since parity could be related to marital status and age, the effect of those two former variables could therefore be partly due to number of children in the household.

9. An important maternal characteristic was not applied in the models used in paper II and III: maternal diet. On one hand maternal diet could be thought of as a mediating factor between Negative Affectivity and child diet. On the other hand, there is no room for this interpretation; since external Parental Locus of Control, which relates to a specific mother-child relationship, completely mediated the association between Negative Affectivity and child diet.
10. The studies on child-feeding, paper II and paper III, was done using maternal characteristics as predictors of child-feeding and diet. Although the mother plausibly has a large influence in early childhood years, I did not look into paternal or child related predictors. One thing is that by including these factors more variance in child diet would be explained. Another more severe point is that paternal and child characteristics could possibly function as moderators of the maternal influence.
11. Although the main characteristic of interest, Negative Affectivity, was measured before the parenting and dietetic outcomes, in paper III Parental Locus of Control, child-feeding practices and child diet was measured without a time lag.
12. The former limitation leads us onto the last limitation, which is of a more philosophical character; a multiple regression model reflects only one form of thinking. Other competing models with rearranged or even novel variables could therefore be specified indefinitely.

Suggestions for Future Research

Future studies ought to focus on the normal variations of personality traits and assess their entire spectrum as represented by the *Big Five trait taxonomy* (John & Srivastava, 1999). More specifically have breastfeeding initiation, as opposed to choosing not to breastfeed, been associated with personality traits related to extraversion (Chamberlain, 1976; Wagner et al., 2006). Moreover did the breastfeeding mothers in Chamberlain's (1976) study report that they would like their children to "become noisy and excited at all times". Future studies should investigate the possible relation between extraversion, sensation seeking, and approach motivation as predictors of breastfeeding behavior. Furthermore, it could be important to examine the impact of Conscientiousness, a trait predicting a wide spectrum of health behaviors (Bogg & Roberts, 2004), on both breastfeeding initiation and follow through.

The finding that mothers with higher levels of Negative Affectivity to a lesser extent breastfed was interpreted as due to inefficient coping. Since lactogenesis and hormonal

control of the let down reflex of breast milk is influenced by maternal stress, future studies should look into specific interactions between Negative Affectivity and breastfeeding problems. E.g. measured or experienced insufficient milk production, or nipple pain during feeding.

Since the much used Child-feeding Questionnaire (Birch et al., 2001), measuring child-feeding practices, is not theoretically derived; should future studies look into the role of personality, parenting strategies, and parenting beliefs in explaining the covariation between different forms of child-feeding practices. In the same vein should the factor structure of the widely established Child-feeding Questionnaire be questioned and reexamined.

CONCLUSION

The overall conclusion is that the children of mothers with a high level of Negative Affectivity to a lesser extent are breastfed and have a diet of poorer nutritional value beyond that of previous findings on maternal demographic and physical risk factors. Moreover, this thesis indicates a link between high levels of Negative Affectivity, not believing to be in control of the child, and harsher control in child-feeding. This link is corroborated by the findings that the impact of maternal Negative Affectivity on child-feeding and child diet is completely mediated by external Parental Locus of Control. These findings are important for future research on risk factors for obesogenic child diet, and awareness of these relationships may have clinical relevance for health personnel giving guidance on child-feeding.

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Abstract

Early dietary habits are formative for dietary habits later in life. Maternal personality might be an important factor in unhealthy feeding of children. The current study aims to assess the degree to which the personality trait of Negative Affectivity in mothers predicts their child's diet at age 18 months. This study is a part of the Norwegian Mother and Child Cohort Study conducted at the Norwegian Institute of Public Health. A total of 27 763 mothers completed 3 repeated assessments of Negative Affectivity before and after childbirth and of the child's diet when the child was 18 months old. Exploratory factor analysis was used to identify the dietary patterns, and structural equation modeling was used to investigate the relationship with Negative Affectivity adjusted for socio-demographical variables. Exploratory factor analysis of a foods frequency questionnaire revealed two dietary patterns in the child, labeled unhealthy diet and healthy diet. The unhealthy diet comprised foods rich in sugar and fat; the healthy diet comprised foods rich in fiber, vitamins and minerals. Mothers high in Negative Affectivity were more inclined to feed their child an unhealthy diet. The results were adjusted for maternal age, years of education, relative income, marital status, number of children, having the child in daycare, maternal smoking, maternal body mass index, and child gender. This study shows that a maternal personality trait, Negative Affectivity, is related to feeding the child an unhealthy diet after controlling for key socio-demographic variables.

Keywords: cohort, diet, infant, mothers, parenting, personality

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The impact of mothers' negative affectivity, parental locus of control, and child-feeding practices on dietary patterns of three-year-old children. The Norwegian Mother and Child Cohort Study

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26 ABSTRACT

27 **Background:** Both the maternal personality trait of Negative Affectivity (NA) and control-
28 oriented child-feeding are related to a low-quality child diet. There is no knowledge on the
29 possible mechanisms for these findings

30 **Objective:** First, to identify dietary patterns in 3-year-old children. Second to investigate the
31 extent to which NA, Parental Locus of Control (PLOC), and child-feeding practices (pressure
32 to eat and restriction) relate to these dietary patterns. Third, examine to what extent PLOC
33 and child-feeding practices serve as mediators for these effects.

34 **Design:** This study is part of the Norwegian Mother and Child Cohort Study, comprising
35 14,122 mothers completing assessments at 6 months, 18 months and 3 years postpartum.

36 **Results:** Factor analysis of the children's diet identified two weakly correlated dietary
37 patterns, labeled 'unhealthy' and 'wholesome', respectively. Mothers high in NA perceived
38 little control over their child's behavior, which in turn was associated with both pressuring
39 their child to eat or to restrict the child's food intake, and a less 'wholesome' and a more
40 'unhealthy' diet in the child. Pressuring the child to eat was associated with a less?
41 'wholesome' and a more 'unhealthy' diet. Restricting the child's diet was associated with a
42 more 'wholesome' and a less 'unhealthy' diet. These findings held after controlling for
43 maternal smoking, education, age, BMI, marital status, homemaker status, and child gender.
44 **Conclusion:** Unhealthy and wholesome eating in 3-year-old children is weakly correlated.
45 Mothers higher in NA perceive less control over their children, use more control-oriented
46 child-feeding, and have children who have a lower-quality diet.

INTRODUCTION

The epidemic increase in childhood obesity has lead to childhood diet becoming the focus of much research interest in recent years(1). Earlier studies of dietary patterns in preschool children have identified two main patterns(2;3); one pattern describes the consumption of ‘unhealthy’ foods, such as soda, chocolate, and sweets, and the other describes the consumption of ‘wholesome’ foods, such as beans, fruit, and fish.

The person with the greatest influence on a child’s diet is arguably the mother, and the mother’s characteristics, in turn, influence her food choices on behalf of her child. Being young, overweight, a smoker, or having lower educational attainment or more than one child increases the likelihood that a mother feeds her child less wholesome foods and more unhealthy ones(2;3).

Meal times can be emotive for both mother and child. Children often prefer foods with a high fat and sugar content(4). However, mothers know that their children should not eat too much of these foods, and that they instead should make them eat healthier alternatives. This can result in a situation familiar to most parents: the frustration of trying to feed a child foods he or she refuses to eat. Such a situation is stressful for most mothers. It might be especially so for emotionally unstable mothers, who could be susceptible to experiencing less control over their child(5) and to responding to him or her more inconsistently(6). Emotional instability, frequently called Negative Affectivity (NA), is a fundamental personality trait that embraces an innate inclination to emotional variability; frequent experience of negative affects such as anxiety, anger, and sadness; and a negative view of one’s own self(7).

In previous studies we have shown that mothers characterized by high levels of NA were less likely to breastfeed exclusively throughout the baby’s first six months(8) and more likely to feed their children an ‘unhealthy’ diet at 18 months of age(3). Persons characterized by high levels of NA believe that the behavior and development of their child is not contingent

on their parenting, but is largely determined by external forces such as child temperament and chance(5). This belief is captured by the construct of external parental locus of control (PLOC). Parents perceiving to have little control over their child tend to compensate by an authoritarian parenting style characterized by excessive control(9). Likewise, parents with higher levels of NA have been found to have poor parental control, both exhibiting authoritarian parenting with excessive control and permissive parenting with insufficient control(6).

Both general parenting and the parents' feeding practices have come into focus as a risk factor for child obesity in recent years(10). Commonly used scales on feeding-specific parenting practices measure the degree of control reported by the parent, whereas scales on general parenting styles measure what the parent believes is essential to do to be in control of their child. Findings show that authoritarian parenting, permissive parenting, and control-oriented child-feeding practices, such as pressuring a child to eat and restricting a child's food intake predict that the child consumes fewer 'wholesome' and more 'unhealthy' foods(11-18).

In this study we firstly aim to re-identify at three years the two child dietary patterns of 'wholesome' and 'unhealthy' diet found in this sample of children 18 months after birth(3) (hypothesis 1).

Secondly, because NA relates to external PLOC, and both NA and PLOC relate to excessive control, we hypothesize that mothers with high levels of NA are more likely to pressure the child to eat and restrict the child's food intake, but that the effect of this personality trait will be mediated through external PLOC (hypothesis 2; figure 1).

Thirdly, we hypothesize that higher levels of NA in the mother and external PLOC will predict more 'unhealthy' and less 'wholesome' dietary patterns, because mothers will be more likely to use the two forms of control-oriented child-feeding practices of pressuring the child to eat and restricting the child's food intake (hypothesis 3; figure 1).

Because it is possible that control-oriented child-feeding practices affect diet over and above the effects of maternal personality and general parenting, we fourthly hypothesize that pressuring the child to eat and restricting the child's food intake will have an independent negative effect on the child's 'wholesome' dietary pattern and a positive effect on the 'unhealthy' dietary pattern (hypothesis 4; figure 1).

We aim to test these hypotheses using data from the Norwegian Mother and Child Cohort Study and to control for key demographic and physical variables.

SUBJECTS AND METHODS

Study population

The data collection was conducted as a part of the Norwegian Mother and Child Cohort Study (MoBa) at the Norwegian Institute of Public Health. The study was launched in 1999 with the purpose of finding causes of serious diseases among mothers and children(19). There are no exclusion criteria, and all maternity units in Norway with more than 100 births annually are included. Mothers are recruited for the study when they undergo their first prenatal ultrasound examination at 17 to 18 weeks gestation. The participation rate in MoBa is 42.7%. Mothers fill out questionnaires at 17 weeks gestation and child age 6 months, 18 months, and 3 years after childbirth. Response rates are 95% at during pregnancy, while after birth they are 87% at 6 months, 77% at 18 months, and 62% at 3 years(19;20). For our study, we used information from the questionnaires administered at the aforementioned assessment points. In addition we used the Medical Birth Registry of Norway, which contains information about all births in Norway(21).

The study was approved by the appropriate regional committees for ethics in medical research and the Norwegian National Data Inspectorate.

At the time that we conducted this study, questionnaires from 15,103 participating mothers with a child that had reached 3 years of age were available. We excluded 6.5 percent (n=981) of the participants because of missing data. The final sample therefore consisted of 14,122 mothers.

Demographic and physical risk factors

We gathered information on child gender and maternal age from the Medical Birth Registry of Norway. We retrieved information on the mothers' smoking status (current regular smoker or non-smoker), education (years attained), current homemaker vs. working status, current body mass index (BMI) and current marital status (single or cohabiting/married) from the MoBa questionnaires.

Negative Affectivity

A measure of mother's NA was compiled from several short scales in the questionnaires(3). Using an 8-item short version of the Hopkins Symptom Checklist (SCL), we assessed the Anxiety-Depression component of NA(22). We measured the anger component of NA using 3 items from the Anger subscale of the Differential Emotions Scale(23), and the Self-Esteem component of NA using a 4-item short version of the Rosenberg Self-Esteem scale(24). By subsuming these short scales into one, we constructed a measure of NA with stronger psychometric characteristics. The assessment points for the NA components were at child age 6 months, 18 months, and 3 years. These components of NA include both time-invariant, dispositional variance and time-specific variance, which reflects the mother's state at the time when she filled out the questionnaire. We constructed a latent variable across the three assessments, to subtract the time-invariant dispositional factor (for details, see the statistics section).

The MoBa cohort study also includes an assessment of the child's father at the 17th week of gestation(19). In this assessment, the items used for modeling NA among mothers were

included together with a measure of Emotional Stability/Neuroticism from the International Personality Item Pool(25). The construct of Emotional Stability/Neuroticism is equivalent to NA(26). When correlating a latent NA variable construed in the fathers' data with a latent variable of Neuroticism/Emotional Stability from the same dataset, we found a correlation of $r=0.92$, suggesting an excellent validity of the NA-measure used our study.

Parental locus of control

The degree of external versus internal PLOC was assessed at child age 3 years using 5 items from the Parental Locus of Control Scale (item number 1, 5, 21, 41, and 44)(27). The PLOC scale is a measure of the extent to which parents believe that the behavior of their child is controlled by their own parenting skills or by other events external to their parenting. A high score on the PLOC scale indicates an internal PLOC, a low score indicates a more external PLOC.

Child-feeding practices

Two forms of control-oriented child-feeding practices, restriction of child food intake , and pressuring the child to eat were measured at child age 3 using the 'restriction' and 'pressure to eat' subscales of the Child-feeding Questionnaire(10). The Child-feeding Questionnaire is a tool for assessing parents' perceptions, beliefs, attitudes, and practices regarding child-feeding relevant to the development of obesity. A typical question from the pressure to eat subscale is "*My child should always eat all of the food on her plate*", and a typical question from the restriction subscale is "*I have to be sure that my child does not eat too many sweets (candy, ice cream, cake or pastries).*" The respondents are asked to 'agree' or 'disagree' with each statement on a five-point scale.

Child's diet

We collected information on the current diet of the 3-year-old children from their mothers, who filled out a 37-item food frequency questionnaire addressing how often the child

consumed foods and drinks such as bread, vegetables, snacks, and dairy products in an average month. Response categories ranged from “*never or less than one serving per week*” to “*four or more servings per day*” for non-dinner foods and drinks, and “*once per month or less*” to “*five or more times per week*” for dinner foods.

Statistical analysis

We conducted independent t-tests with the continuous variables and chi-square tests with the categorical variables to compare the characteristics of the mothers included in the analysis and those excluded because of missing data. To perform exploratory factor analysis (EFA), the confirmatory factor analyses (CFA), and the structural equation modeling (SEM), we used Mplus 5.1(28).

Dietary patterns

To identify dietary patterns from the 37 dietary items, we produced a polychoric correlation coefficient matrix from the frequency with which each child was said to eat each food in a month. This correlation matrix was then subject to EFA. The combination of the polychoric correlation matrix and EFA comprise a technique for assessing the multivariate factor structure of data measured on an ordinal scale. To rotate the factor solution, we used the geomin oblique rotation(29). We analyzed the scree plot and identified the first two dietary-pattern factors. In this evaluation we sought to find the smallest number of factors that could explain the most multivariate covariance.

Negative Affectivity and Parental Locus of Control

We used CFA for ordinal data with polychoric correlations to construct the NA components of Anxiety-Depression, Anger, and Self-Esteem(30). By forcing the thresholds of the response categories within each item, the scaling of each item, and the factor structure of each scale to be equal across time points, we secured syntactically equal measurement. As a first step, we combined the 3 NA components at each time point into a latent variable of time-

specific NA. Secondly, we forced the factor loadings of the NA measure to be equal across time. In the last step, we constructed a cross-time NA latent variable by setting the factor loadings equal across time. This procedure secured that the time-specific individual deviations were removed from the NA variable. The score therefore constitutes the individual characteristic across time.

To produce a variable of PLOC, we did a CFA for ordinal data of the items from the PLOC scale. The items loaded freely on a factor with variance set to 1. Since the PLOC scale can be divided into sub-dimensions, we let the items which were from the same sub-dimension correlate in the CFA.

Child-feeding practices

To construct the variables on child-feeding practices, ‘restriction’ and ‘pressure to eat,’ we used CFA for ordinal data with polychoric correlations. The items loaded freely on a factor with variance set to 1. To account for the internal dependencies between the items from the ‘restriction’ scale combined in parcels by Birch, et al.(10), the residual variance of the indicators within each item parcel was allowed to be correlated.

Mediation analysis

A mediator is the generative mechanism that the independent influences the dependent variable through(31). Baron & Kenny (1986) specifies four specific steps as the sine qua non of mediation. The independent and dependent variable have to be associated. Secondly, the independent variable has to be related to the mediator. Thirdly, the mediator has to be related to the independent variable. Lastly, the relationship between the independent variable and the dependent variable has to disappear or be weakened. Complete mediation is achieved when the association between the independent variable vanishes when controlling for the mediator, partial mediation when the association is weakened. Although not a specific criterion for mediation, if there is not an interaction effect between the mediator and the independent

variable in relation to the dependent variable there is no possibility for a competing moderator approach.

Structural equation modeling

The EFA of child diet, the CFA's of the psychometric measures, and the medical and demographic variables were included in a final SEM model and jointly estimated. We defined NA, the demographic, and the physical variables as independent variables, PLOC and child-feeding practices as independent or mediation variables, and the two dietary patterns predicted as correlated dependent variables in a multivariate linear regression using SEM.

We chose robust weighted least-squares estimation (robust WLS) to identify the model(28;30), since CFA using polychoric correlations has proven to be robust to the non-normal distribution typical for behavioral data. Using robust WLS in Mplus 5.1 with covariates included in the model prohibited us from estimating confidence intervals of the standardized coefficients. The unstandardized coefficients and confidence intervals are available upon request.

As a part of the final SEM model, we estimated missing data for dependent variables as a function of the covariates in the model. We imputed missing data on continuous independent variables with the information from continuous covariates using the expectation-maximization algorithm. Furthermore, we excluded cases with missing data on categorical independent variables from the analyses. To evaluate model fit to the data, we interpreted the root mean square of approximation, where a point-value below .06 is considered necessary for a good fit(32). Using robust WLS, it was not possible for us to calculate a confidence interval for the RMSEA.

RESULTS

Participants

Compared to participants, a greater proportion of the mothers excluded because of missing data were single. There was no other significant difference in demographic and physical variables between participating mothers and those excluded because of missing data (Table 1).

Identification of dietary patterns (hypothesis 1)

From the EFA, we extracted two dietary patterns for the child. Since the factors were nearly identical to the patterns found at child age 18 months the same sample, we labeled the first factor '*unhealthy*' and the second factor '*wholesome*'. In summing the indicators with factor loadings above .30, the '*unhealthy*' factor describes a pattern of eating characterized by consumption of chips, buns, cakes, waffles, chocolate, cookies, sweets, soda, ice cream, popsicles, bread with jam or honey, pizza, and soda with artificial sweeteners (Table 2). The '*wholesome*' factor describes a pattern characterized by consumption of lean fish, oily fish, boiled vegetables, raw vegetables, fruit, bread with fish products, egg, bread with meat, Norwegian brown cheese, and fish products (table 2).

The two factors of unhealthy and wholesome diet was modestly associated ($r = -.11$; 95% *CI* -.09 to -.12). The residual correlation, after adjusting for NA, PLOC, child-feeding, and medical and demographic characteristics, was non-significant ($r = -.04$; 95% *CI* -.08 to .00).

CFA of mother's Negative Affectivity, Parental Locus of Control and child-feeding practices

The factor structure and loadings from the CFA for ordinal data on mother's personality was meaningful and reproduced the SCL, Anger and Rosenberg Self-Esteem scales. The median item factor loadings for these scales were .79, .79, and .78, respectively. The median factor loading of the time-specific NA variables was .74. For the cross-time NA variable, the median factor loading was .86. The CFA on the items from the PLOC scale returned a below adequate median factor loading of .41. The factor loadings for the two scales measuring child-

feeding practices were less coherent. The ‘pressure to eat’ and the ‘restriction’ scales showed median factor loadings of .70 and .47, respectively.

Test of mediation of Negative Affectivity through Parental Locus of control on child dietary patterns and child-feeding practices.

To investigate whether there was no, partial or full mediation of NA through PLOC on the dietary patterns, we firstly identified the statistically significant associations between NA and the dietary patterns. Subsequently we determined the significant association between both NA and PLOC, and PLOC and the dietary patterns. The criteria, as described in the statistics section, for mediation was met, since all associations between independent, mediator and dependent variable were significant and there were no interaction effects between the independent and mediation variable(31). When we allowed for mediation of NA through PLOC on the dietary patterns, the mediation was complete, meaning that the entire effect of NA on diet went through PLOC.

In the same manner, we tested the extent of mediation of NA through PLOC on the two child-feeding practices. There was a positive association between NA, PLOC and both child-feeding practices, and no interaction effects. When we tested for mediation, the entire effect of NA on both Pressure to Eat and Restriction was completely mediated by PLOC.

Mediation of Negative Affectivity and Parental Locus of Control through child-feeding practices on child dietary patterns.

Likewise, we sought out to investigate whether the effect of PLOC on diet was mediated through feeding practices. A small portion of the effect of both PLOC and the indirect effect of NA were partially mediated through both Pressure to Eat and Restriction to both ‘wholesome’ and ‘unhealthy’ diet. The mediation was only partial, and most of the effect of child-feeding on child diet was independent to that of NA and PLOC.

Child-feeding practices predicted by Negative Affectivity mediated through Parental Locus of Control

The results clearly showed that those mothers who had an external PLOC were more likely to both pressure their children to eat and to restrict their diets (Figure 2). An equally clear finding was that, since the effect of NA on diet was fully mediated by PLOC, the more NA the mother displayed, the greater external PLOC, and therefore she was more likely to pressure the child to eat or restrict her child's food intake (Figure 2).

An additional finding was that external PLOC significantly explained part of the correlation between Pressure to Eat and Restriction (χ^2 16.61, 1 *df*).

The demographic and physical variables had an impact on child-feeding practices in several ways (Table 3). Mothers who had more years of education, higher BMI, were older or single were less likely to pressure their child to eat. Mothers who were homemakers were more likely to pressure their child to eat. Mothers who were homemakers, had more years of education, or who had a boy were more likely to restrict their children's food intake, unlike mothers who were older or had a higher BMI who were less likely. In terms of impact on child-feeding, external PLOC, several years of education, and being a homemaker were all strongly associated with pressuring the child to eat. The mothers' level of external PLOC was the only strong predictor of restricting the child's food intake.

Child dietary patterns predicted by negative affectivity mediated through parental locus of control and child-feeding practices (hypothesis 3)

In the SEM analysis, both the mother's level of NA, external PLOC and child-feeding practices were associated with the child's diet (figure 2). A higher score of NA in the mothers was associated with external PLOC, which was associated with both a more 'unhealthy' and less 'wholesome' diet in the child. Furthermore, only a minor part of the effect of NA and PLOC was mediated through child-feeding practices (figure 2). Mothers with a high level of

NA and an external PLOC were more inclined to both pressure their child to eat and restrict their child's diet (figure 2). The children of those mothers were therefore more likely to have a less 'wholesome' and more 'unhealthy' diet due to pressuring their child to eat and at the same time more likely to have a 'wholesome' diet due to restricting their child's diet and not pressuring their child to eat. When combined, these two small opposite indirect effects of high NA and external PLOC on 'wholesome' diet fully cancel each other and partially cancel each other on 'unhealthy' diet, with the effect through pressure to eat being somewhat stronger.

Independent effect of child-feeding practices (hypothesis 4)

Most of the effect of the two control-oriented child-feeding practices on diet were independent of NA and PLOC. Mothers who pressured their child to eat had children with a less 'wholesome' and more 'unhealthy' diets (figure 2). Restriction had the opposite effect on diet; mothers who restricted their children's diets had children with more 'wholesome' diets and less 'unhealthy' diets.

Association between demographic and physical variables and dietary patterns.

Demographic and physical variables were associated with children's diet in several ways (table 3). The effects of the continuous variables in Table 3, i.e. maternal education, age, and BMI, are given as incremental change per interval. For example; a three-year increase in maternal education should be interpreted as a threefold incremental difference in standard deviation on the dependent variable. Mothers who were regular smokers, had a higher BMI, or who had boys were less likely to have children with a 'wholesome' diet. Mothers with more years of education, who were homemakers, or older tended to have children with more 'wholesome' diets. Mothers who had more years of education or were single tended not to have children with an 'unhealthy' diet. Mothers who were regular smokers, homemakers, older, or had a higher BMI were more likely to have children with an 'unhealthy' diet.

The SEM analysis, which simultaneously included all the CFA's and the multiple regression analysis, had a good fit to the covariance matrix (root mean square error of approximation of .03).

DISCUSSION

The key findings of this study are as follows: First, the two child dietary patterns identified in the MoBa-sample at 18 months after birth were corroborated by being identified again at 3 years. Unhealthy and wholesome diet was only modestly associated, and furthermore non-significantly associated after adjusting for other variables. This means that a child's intake of chocolate, chips, and soda at 3-years of age is only weakly related to his or her intake of vegetables, fish, and fruit. Second, mothers with high levels of NA were more inclined to restrict their child's diet or to pressure the child to eat, and these behaviors were fully mediated through external PLOC. Moreover, external PLOC explained a part of the association between Pressure to Eat and Restriction; mothers' external PLOC could therefore be interpreted as a common etiological factor for the mother's tendency to pressure the child to eat and to restrict the child's food intake. Third, mothers high in NA and with an external PLOC were more likely to have a child eating a less 'wholesome' and more 'unhealthy' diet. Further, these effects were partly mediated by the restriction of the child's food intake or pressuring the child to eat. Fourth, in accordance with our hypotheses, mothers who pressured the child to eat tended not to have a child with 'wholesome' diets and were more likely to have children with more 'unhealthy' diets. Contrary to our hypotheses, mothers who restricted their children's food intake tended to have a child with more 'wholesome' diets and less 'unhealthy' diets. The effects of child feeding practices were largely independent of NA and PLOC.

Relationships between the demographic and physical variables and children's diets were in accordance with earlier studies on 18-months-old and three-year-old children(2;3). Maternal smoking and the mother being a homemaker were substantial risk factors for unhealthy eating in the children.

To date, findings relating control-oriented feeding practices to quality of children's diet have been contradictory. On the one hand, control-oriented feeding practices have been associated with a preference for and consumption of an 'unhealthy' diet in children of various ages(11-14). On the other hand, parenting characterized by insufficient control has been also been associated with intake of an 'unhealthy' and less 'wholesome' diet in children of various ages(16;17).

Mothers characterized by high levels of NA will tend to have an external PLOC because of their ineffective general coping skills(5;33). Perceiving that they have little control over the child's eating behavior, such mothers will tend to enforce control by using pressure and restriction as feeding strategies. At the same time, mothers perceiving little control will be less able to cope with the child's demand for sweet and fatty foods and less able to ensure that the child eats a wholesome diet. Lastly, mothers perceiving little control tend to believe that the child is capable of internal self regulation in the feeding situation; therefore it makes sense for them to exert control.

The finding that pressuring a child to eat is associated with a less 'wholesome' diet and a more 'unhealthy' diet is in line with earlier research(13;18). Children that are pressured to eat certain foods are at risk to build an aversion towards just these foods(13). In a similar vein, the control-oriented feeding practice of restriction appears to be related to a preference for and the intake of an 'unhealthy' diet(11;12). Our results did not replicate this finding; on the contrary, we found restriction to be associated with the opposite dietary pattern, a more 'wholesome' diet and a less 'unhealthy' diet.

The finding that external PLOC partially explained the association between Pressure to Eat and Restriction is novel. This study implicates that if Pressure to Eat and Restriction is conceptualized as caused by a common factor of control-oriented child-feeding, this factor could be confounded with the parent's belief of being efficiently in control.

While pressure to eat has been related to an overt form of child-feeding, hence perceivable to the child, restriction has on the other hand been described as a covert form of child-feeding(34). While the overt form of child-feeding has been related to more unhealthy snacking and less fruit and vegetable intakes, the covert form of child-feeding relates to less snacking and fruit and vegetable intake(18). It could be that when a mother attempts to restrict her child's food intake, it is less obvious than pressuring the child to eat, and therefore the child does not react negatively to the mother's control efforts.

There are some limitations to the current study that should be addressed. Firstly, the food-frequency questionnaire was limited in range of foods. Then again, three-year-olds have a limited diet. Secondly, the mediated effect of NA on diet was small. Yet it was arguably the same size or larger than the effects of some demographic and physical factors commonly deemed important, such as maternal age and maternal BMI,. Thirdly, unlike in the study of dietary patterns in this sample at 18 months after birth, marital status and age were not controlled for parity. Since parity may be related to marital status and age, the effect of those two former variables could therefore be partly due to number of children in the household. The fourth limitation is of a more philosophical character; a multiple regression model reflects only one form of thinking, and the parental variables were measured at the same time as the dietary information. Other competing models with rearranged or even novel variables could therefore be specified.

We suggest that the clinical implications of our findings relates firstly to the form of dietary recommendations and advice given by health professionals. NA manifests as readily

418 recognizable anxiousness, insecurity, and helplessness. Health professionals who meet
419 mothers showing these signs may prevent child-feeding problems by asking whether these
420 mothers feel that they have control of the feeding situation. Secondly, the finding that the
421 unhealthy and the wholesome diets were only weakly correlated implicates that to the
422 promotion of healthy eating in pre-school-aged children must target both dietary patterns
423 separately. Reducing the intake of sweet foods will not automatically increase the intake of
424 wholesome foods (e.g. fruit and vegetables).

425 Since PLOC partially explained the association between Pressure to Eat and Restriction,
426 future studies should investigate the role of personality and parenting in explaining the
427 covariation between child-feeding practices. Second, since the effect of external PLOC was
428 largely independent of the two control-oriented-child-feeding practices, future research ought
429 to assess a range of child-feeding practices and aspects of parenting other than those directly
430 related to feeding. Furthermore, a full spectrum of personality traits should be included to
431 relate both child-feeding and diet to different forms of stress coping(33).

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433 EY conceived the design of this study, performed all data analysis, and drafted and finalized
434 the manuscript. MEV designed the study and participated in strategic decisions concerning
435 the analysis and interpretation of data. MB participated in interpretation of the data and
436 writing of the manuscript. All of the authors reviewed the manuscript for important content
437 and approved the final manuscript. None of the authors had a conflict of interest.

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Table 1. Characteristics of the mothers included and those excluded because of missing data*

	Included (n=14,122)	Excluded (n=981)
Child gender boy (%)	51.2	48.9 [978]
Daily smoking (%)	11.0	23.1 [26]
Education (y)	14.4 ± 2.4†	14.4 ± 2.4
Homemaker (%)	30.2	27.6 [261]
Maternal age (y)	33.0 ± 4.6	32.9 ± 4.5
Maternal BMI§	24.8 ± 4.4	24.7 ± 3.8
Single marital status (%)	6.0	10.1 [238] ‡

*Number of cases in brackets.

†Mean ± standard deviation (all such values).

‡Significantly different from the included cases (χ^2 test): $P < .05$.

§Body mass index

Table 2. Standardized rotated factor loadings of various dietary items in the two dietary factors identified in 3 year old children based on the food frequency questionnaire (loadings above 0.3 are shown in bold).

	Unhealthy	Wholesome
Chocolate	.62	-.08
Chips	.56	-.06
Sweets	.56	-.07
Buns, cakes, and waffles	.54	.05
Ice cream	.54	.10
Cookies	.54	-.02
Popsicle	.51	.08
Soda	.48	-.07
Bread with jam or honey	.33	-.02
Pizza	.30	.02
Soda with artificial sweeteners	.30	-.15
Pancakes	.21	.03
Juice	.18	.11
Meat, sausage, and meatballs	.16	.08
Slices per day of fiber rich bread	-.14	.09
Flavored yogurt	.13	.04
Bread slices per day	-.11	.07
Skimmed and semi-skimmed milk	-.07	.00
Boiled vegetables	-.10	.50
Lean fish	-.04	.50
Oily fish	-.08	.49

Raw vegetables	-.07	.44
Fruit	-.09	.37
Bread with fish products	-.05	.35
Egg	.16	.35
Potatoes	.00	.28
Bread with cheese	.04	.27
Soup	.16	.26
Fish products	.05	.26
Raisins	.08	.25
Bread with meat	.04	.24
Rice	.02	.18
Plain yogurt	-.06	.17
Norwegian brown cheese	-.03	.17
Soured milk with LGG	-.07	.16
Pasta	.09	.15
Full-cream milk	.08	.14

Table 3. Regression coefficients for the demographic and physical adjusting variables in the SEM analysis.

	'Pressure to Eat' [†] (Adj. β)	'Restriction' [†] (Adj. β)	'Wholesome' [†] (Adj. β)	'Unhealthy' [†] (Adj. β)
Child gender boy	0.00	0.04§	-0.08	-0.00
Daily smoking	0.04	-0.05	-0.07§	0.22
Education (y)	-0.05	0.02	0.03	-0.01
Homemaker	0.13	0.08	-0.03	0.34
Maternal age (y)	-0.01	-0.01	0.02	0.01
Maternal BMI	-0.01§	-0.01	-0.01	0.01
Single marital status	-0.08§	-0.01	0.08	-0.12

* Standardized score.

† Adjusted for Parental Locus of Control.

‡ Adjusted for Parental Locus of Control, Pressure to Eat, and Restriction.

§ $p < 0.05$

|| $p < 0.01$

LEGEND FOR FIGURES

FIGURE 1. Conceptual model of the interrelation between maternal Negative Affectivity, external Parental Locus of Control, child-feeding practices, and child diet.

FIGURE 2. Structural equation model on influences of maternal Negative Affectivity and external Parental Locus of Control on child-feeding practices and child diet.

* Residual correlation coefficient, $p < 0.01$.

† Standardized regression coefficient, $p < 0.01$.

‡ Standardized regression coefficient adjusted for physical and medical variables (results from adjusting variables in table 3), $p < 0.01$.

APPENDIX I - III

APPENDIX I

Standardized Factor Loadings From the Measurement Models in Paper III

Negative Affectivity at 3 years postpartum: Subscales, items and factor loadings

	NA*
Hopkins Symptom Checklist (SCL-8)	.82
Feeling fearful	.81
Nervousness or shakiness inside	.85
Feeling hopeless about the future	.83
Feeling blue	.86
Worrying too much about things	.84
Feeling everything is an effort	.76
Feeling tense or keyed up	.76
Suddenly scared for no reason	.79
Rosenberg Self-esteem scale	.76
I take a positive attitude toward myself	-.84
I certainly feel useless at times	.85
I feel I do not have much to be proud of	.73
I feel that I'm person of worth, at least on an equal plane with others	-.74
Anger subscale of Differential Emotions Scale	.72
Feel like screaming at somebody or banging or something	.78
Feel angry, irritated, annoyed	.82
Feel mad at somebody	.79

*NA Negative Affectivity

Factor loadings for the latent Parental Locus of Control variable used in

	Item# in PLOC-scale	Factor loading
What I do has little effect on my child's behavior	1	.39
My child usually ends up getting his/her way, so why try	5	.50
My life is chiefly controlled by my child	21	.52
It is often easier to let my child have his/her way than to put up with a tantrum	41	.50
Sometimes when I'm tired I let my children do things I normally wouldn't	44	.48

Factor loadings for the latent variables of the Restriction and Pressure to Eat subscales of Child Feeding Questionnaire.

	Factor loading
<i>Restriction</i>	
1. I have to be sure that my child does not eat too many sweets (candy, ice cream, cake or pastries)	.45
2. I have to be sure that my child does not eat too many high fat foods	.38
3. I have to be sure that my child does not eat too much of his/her favorite foods	.56
4. I intentionally keep some foods out of my child's reach	.45
5. I offer sweets (candy, ice cream, cake, pastries) to my child as a reward for good behavior	.38
6. I offer my child his/her favorite food as a reward for good behavior	.42
7. If I did not regulate my child's eating he/she would eat too much unhealthy food	.76
8. If I did not guide or regulate my child's eating he/she would eat too much of his/her favorite foods	.78
<i>Pressure to Eat</i>	
9. My child should always eat all the food on her plate	.26
10. I have to be especially careful to make sure my child eats enough	.83
11. If my child says "I'm not hungry", I try him/her to eat anyway	.55
12. If I did not regulate my child's eating, she would eat much less than she should	.92
Note. Restriction and Pressure to Eat correlated $r=.28$.	

APPENDIX II

Correlations of latent variable used in paper III.

	1	2	3	4	5	6
Negative Affectivity	1					
External Parental Locus of Control	.55	1				
Pressure to Eat	.16	.29	1			
Restriction	.19	.34	.28	1		
Unhealthy	.14	.26	.20	.05	1	
Wholesome	-.08	-.15	-.18	.02	-.11	1

Note. N=14122; only those variables used in the structural mediation model are given, not those which only were a part of the measurement model.

APPENDIX III

Questionnaires

1. Questionnaire 1 – 17th week of gestation
2. Questionnaire 4 – 6 months postpartum
3. Questionnaire 5 – 18 months postpartum
4. Questionnaire 6 – 36 months postpartum

Tidligere svangerskap

31. Har du vært gravid tidligere? (Dette gjelder også svangerskap som endte med abort eller dødfødsel.)

- ☐ Ja
☐ Nei (Gå til spørsmål 36.)

32. Hvis ja, kryss av for alle tidligere svangerskap. Tryk også med svangerskap som endte med abort eller dødfødsel, eller der du ikke fikk barn. Oppgi navn på medisin, i hvilke svangerskapsuker du brukte medisin og antall dager du brukte dem. (Dette gjelder alle typer medikamenter, både faste og ikke-faste og naturmedisiner. Kne for inn vitaminer og kosttilskudd - disse spør vi om senere i skjemaet)

Svangerskapsnummer	Areal for svanger- skap start	Levende barn	Spontan- abort/ dødfødsel	Frem- tidig abort	Svanger- skap utenfor livmoren	Svangerskaps- ute for aborten/ dødfødselen	Antall måneder med svanger- skap (antall år)	Veksting i svanger- skap (antall kg)	Barns i svanger- skap										
1	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

33. Har du hatt noen av følgende plager i tidligere svangerskap?

(Kryss av for hver plage.)

1	Bekkenløsning som førte til sykdom	Nei	Ja
2	Bekkenløsning som gjorde det nødvendig med sengeløse	☐	☐
3	Mye plaget av kvalme og oppkast	☐	☐
4	Svangerskapsforgiftning	☐	☐
5	Svangerskapsdiabetes	☐	☐
6	Sukker i urinen	☐	☐
7	Mye plaget av uventlig umåttelighet	☐	☐

34. Hvis du hadde bekkenløsning i tidligere svangerskap som gjorde det nødvendig med sengeløse eller sykdom, når begynte plagene?

☐ måneder etter påbegynt svangerskap

35. Når sluttet plagene?

☐ måneder etter fødselen
☐ har hatt vedvarende plager

Sykdommer og helseplager i dette svangerskapet

36. Har du hatt en eller flere blødninger fra skjeden i løpet av dette svangerskapet?

- ☐ Nei
☐ Ja

37. Hvis ja, beskriv den første og den siste blødningen. Angi dato da blødningen startet, hvor mange dager det varte og hvor mye du blødde?

Kryss av for blødningsmengde (sporblødning betyr noen dråper)

Første blødning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Siste blødning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	dag	min	år																

Hvis mer enn to blødningsepisoder angitt, antall

38. Har du opplevd noen av følgende sykdommer eller helseplager i dette svangerskapet? Hvis du har brukt medisin i forbindelse med disse plagene, oppgi navn på medisin, i hvilke svangerskapsuker du brukte medisin og antall dager du brukte dem. (Dette gjelder alle typer medikamenter, både faste og ikke-faste og naturmedisiner. Kne for inn vitaminer og kosttilskudd - disse spør vi om senere i skjemaet)

Sykdommer / helseplager i dette svangerskapet		Bruk av medisin i dette svangerskapet										Antall dager brukt				
Sykdom/helseplage	+	I svangerskapsuker					Navn på medisin du brukte						I svangerskapsuker			
		0-4	5-8	9-12	13+		0-4	5-8	9-12	13+		0-4	5-8	9-12	13+	
1	Bekkenløsning	☐	☐	☐	☐							☐	☐	☐	☐	☐
2	Magesmerter	☐	☐	☐	☐							☐	☐	☐	☐	☐
3	Vondt i ryggen	☐	☐	☐	☐							☐	☐	☐	☐	☐
4	Nakke-/skuldersmerter	☐	☐	☐	☐							☐	☐	☐	☐	☐
5	Kvalme	☐	☐	☐	☐							☐	☐	☐	☐	☐
6	Kvalme med brekninger/opkast	☐	☐	☐	☐							☐	☐	☐	☐	☐
7	Soppinfeksjon i skjeden	☐	☐	☐	☐							☐	☐	☐	☐	☐
8	Skjeddoktariruvning utflod	☐	☐	☐	☐							☐	☐	☐	☐	☐
9	Svangerskapskole	☐	☐	☐	☐							☐	☐	☐	☐	☐
10	Treg mageforstoppelse	☐	☐	☐	☐							☐	☐	☐	☐	☐
11	Daré/omgangssyke	☐	☐	☐	☐							☐	☐	☐	☐	☐
12	Uvanlig tretthet/søvnighet	☐	☐	☐	☐							☐	☐	☐	☐	☐
13	Søvnp problemer	☐	☐	☐	☐							☐	☐	☐	☐	☐
14	Halsbrann/sure oppstøt	☐	☐	☐	☐							☐	☐	☐	☐	☐
15	Hvelsel i kroppen (edem)	☐	☐	☐	☐							☐	☐	☐	☐	☐
16	Fiber med utsett	☐	☐	☐	☐							☐	☐	☐	☐	☐
17	Fiber over 38,5oC	☐	☐	☐	☐							☐	☐	☐	☐	☐
18	Forkjølelse	☐	☐	☐	☐							☐	☐	☐	☐	☐
19	Halsbetennelse	☐	☐	☐	☐							☐	☐	☐	☐	☐
20	Bhule-/orbittbetennelse	☐	☐	☐	☐							☐	☐	☐	☐	☐
21	Influenza	☐	☐	☐	☐							☐	☐	☐	☐	☐
22	Lungebetennelse/bronkitt	☐	☐	☐	☐							☐	☐	☐	☐	☐
23	Sukker i urin	☐	☐	☐	☐							☐	☐	☐	☐	☐
24	Egghvite (protein) i urin	☐	☐	☐	☐							☐	☐	☐	☐	☐

+

+

+

Tidligere og nåværende sykdommer og helseplager

39. Kryss av hvis du har eller har hatt noen av følgende sykdommer eller helseplager. Hvis du har brukt tabletter, miksturer, stikkpiller, inhalasjoner, salver osv. i forbindelse med sykdommen eller helseplager, oppgi navnet på medisinen(e) og når du brukte disse.

Sykdommer / helseplager		Bruk av medisiner			
Sykdom / helseplage	For svanger- slepet	Navn på medisin(er)	State 6 md. for svanger- slepet	I svangerskapsuke 0-4 5-8 9-12 13+	Antall dager brukt
Astma / Allergi / Hud					
1 Astma	☐		☐	☐	☐
2 Høysnus, pollenallergi	☐		☐	☐	☐
3 Dyrehårsallergi	☐		☐	☐	☐
4 Annen allergi	☐		☐	☐	☐
5 Atopisk eksem (ofte kalt barneeksem)	☐		☐	☐	☐
6 Ekteblest (urticaria)	☐		☐	☐	☐
7 Psoriasis	☐		☐	☐	☐
8 Annen eksem	☐		☐	☐	☐
9 Munnslår (herpes)	☐		☐	☐	☐
10 Akne/kviser (alvorlig)	☐		☐	☐	☐
Diabetes / Sukkersyke			☒		
11 Diabetes behandlet med insulin	☐		☐	☐	☐
12 Diabetes ikke behandlet med insulin	☐		☐	☐	☐
Hjerte / Blod / Stofskifte / Blodkar					
13 Medfødt hjertefeil	☐		☐	☐	☐
14 Annen hjerte-ka-sykdom	☐		☐	☐	☐
15 For høyt kolesterol	☐		☐	☐	☐
16 For høyt blodtrykk	☐		☐	☐	☐
17 For høyt eller for lavt stoffskifte	☐		☐	☐	☐
18 Anemi/lav blodprosent	☐		☐	☐	☐
19 B-12-/jernetilførselmangel	☐		☐	☐	☐
Mage / Tarm	☒		☐	☐	☐
20 Hepatitt/leverbetennelse	☐		☐	☐	☐
21 Gallestein	☐		☐	☐	☐
22 Mageulr	☐		☐	☐	☐
23 Crohns sykdom / Ulceres colitt	☐		☐	☐	☐
24 Colikk	☐		☐	☐	☐
25 Annen mage-tarmplager	☐		☐	☐	☐
Muskel / Skjelett / Bindevev	☒		☒	☐	☐
26 Leddgikt (reumatoid/artritt) / Baktens sykdom	☐		☐	☐	☐

Sykdommer / helseplager

39. Kryss av hvis du har eller har hatt noen av følgende sykdommer eller helseplager. Hvis du har brukt tabletter, miksturer, stikkpiller, inhalasjoner, salver osv. i forbindelse med sykdommen eller helseplager, oppgi navnet på medisinen(e) og når du brukte disse.

Sykdommer / helseplager		Bruk av medisiner			
Sykdom / helseplage	For svanger- slepet	Navn på medisin(er)	State 6 md. for svanger- slepet	I svangerskapsuke 0-4 5-8 9-12 13+	Antall dager brukt
27 Lupus (SLE)	☐		☐	☐	☐
28 Igjuss	☒		☐	☐	☐
29 Fibromyalgi	☐		☐	☐	☐
Underlivet / Urinveier					
30 Betennelse i eggstøker/ledere	☐		☐	☐	☐
31 Endometriose	☐		☐	☐	☐
32 Nedfall av livmor	☐		☐	☐	☐
33 Cyste på eggstokk	☒		☐	☐	☐
34 Muskelknuter på livmor	☐		☐	☐	☐
35 Celleforandringer på livmorhals	☐		☐	☐	☐
36 Herpes	☐		☐	☐	☐
37 Kjønnsvorter/konysylomer	☐		☐	☐	☐
38 Gonorré	☐		☐	☐	☐
39 Chlamydia	☐		☐	☐	☐
40 Nyrstein	☐		☐	☐	☐
41 Nyrsteinbetennelse	☐		☐	☐	☐
42 Urinveisinfeksjon (blærekatarr)	☐		☐	☐	☐
43 Urinvekkasje	☐		☐	☐	☐
Andre sykdommer eller helseplager					
44 Anorexi/bulimi/spiseforstyrrelser	☐		☐	☐	☐
45 Migrene	☐		☐	☐	☐
46 Annen hodpine	☐		☐	☐	☐
47 Epilepsi	☐		☐	☐	☐
48 Multiippel sklerose	☐		☐	☐	☐
49 Cerebral parese	☐		☐	☐	☐
50 Kraft	☐		☐	☐	☐
51 Depresjon	☒		☐	☐	☐
52 Angst	☐		☐	☐	☐
53 Annen sykdom eller helseplage	☐		☐	☐	☐
Hviken:					

43. Hvis du havde diabetes/sukkersyge før du blev gravid, hva-
 sket det med din blodsukker (HbA1c) ved sidste
 måling før dette svangerskabsopfølgende? +

☐ Ja

☐ Mindre enn 7,5

☐ 7,5 - 12

☐ Mer enn 12

☐ Vet ikke

44. Har du selv en medfødt misdannelse/skolestase? +

☐ Ja

☐ Nei

45. Hvis ja, hvilken? _____

46. Blor du for tiden fra tankkjøttet når du pusler lenge? +

☐ Ja, av og til

☐ Nei, sjelden eller aldri

☐ Ja, ofte

☐ Ja, nesten alltid

Andre medisinger

44. Har du brukt andre medisiner som du ikke har nevnt tidligere? Hvis ja, oppgi navn og når du har tatt disse i tabellen nedenfor.

Navn på medisin(er) (f.eks. Valium, Ritalin, Paracet)	Siste 6 mnd. før svanger-skepet						Bak av medisin(er)				Antall dager brukt
	0-4	5-8	9-12	13+	I svangerskapsuke(r)						
_____	☐	☐	☐	☐	☐	☐					
_____	☐	☐	☐	☐	☐	☐					
_____	☐	☐	☐	☐	☐	☐					
_____	☐	☐	☐	☐	☐	☐					
_____	☐	☐	☐	☐	☐	☐					
_____	☐	☐	☐	☐	☐	☐					

Vitaminer, mineraler og kosttilskudd

45. Bruker du vitaminer, mineraler eller annet kosttilskudd?

☐ Nei, (Gå til spørsmål 49.) ☐ Ja,

Hvis du bruker kosttilskudd, vennligst finn frem eske/glass.

46. Kryss av i tabellen nedenfor for de vitaminer og mineraler som finnes i innholdslisten på vitamineske/glass. Kryss også av for når og omtrent hvor ofte du har brukt dem.

[illegible]

+

47

Oppgi fullstendig produktnavn på alle de vitaminer eller kosttilskudd du bruker. Ta også med naturmedisiner og slankepulver. (Skriv tydelig med bokstaver for det fjerde rødes maskinlett)

Feks

V I T A M I N E R

M E D

1

2

3

4

5

6

48. Hvis du bruker multivitaminer (med eller uten mineraler), inneholder disse folat/folsyre?

☐ Ja
 ☐ Nei
 ☐ Vet ikke

Sivilstand og utdannelse

48. hvilken civilstand har du nå?

☐ Gift	☐ Skilt/separert	
☐ Samboer	☐ Enke	
☐ Enlig	☐ Alene	

50. hvilken uddannelse har du og barnets far? (Sæt kun et kryds for den højeste uddannelse dere har fulført. Kryds også av for den uddannelse dere eventuelt holder på med.)

	Dag		Barnets far	
	Fulført	Holder på med	Fulført	Holder på med
1 9-årg grunnskole	☐	☐	☐	☐
2 1-2-årg videregående	☐	☐	☐	☐
3 Videregående yrkesfaglig	☐	☐	☐	☐
4 3-årg videregående allmenntaglig gymnas	☐	☐	☐	☐
5 Distrikthøgskole, universitet inntil 4 år (<i>cand. mag., sykepleier, lærer, ingeniør</i>)	☐	☐	☐	☐
6 Universitet, høyskole, mer enn 4 år (<i>foredrag, embetseksamen</i>)	☐	☐	☐	☐
7 Annen utdanning	☐	☐	☐	☐

Arbeid og fritid

51. Hva var arbeidssituasjonen før dag og barnets år du ble gravid? (Søt eventuelt flere kryss.)

	Dag	Barnets år
1	☐	☐
2	☐	☐
3	☐	☐
4	☐	☐
5	☐	☐
6	☐	☐
7	☐	☐
8	☐	☐
9	☐	☐
10	☐	☐
11	☐	☐

12 Annet _____

[illegible]

63. Hvor ofte har du arbejdet ved radiosender eller radar efter at du blev gravid? ☐ 0 gange i ugen ☐ 1-2 gange i ugen ☐ 3-4 gange i ugen ☐ 5-6 gange i ugen ☐ 7-8 gange i ugen ☐ 9-10 gange i ugen ☐ 11-12 gange i ugen ☐ 13-14 gange i ugen ☐ 15-16 gange i ugen ☐ 17-18 gange i ugen ☐ 19-20 gange i ugen ☐ 21-22 gange i ugen ☐ 23-24 gange i ugen ☐ 25-26 gange i ugen ☐ 27-28 gange i ugen ☐ 29-30 gange i ugen ☐ 31-32 gange i ugen ☐ 33-34 gange i ugen ☐ 35-36 gange i ugen ☐ 37-38 gange i ugen ☐ 39-40 gange i ugen ☐ 41-42 gange i ugen ☐ 43-44 gange i ugen ☐ 45-46 gange i ugen ☐ 47-48 gange i ugen ☐ 49-50 gange i ugen ☐ 51-52 gange i ugen ☐ 53-54 gange i ugen ☐ 55-56 gange i ugen ☐ 57-58 gange i ugen ☐ 59-60 gange i ugen ☐ 61-62 gange i ugen ☐ 63-64 gange i ugen ☐ 65-66 gange i ugen ☐ 67-68 gange i ugen ☐ 69-70 gange i ugen ☐ 71-72 gange i ugen ☐ 73-74 gange i ugen ☐ 75-76 gange i ugen ☐ 77-78 gange i ugen ☐ 79-80 gange i ugen ☐ 81-82 gange i ugen ☐ 83-84 gange i ugen ☐ 85-86 gange i ugen ☐ 87-88 gange i ugen ☐ 89-90 gange i ugen ☐ 91-92 gange i ugen ☐ 93-94 gange i ugen ☐ 95-96 gange i ugen ☐ 97-98 gange i ugen ☐ 99-100 gange i ugen ☐ 101-102 gange i ugen ☐ 103-104 gange i ugen ☐ 105-106 gange i ugen ☐ 107-108 gange i ugen ☐ 109-110 gange i ugen ☐ 111-112 gange i ugen ☐ 113-114 gange i ugen ☐ 115-116 gange i ugen ☐ 117-118 gange i ugen ☐ 119-120 gange i ugen ☐ 121-122 gange i ugen ☐ 123-124 gange i ugen ☐ 125-126 gange i ugen ☐ 127-128 gange i ugen ☐ 129-130 gange i ugen ☐ 131-132 gange i ugen ☐ 133-134 gange i ugen ☐ 135-136 gange i ugen ☐ 137-138 gange i ugen ☐ 139-140 gange i ugen ☐ 141-142 gange i ugen ☐ 143-144 gange i ugen ☐ 145-146 gange i ugen ☐ 147-148 gange i ugen ☐ 149-150 gange i ugen ☐ 151-152 gange i ugen ☐ 153-154 gange i ugen ☐ 155-156 gange i ugen ☐ 157-158 gange i ugen ☐ 159-160 gange i ugen ☐ 161-162 gange i ugen ☐ 163-164 gange i ugen ☐ 165-166 gange i ugen ☐ 167-168 gange i ugen ☐ 169-170 gange i ugen ☐ 171-172 gange i ugen ☐ 173-174 gange i ugen ☐ 175-176 gange i ugen ☐ 177-178 gange i ugen ☐ 179-180 gange i ugen ☐ 181-182 gange i ugen ☐ 183-184 gange i ugen ☐ 185-186 gange i ugen ☐ 187-188 gange i ugen ☐ 189-190 gange i ugen ☐ 191-192 gange i ugen ☐ 193-194 gange i ugen ☐ 195-196 gange i ugen ☐ 197-198 gange i ugen ☐ 199-200 gange i ugen ☐ 201-202 gange i ugen ☐ 203-204 gange i ugen ☐ 205-206 gange i ugen ☐ 207-208 gange i ugen ☐ 209-210 gange i ugen ☐ 211-212 gange i ugen ☐ 213-214 gange i ugen ☐ 215-216 gange i ugen ☐ 217-218 gange i ugen ☐ 219-220 gange i ugen ☐ 221-222 gange i ugen ☐ 223-224 gange i ugen ☐ 225-226 gange i ugen ☐ 227-228 gange i ugen ☐ 229-230 gange i ugen ☐ 231-232 gange i ugen ☐ 233-234 gange i ugen ☐ 235-236 gange i ugen ☐ 237-238 gange i ugen ☐ 239-240 gange i ugen ☐ 241-242 gange i ugen ☐ 243-244 gange i ugen ☐ 245-246 gange i ugen ☐ 247-248 gange i ugen ☐ 249-250 gange i ugen ☐ 251-252 gange i ugen ☐ 253-254 gange i ugen ☐ 255-256 gange i ugen ☐ 257-258 gange i ugen ☐ 259-260 gange i ugen ☐ 261-262 gange i ugen ☐ 263-264 gange i ugen ☐ 265-266 gange i ugen ☐ 267-268 gange i ugen ☐ 269-270 gange i ugen ☐ 271-272 gange i ugen ☐ 273-274 gange i ugen ☐ 275-276 gange i ugen ☐ 277-278 gange i ugen ☐ 279-280 gange i ugen ☐ 281-282 gange i ugen ☐ 283-284 gange i ugen ☐ 285-286 gange i ugen ☐ 287-288 gange i ugen ☐ 289-290 gange i ugen ☐ 291-292 gange i ugen ☐ 293-294 gange i ugen ☐ 295-296 gange i ugen ☐ 297-298 gange i ugen ☐ 299-300 gange i ugen ☐ 301-302 gange i ugen ☐ 303-304 gange i ugen ☐ 305-306 gange i ugen ☐ 307-308 gange i ugen ☐ 309-310 gange i ugen ☐ 311-312 gange i ugen ☐ 313-314 gange i ugen ☐ 315-316 gange i ugen ☐ 317-318 gange i ugen ☐ 319-320 gange i ugen ☐ 321-322 gange i ugen ☐ 323-324 gange i ugen ☐ 325-326 gange i ugen ☐ 327-328 gange i ugen ☐ 329-330 gange i ugen ☐ 331-332 gange i ugen ☐ 333-334 gange i ugen ☐ 335-336 gange i ugen ☐ 337-338 gange i ugen ☐ 339-340 gange i ugen ☐ 341-342 gange i ugen ☐ 343-344 gange i ugen ☐ 345-346 gange i ugen ☐ 347-348 gange i ugen ☐ 349-350 gange i ugen ☐ 351-352 gange i ugen ☐ 353-354 gange i ugen ☐ 355-356 gange i ugen ☐ 357-358 gange i ugen ☐ 359-360 gange i ugen ☐ 361-362 gange i ugen ☐ 363-364 gange i ugen ☐ 365-366 gange i ugen ☐ 367-368 gange i ugen ☐ 369-370 gange i ugen ☐ 371-372 gange i ugen ☐ 373-374 gange i ugen ☐ 375-376 gange i ugen ☐ 377-378 gange i ugen ☐ 379-380 gange i ugen ☐ 381-382 gange i ugen ☐ 383-384 gange i ugen ☐ 385-386 gange i ugen ☐ 387-388 gange i ugen ☐ 389-390 gange i ugen ☐ 391-392 gange i ugen ☐ 393-394 gange i ugen ☐ 395-396 gange i ugen ☐ 397-398 gange i ugen ☐ 399-400 gange i ugen ☐ 401-402 gange i ugen ☐ 403-404 gange i ugen ☐ 405-406 gange i ugen ☐ 407-408 gange i ugen ☐ 409-410 gange i ugen ☐ 411-412 gange i ugen ☐ 413-414 gange i ugen ☐ 415-416 gange i ugen ☐ 417-418 gange i ugen ☐ 419-420 gange i ugen ☐ 421-422 gange i ugen ☐ 423-424 gange i ugen ☐ 425-426 gange i ugen ☐ 427-428 gange i ugen ☐ 429-430 gange i ugen ☐ 431-432 gange i ugen ☐ 433-434 gange i ugen ☐ 435-436 gange i ugen ☐ 437-438 gange i ugen ☐ 439-440 gange i ugen ☐ 441-442 gange i ugen ☐ 443-444 gange i ugen ☐ 445-446 gange i ugen ☐ 447-448 gange i ugen ☐ 449-450 gange i ugen ☐ 451-452 gange i ugen ☐ 453-454 gange i ugen ☐ 455-456 gange i ugen ☐ 457-458 gange i ugen ☐ 459-460 gange i ugen

106. Har du noen gang brukt noen av de følgende stoffene?		Siste måned for svangerskapet		+ Siste måned for svangerskapet	
1	Høst	☐	☐	☐	☐
2	Anisemai	☐	☐	☐	☐
3	Eccasy	☐	☐	☐	☐
4	Kokain	☐	☐	☐	☐
5	Heroin	☐	☐	☐	☐

107. Har du noen gang drukket alkohol?

☐ Nei (gi et spørsmål 117.) ☐ Ja

Enheter alkohol
 1 flaske øl eller 1 glass vin (12% alkohol) = 1 enhet alkohol
 1 flaske vodka eller 1 glass (40% alkohol) = 1 enhet alkohol
 1 flaske rom eller 1 glass (40% alkohol) = 1 enhet alkohol
 1 flaske gin og tonik eller 1 glass (40% alkohol) = 1 enhet alkohol
 1 flaske gin og tonic eller 1 glass (40% alkohol) = 1 enhet alkohol
 1 flaske gin og tonic eller 1 glass (40% alkohol) = 1 enhet alkohol
 1 flaske gin og tonic eller 1 glass (40% alkohol) = 1 enhet alkohol

108. Hvor ofte drakk du alkohol de siste 3 månedene før svangerskapet og hvor ofte drakk du i svangerskapet?

Siste 3 måneder før svangerskapet		+ Siste 3 måneder for svangerskapet	
1	Omrent 6-7 ganger pr uke	☐	☐
2	Omrent 4-5 ganger pr uke	☐	☐
3	Omrent 2-3 ganger pr uke	☐	☐
4	Omrent 1 gang pr uke	☐	☐
5	Omrent 1-3 ganger pr måned	☐	☐
6	Sjeldnere enn 1 gang pr måned	☐	☐
7	Adri	☐	☐

109. Hvilken type alkohol drikker du vanligvis? (Satt eventuelt flere kryss.)

1	Leilø	☐	☐	☐	☐
2	Øl	☐	☐	☐	☐
3	Redvin	☐	☐	☐	☐
4	Hvittvin	☐	☐	☐	☐
5	Hvittvin (sherry, portvin, madvin)	☐	☐	☐	☐
6	Brennvin (vodka, gin, akvett, cognac, whiskey, likør)	☐	☐	☐	☐

110. Har du drukket 5 alkoholenheter eller mer ved minst en anledning de siste 3 månedene før svangerskapet eller i svangerskapet?

Siste 3 måneder før svangerskapet		+ Siste 3 måneder for svangerskapet	
1	Flere ganger i uken	☐	☐
2	1-3 ganger i uken	☐	☐
3	1-3 ganger pr måned	☐	☐
4	Omrent en gang pr måned	☐	☐
5	Adri	☐	☐

111. Hvor mange enheter drikker du vanligvis når du nyter alkohol?

Siste 3 måneder før svangerskapet		+ Siste 3 måneder for svangerskapet	
1	0 eller flere	☐	☐
2	7-9	☐	☐
3	5-6	☐	☐
4	3-4	☐	☐
5	1-2	☐	☐
6	Perre enn 1	☐	☐

112. Hvor mange alkoholenheter kan du drikke før du merker det?

☐ enheter ☐ +

Fysisk aktivitet

123. Hvor ofte er du fysisk aktiv? (Kryss av for hver linje, både for og i dette svangerskapet.)

	Siste 3 måneder for dette svangerskapet		+ Siste 3 måneder for dette svangerskapet	
	1-3 ganger pr uke	3 ganger eller mer pr uke	1-3 ganger pr uke	3 ganger eller mer pr uke
1	Ridg gange/østet...	☐	☐	☐
2	Ridg gange/østet...	☐	☐	☐
3	Ridg gange/østet...	☐	☐	☐
4	Ridg gange/østet...	☐	☐	☐
5	Ridg gange/østet...	☐	☐	☐
6	Ridg gange/østet...	☐	☐	☐
7	Ridg gange/østet...	☐	☐	☐
8	Ridg gange/østet...	☐	☐	☐
9	Ridg gange/østet...	☐	☐	☐
10	Ridg gange/østet...	☐	☐	☐
11	Ridg gange/østet...	☐	☐	☐
12	Ridg gange/østet...	☐	☐	☐
13	Ridg gange/østet...	☐	☐	☐
14	Ridg gange/østet...	☐	☐	☐

124. Hvor ofte gjør du øvelser for disse muskelgruppene? (Kryss av for hver linje, både for og i dette svangerskapet.)

	Siste 3 måneder for dette svangerskapet		+ Siste 3 måneder for dette svangerskapet	
	1-3 ganger pr uke	3 ganger eller mer pr uke	1-3 ganger pr uke	3 ganger eller mer pr uke
1	Ridg gange/østet...	☐	☐	☐
2	Ridg gange/østet...	☐	☐	☐
3	Ridg gange/østet...	☐	☐	☐
4	Ridg gange/østet...	☐	☐	☐
5	Ridg gange/østet...	☐	☐	☐
6	Ridg gange/østet...	☐	☐	☐
7	Ridg gange/østet...	☐	☐	☐
8	Ridg gange/østet...	☐	☐	☐
9	Ridg gange/østet...	☐	☐	☐
10	Ridg gange/østet...	☐	☐	☐
11	Ridg gange/østet...	☐	☐	☐
12	Ridg gange/østet...	☐	☐	☐
13	Ridg gange/østet...	☐	☐	☐
14	Ridg gange/østet...	☐	☐	☐

125. Hvor ofte er du så fysisk aktiv (i friid eller på arbeid) at du blir andpusten eller svett?

	Siste 3 måneder for dette svangerskapet		+ Siste 3 måneder for dette svangerskapet	
	1-3 ganger pr uke	3 ganger eller mer pr uke	1-3 ganger pr uke	3 ganger eller mer pr uke
1	Ridg gange/østet...	☐	☐	☐
2	Ridg gange/østet...	☐	☐	☐
3	Ridg gange/østet...	☐	☐	☐
4	Ridg gange/østet...	☐	☐	☐
5	Ridg gange/østet...	☐	☐	☐

126. Kryss av om du er enig eller uenig i de følgende påstandene. (Kryss av for hver linje.)

	Helt enig	Uenig	Litt enig	Uenig	Litt enig	Uenig	Helt enig
1	☐	☐	☐	☐	☐	☐	☐
2	☐	☐	☐	☐	☐	☐	☐
3	☐	☐	☐	☐	☐	☐	☐
4	☐	☐	☐	☐	☐	☐	☐
5	☐	☐	☐	☐	☐	☐	☐

127. Hvor enig er du i disse beskrivelsene av ditt parforhold? (Besvar bare dersom du er i et parforhold.)

	Helt enig	Uenig	Litt enig	Uenig	Litt enig	Uenig	Helt enig
1	☐	☐	☐	☐	☐	☐	☐
2	☐	☐	☐	☐	☐	☐	☐
3	☐	☐	☐	☐	☐	☐	☐
4	☐	☐	☐	☐	☐	☐	☐
5	☐	☐	☐	☐	☐	☐	☐

Litt mer om deg selv og hvordan du har det nå

128. Har du noen utenom din ektefelle/samboer/partner som du kan søke råd hos i en vanskelig situasjon?

☐ Nei

☐ Ja 1-2 personer

☐ Ja flere enn to personer

129. Hvor ofte treffer du eller snakker i telefonen med familie utenom ektefelle/samboer/partner?

☐ 1 gang i måneden eller sjeldnere

☐ 2-5 ganger i måneden

☐ Mer enn 5 ganger i uken

130. Føler du deg ofte ensom?

☐ Nesten aldri

☐ Sjelden

☐ Ofte og til tider

☐ Som alltid

131. Har du i løpet av de to siste ukene vært plaget med noe av det følgende? (Kryss av for hver tittel.)

Ikke plaget

Litt plaget

Ganske mye plaget

Veldig mye plaget

Stadig redd eller engstelig

Følelse av hjelpeløshet

Med hensyn til fremtiden

Nedtrykt, tungsinnet

Mye bekymret eller urolig

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

132. Har du noen gang som voksen opplevd at noen har gitt deg en ondtall, slått eller sparket deg eller plaget deg fysisk på annen måte? (Satt eventuelt flere kryss.)

I dette svangerskapet

6 mnd før svangerskapet

Siste svangerskap

Tidligere

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

133. Har du noen gang opplevd at du ble presset eller tvunget til seksuell omgang? (Satt eventuelt flere kryss.)

I dette svangerskapet

Siste svangerskap

Tidligere

☐

☐

☐

☐

☐

☐

☐

☐

☐

16

Kommentarer

+

+

+

+

+

Har du husket å fylle ut dato for utfylling av skjema på side 1?

Tusen takk for hjelpen!

Legg det utfylte skjemaet i den frankerte returkonvolutten og send det til:

Den norske Mor og Barn undersøkelsen
Medisinsk fødselsregister
Armauer Hansens Hus
5839 Bergen

+

Er det noe du gjerne vil fortelle oss om dette svangerskapet eller tidligere fødsler/svangerskap, som ikke er omhandlet i dette spørreskjemaet, setter vi stor pris på om du noterer det på neste side.

Beyer-Heinos

den norske Mor & barn undersøkelsen

+

Spørreskjema 4 - Når barnet er ca. 6 måneder gammel

Dette spørreskjemaet er to-delt. Den første delen dreier seg om barnet, den andre delen handler om deg selv. Det ville være en fordel om du finner frem barnets lesebok for du begynner, slik at du kan benytte opplysningene som står der under utfyllingen av spørreskjemaet. Hvis du synes at et spørsmål er vanskelig å svare på, kan du hoppe over det og gå videre til neste spørsmål.

Hvis du fikk tvillinger eller trillinger vennligst fyll ut et spørreskjema for hvert barn.

Skjemaet skal leses av en maskin. Det er derfor viktig at du legger vekt på følgende ved utfyllingen:

- Bruk blå eller sort kulepenn.
 - I de små avkrytningsboksene setter du et kryss for det svaret som du mener passer best, slik: ☒
 - Skriver du feil, kan du bare ta bort krysset ved å fylle boksen helt, slik: ☐
 - I de store, grønne boksene skrives du tall.
- Det er viktig at du bare skriver i det hvite feltet i boksene, slik:**
- Tall: år
- I talbokser med flere rader skriver du et ett-sifret tall i den høyre raden. Eksempel: 5 skrives slik
 - Databokser er delt opp i tre deler, den første for dag i måned, den neste for månedstallet og den siste for årstallet slik at datoen skal skrives slik: dag måned år
 - Spesielle opplysninger som f.eks. medisinering skrives du fritt på de åpne linjene. Vennligst skriv tydelig!
- Så snart du har fylt ut skjemaet, sender du det tilbake til oss i den vedlagte frankerte svarkonvolutten.

Oppgi dag, måned og år for utfylling av skjemaet

dag måned år

(skriv årstall med 4 tall, f.eks. 2002)

+

Om fødselen

1. Er barnet en gutt eller jente?

- ☐ Gutt
- ☐ Jente

2. Hvor stort var barnet ved fødselen?

Fødselsvekt: g

Lengde: cm

3. I hvilken svangerskapsuke fødte du?

uke

+

4. Hvor lenge lå barnet på sykehus etter fødselen?

Antall dager eller lenger

5. Ble barnet overflyttet til en annen avdeling eller sykehus etter fødselen?

- ☐ Nei
- ☐ Ja
- Hvis ja, hvilken? _____

6. Ble barnet forløst ved keisersnitt?

- ☐ Nei
- ☐ Ja

+

7. Hvis ja, var keisersnittet planlagt?

- ☐ Nei
- ☐ Ja

+

Hvis ja, hvorfor?

- ☐ Selelele
- ☐ Tidligere keisersnitt
- ☐ Svangerskapskomplikasjon eller sykdom hos mor
- ☐ Dårlig tilvekt eller annen tilstand hos fosteret
- ☐ Eget ønske
- ☐ Annet

8. Oppsto det komplikasjoner under fødselen?

- ☐ Nei
- ☐ Ja

Hvis ja, beskriv: _____

9. Ble du innlagt eller overflyttet til annen avdeling eller sykehus etter fødselen? (Skriv eventuelt flere årsaker til innleggelse med fødselen? (Gjelder både før og etter fødselen).

- ☐ Nei
- ☐ Ja

10. Hvis ja, hvor?

Avdeling: _____

Sykehus: _____

Om barnet

Ernæring

15. Hva fikk barnet å drikke første leveuke?

(Skriv eventuelt flere kryss.)

- ☐ Brystmelk
- ☐ Vann
- ☐ Sukkervann
- ☐ Morsmelkstaining
- ☐ Annet, beskriv: _____
- ☐ Vet ikke/husker ikke

+

16. Hva slags drikke har barnet fått de første 6 leveukene? (Satt et kryss for hver måned barnet har fått den aktuelle drikke.)

	0	1	2	3	4	5	6
Brystmelk	☐	☐	☐	☐	☐	☐	☐
Collett vanlig	☐	☐	☐	☐	☐	☐	☐
Collett med Omega 3	☐	☐	☐	☐	☐	☐	☐
NAN vanlig	☐	☐	☐	☐	☐	☐	☐
Nan HA1	☐	☐	☐	☐	☐	☐	☐
Annen melk, beskriv: _____	☐	☐	☐	☐	☐	☐	☐
Vann	☐	☐	☐	☐	☐	☐	☐
Salt / Juice	☐	☐	☐	☐	☐	☐	☐

17. Hvor ofte får barnet følgende drikke nå for tiden? (Sett ett kryss for hver linje.)

	1-3 ganger pr. uke	4-6 ganger pr. uke	Minst 1 gang daglig
1. Brystmelk	☐	☐	☐
2. Morsmelklégg	☐	☐	☐
3. Vanlig søt melk, alle typer	☐	☐	☐
4. Surmelk (yoghurt, kulturmelk osv.)	☐	☐	☐
5. Økologiske melkeprodukter (melk, yoghurt)	☐	☐	☐
6. Kaldt vann	☐	☐	☐

+

Forts.

	+	1-3 ganger pr. uke	4-6 ganger pr. uke	Minst 1 gang daglig
7. Vann fra springen		☐	☐	☐
8. Vann kjøpt på flaske		☐	☐	☐
9. Barnesaft kjøpt på flaske		☐	☐	☐
10. Annen saft, suket		☐	☐	☐
11. Saft, kunstig søt		☐	☐	☐
12. Juice		☐	☐	☐
13. Annet, beskriv:		☐	☐	☐

+

18. Hvor ofte spiser barnet følgende mat nå for tiden, og hvor gammelt var barnet da dere startet med denne maten?

	+	Aldri/ sjelden	Hvor ofte får barnet dette? 1-3 ganger pr. uke	4-6 ganger pr. uke	Minst 1 gang daglig	Hvor gammelt var barnet da hun/han fikk denne maten første gang?
Industrifremstilt grøt (grot/pulver):						
1. Risgrøt, malsgrøt		☐	☐	☐	☐	måner
2. Havregrøt, ulike typer		☐	☐	☐	☐	måner
3. Hvetegrøt, alle typer, kvevingsgrøt		☐	☐	☐	☐	måner
Hjemmelaget grøt av:						
4. Hvetemel (grovfint) kveving, semule, havre		☐	☐	☐	☐	måner
5. Jernberiket hvetemel		☐	☐	☐	☐	måner
6. Helios barneemel		☐	☐	☐	☐	måner
7. Hirse		☐	☐	☐	☐	måner
Industrifremstilt middag på glass:						
8. Grønnsaker		☐	☐	☐	☐	måner
9. Grønnsaker og kjøtt		☐	☐	☐	☐	måner
Hjemmelaget middag:						
10. Potet/grønnsaks		☐	☐	☐	☐	måner
11. Kjøtt og grønnsaker/potet		☐	☐	☐	☐	måner
12. Fisk og grønnsaker/potet		☐	☐	☐	☐	måner
13. Annen hjemmelaget middag		☐	☐	☐	☐	måner
Mellommåltid/dessert:						
14. Hjemmelaget fruktmos		☐	☐	☐	☐	måner
15. Fruktbarmos kjøpt på glass		☐	☐	☐	☐	måner
16. Kveving/kjeksbrød		☐	☐	☐	☐	måner
17. Annet, beskriv:		☐	☐	☐	☐	måner

+

19. Tror du, eller vet du, at barnet reagerer på melk/melkeprodukter?

☐ Nei
 ☐ Ja

20. Hvis ja, hvilke produkter?

☐ Helmelk
 ☐ Lettmelkskummet melk
 ☐ Fiskekrem/skrem
 ☐ Yoghurt/surmelk
 ☐ Morsmelk når mor drikker melk
 ☐ Annet

+

21. Får barnet tren, vitaminer, jern eller annet kosttilskudd?

☐ Nei
 ☐ Ja

22. Hvis barnet får tren, vitaminer, jern eller annet kosttilskudd, angir hvor mye barnet får pr. gang og hvor ofte. Hvor gammelt var barnet i måneder og dager da familien fikk preparatet for første gang?

Navn på preparat

Hvor mange teskjeer pr. gang?

Hvor ofte får barnet dette?

Hvor gammelt var barnet da dere startet med preparatet?

1. Tren

teskjeer

daglig

måned

og

uker

2. Bløtt

teskjeer

daglig

måned

og

uker

3. Sannasol

teskjeer

daglig

måned

og

uker

4. Nycoplus Multi Vitaminmiks for barn

teskjeer

daglig

måned

og

uker

5. Flor

teskjeer

daglig

måned

og

uker

6. Jerntilskudd, hvilket:

teskjeer

daglig

måned

og

uker

7. Annet kosttilskudd, hvilket:

teskjeer

daglig

måned

og

uker

Vekt, helse og medisinerbruk

23. Hvor mange ganger har du/dere vært på helsestasjonen med barnet?

☐ Ingen ganger
 ☐ 1-2 ganger
 ☐ 3-5 ganger
 ☐ mer enn 10 ganger

24. Har barnet fått de vaksinene som helsestasjonen anbefaler?

☐ Ja
 ☐ Nei, ender ikke vaksino
 ☐ Nei, barnet har vært mye syk
 ☐ Nei, vaksine utsett av praktiske grunner
 ☐ Vet ikke

Vekst, helse og medisinbruk

Du finner opplysning for å kunne svare på de neste spørsmålene i barnets helsekort.

23. Hvor mange gange har du/dere været på helstestasjonen med barnet?

☐ Ingen gange

☐ 1-2 gange

☐ 3-5 gange

☐ 6-10 gange

☐ mer enn 10 ganger

24. Har barnet fått de viktigste og mest aktuelle anbefalinger?

☐ Ja

☐ Nei, ønsker ikke vaksiner

☐ Nei, barnet har vært mye syk

☐ Nei, vaksiner utsatt av praktiske grunner

☐ Vot ikke

25. Ta utgangspunkt i barnets helsekort og kryss av for hvilke vaksiner barnet har fått og om det har vært noen bivirkning av vaksinen. (Kryss av for hver linje).

	Har barnet fått vaksinen?	Har det vært bivirkning som medfører at barnet må leges?	Har det vært bivirkning som medfører at barnet må innlegges?
Vaksiner			
1. DTP (Infanrix)	Nei Ja	Nei Ja	Nei Ja
2. DT (Difteri / tetanus)			
3. Polio – Hib (Ac-Hib polio)			
4. Hepattitt B (Engix-B)			
5. BCG (Tuberkulose)			
6. Pneumokokk (Prevenar)			
7. Annen vaksine:			

26. Ta utgangspunkt i barnets helsekort og fyll inn i skjemaet nedenfor barnets vekt, lengde og hodeomkrets når barnet var omtrent 6 uker, 3 måneder og 6 måneder:

	Dato for undersøkelse		Lengde		Hodeomkrets		Vekt	
	dag	måned	år	cm	cm	cm	g	
Ca. 6 uker								
Ca. 3 måneder								
5 - 6 måneder								

Nå følger spørsmål om sykdom og helseproblemer hos barnet. Først spør vi om mer langvarige plager, og deretter om sykdommer og plager av mer forbigående type.

27. Har eller har barnet hatt noen av følgende helseproblemer. Hvis ja, har helsebasjonen eller andre henvist barnet til videre spesialistundersøkelse? (Kryss av for hver linje.)

	Har barnet (hatt) problemer?		Er barnet henvist til spesialistundersøkelse?	
	Nei	Ja	Nei	Ja, henvist fra helsebasjon Ja, henvist fra andre
1. Hodeleide/hodeulaksjon	☐	☐	☐	☐
2. Nedsatt hørsel	☐	☐	☐	☐
3. Nedsatt syn	☐	☐	☐	☐
4. Forsinnet motorisk utvikling (bevegelsesutvikling)	☐	☐	☐	☐
5. For liten vektøkning	☐	☐	☐	☐
6. For stor vektøkning	☐	☐	☐	☐
7. Avvikende hodeomkrets	☐	☐	☐	☐
8. Hjertefeil	☐	☐	☐	☐
9. Testiklene ikke kommet ned i pungen	☐	☐	☐	☐
10. Astma	☐	☐	☐	☐
11. Atopisk (barn)eksem	☐	☐	☐	☐
12. Elveblest	☐	☐	☐	☐
13. Matallergi/intoleranse	☐	☐	☐	☐
14. Psykomotorisk forsinkelse (forsinkelse av flere funksjoner)	☐	☐	☐	☐
15. (Annen) misdannelse:	☐	☐	☐	☐
16. Annet:	☐	☐	☐	☐

28. Hvis barnet var henvist til spesialistundersøkelse, hva viste denne undersøkelsen?

☐ Alt var i orden	+
☐ Fortsatt utvikledes videre	
☐ Var ikke	
☐ Fått følgende diagnose:	

29. Er det mistanke om at barnet ditt har et syndrom eller kromosomfeil?

☐ Nei	+
☐ Ja, et syndrom	
☐ Ja, en kromosomfeil	
☐ Hvis ja, skriv navn eller beskriv problemet:	

30. Har barnet vært behandlet for hodeleide (hoflededdysplasi)?

☐ Nei	+
☐ Ja, behandler med gips	
☐ Ja, behandler med skinner	Hvis ja, hvor lenge pågått behandling <input type="text"/> måneder
☐ Ja, behandler med pute	

31. Har barnet hatt følgende sykdom/helseproblem? Hvis ja, oppsøkte dere lege eller sykehus for det? (Kryss av for hver linje.)

	+	Har barnet hatt helseproblemer?	Antall ganger	Oppsøkte dere lege/poliklinikk for dette?	Har barnet vært innlagt på sykehus for dette?
		Nei	Ja	Nei	Ja
1. Forkjølelse		☐	☐	☐	☐
2. Halsbetennelse		☐	☐	☐	☐
3. Ørebetennelse		☐	☐	☐	☐
4. Falak krupp		☐	☐	☐	☐
5. Bronkitt/RS-viruslungebetennelse		☐	☐	☐	☐
6. Omgangsykkelare		☐	☐	☐	☐
7. Urinveisinfeksjon		☐	☐	☐	☐
8. Øyekatar		☐	☐	☐	☐
9. Feberkramper		☐	☐	☐	☐
10. Andre kamper (uten feber)		☐	☐	☐	☐
11. Kolikk		☐	☐	☐	☐
12. Blæreslett		☐	☐	☐	☐
13. Annet, beskriv		☐	☐	☐	☐

32. Har barnet noen gang fått medisiner?

☐ Nei	+
☐ Ja	

33. Hvis ja, oppgi navn på medisinen(e) og når den(ene) ble brukt. (Ta med alle typer medisiner også naturmedisiner, både faste og ikke-faste.)

Navn på medisinen (f.eks. Apoclin, Paracet)	Hvor gammelt var barnet ved medisinerbruk?				Antall dager brukt til sammen
	<1 måned	1-2 måneder	3-4 måneder	5-6 måneder	
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

+

34. Har barnet vært undersøkt eller innlagt på sykehus (etter at dere kom hjem fra sykehuset etter fødselen)?

☐ Nei

☐ Ja, hvilket sykehus:

35. Har barnet blitt operert eller har en tilstand som skal opereres?

☐ Nei

☐ Ja, hvilken:

+

+

Utvikling, barnepass og livsstil

36. Her følger noen spørsmål om barnets utvikling. Hvis du ikke har lagt merke til det, bruk litt tid til å se hva barnet faktisk gjør. (Sett et kryss for hvert spørsmål)

+

+

1. Når barnet ligger på ryggen, leker hun/han ved å gripe rundt føttene sine?

Ja, ofte

Ja, men sjelden

Nei, ikke ennå

Vet ikke

2. Når barnet ligger på magen, lefter hun/han overkroppen fra underlaget med strake armer?

Ja

Ja

Ja

Ja

3. Ruller barnet seg over fra rygg til mage?

Ja

Ja

Ja

Ja

4. Når du "prater" med barnet ditt, prøver hun/han å "prate" tilbake til deg?

Ja

Ja

Ja

Ja

5. Bakker barnet og lager lyden når hun/han ligger for seg selv?

Ja

Ja

Ja

Ja

6. Kan du høre hvordan barnet har det bare ved å høre på lydene hun/han lager (flaks, knusyd, sulen, snif, har smertefull)?

Ja

Ja

Ja

Ja

7. Får du et smil fra barnet ditt bare ved at du smiler mot henne/han (uten å røre eller fikle barnet og uten at du holder fram en leke)?

Ja

Ja

Ja

Ja

8. Når du roper på barnet ditt, svarer hun/han seg seg mot deg en av de første gangene du sier navnet?

Ja

Ja

Ja

Ja

9. Griper barnet ditt en leke du gir henne/han for så å putte den i munnen, eller holde den?

Ja

Ja

Ja

Ja

10. Når barnet sitter på lenger ditt, strekker hun/han seg etter en leke eller annet som ligger på bordet foran dere?

Ja

Ja

Ja

Ja

11. Holder barnet ditt i en leke med begge hendene når hun/han undersøker den?

Ja

Ja

Ja

Ja

+

37. Hvor passet barnet på dagtid?

☐ Hjemme med mor/far/annet famillemedlem

☐ Hjemme med dagmamma, praktkant

☐ Hos dagmamma

☐ Familiebarnehage

☐ Barnehage

38. Hvor mange barn er barnet ditt vanligvis sammen med på dagtid?

barn

+

39. Deltar barnet i babyvømming?

☐ Nei

☐ Ja

Hvis ja, oppgi antall ganger de siste 2 måneder

40. Hvor mye er barnet utendørs? (Sett kun ett kryss.)

☐ Sjelden

☐ Ofte, men mindre enn 1 time daglig

☐ 1–3 timer daglig

☐ Mer enn 3 timer daglig

41. Bruker barnet narreansatt?

☐ Sjelden eller aldri

☐ Bare når hun/han skal sove

☐ Ofte

☐ Mesteparten av tiden

42. Hvor mange timer sover barnet til sammen pr. døgn?

☐ Mindre enn 8 timer

☐ 8 - 10 timer

☐ 11 – 12 timer

☐ 13 – 14 timer

☐ Mer enn 14 timer

+

43. Hvordan er barnet blitt lagt når det skulle sove? (Sett ett kryss for hver farge.)

+

+

44. Sover barnet (minst halve natten) i samme seng som mor/far? (Sett ett kryss for hver farge.)

+

45. Kryss av om du er enig eller uenig i følgende påstander om barnets humør og temperament. Tenk på hvordan dere vanligvis har det. (Sett ett kryss for hver farge.)

+

+

46. Hvor ofte hender det at barnet våkner om natten nå for tiden? (Sett kun ett kryss.)

☐ 3 eller flere ganger hver natt

☐ 1-2 ganger hver natt

☐ Noen ganger i uken

☐ Sjelden eller aldri

Kommentarer

Om deg selv

Siste gang du fylte ut spørreskjema var ved ca. 30. svangerskapsuke. Spørsmålene vi stiller nå handler for det meste om tiden etter dette og frem til barnet ditt var 6 måneder.

Helse og medisninbruk

47. Oppsakte du legjeforordn/helseeseter for egne helseproblemer den første måneden etter fødselen?

Nei

Ja.

ganger

+

48. Hvis ja, hva var årsaken?

- ☐ Sårsting nedentill
- ☐ Keisernitakt
- ☐ Brystetennelse
- ☐ Sårre brystvorter
- ☐ Amneproblemer
- ☐ Annet, beskriv: _____

49. Når du tenker tilbake på tiden etter fødselen, følte du deg deprimert i den tiden?

Nei

Ja, hvor lenge: uker

+

50. Utenom opphold i forbindelse med fødselen, har du vært innlagt på sykehus etter at du fylte ut forrige spørreskjema?

Nei

Ja, hvilket sykehus: _____

51. Har du en kronisk/langvarig sykdom som oppstod etter at du besvarte forrige spørreskjema?

Nei

Ja, hvilken: _____

52. Allt i alt, hvordan vil du nå for tiden karakterisere din fysiske helse?

☐ Meget god

☐ God

☐ Dårlig

☐ Svært dårlig

+

53. Har du hatt noen av følgende plager/sykdommer siden du besvarte forrige spørreskjema? Hvis ja, bruker du eller har du brukt medisiner mot disse plagene? (Dette gjelder alle typer medikamenter også naturmedisiner, både faste og fke-faste.) (Kryss av for hver inge.)

Sykdom / plage	Har du vært plaget?		Hvis du har brukt medisiner		Antall dager etter fødselen 0-3 mndr. 4-6 mndr. tilsammen
	Ja, siste del av svangerskapet	Nei	Navn på medisiner du brukte	Siste del av svangerskapet	
1. Sukker i urinen	☐	☐	_____	☐	<div><div></div><div></div></div>
2. Eggvite (protein) i urin	☐	☐	_____	☐	<div><div></div><div></div></div>
3. Høyt blodtrykk	☐	☐	_____	☐	<div><div></div><div></div></div>
4. Hevelse i kroppen (ødem)	☐	☐	_____	☐	<div><div></div><div></div></div>
5. Blærekatarr	☐	☐	_____	☐	<div><div></div><div></div></div>
6. Treg mage/forstoppelse	☐	☐	_____	☐	<div><div></div><div></div></div>
7. Dure/oppkast	☐	☐	_____	☐	<div><div></div><div></div></div>
8. Halsbrann/sure oppstøt	☐	☐	_____	☐	<div><div></div><div></div></div>
9. Forfølelse/influensa	☐	☐	_____	☐	<div><div></div><div></div></div>
10. Hals-ibhule-/rebetennelse	☐	☐	_____	☐	<div><div></div><div></div></div>

+

fors. neste side

+

Sykdom / plage	Har du vært plaget?		Hvis du har brukt medisiner		Antall dager etter fødselen 0-3 mndr. 4-6 mndr. tilsammen
	Ja, siste del av svangerskapet	Nei	Navn på medisiner du brukte	Siste del av svangerskapet	
11. Lungebetennelse/brontitt	☐	☐	_____	☐	<div><div></div><div></div></div>
12. Astma	☐	☐	_____	☐	<div><div></div><div></div></div>
13. Heysnue/annen allergi .	☐	☐	_____	☐	<div><div></div><div></div></div>
14. Hodene/andre smerter	☐	☐	_____	☐	<div><div></div><div></div></div>
15. Skjedekatarr	☐	☐	_____	☐	<div><div></div><div></div></div>
16. Psykiske vansker	☐	☐	_____	☐	<div><div></div><div></div></div>
17. Brystetennelse	☐	☐	_____	☐	<div><div></div><div></div></div>
18. Feber	☐	☐	_____	☐	<div><div></div><div></div></div>
19. Annet, beskriv: _____	☐	☐	_____	☐	<div><div></div><div></div></div>

54. Har du brukt andre medisiner enn nevnt i spørsmål 52? (For eksempel sovemidler, beroligende midler eller smertestillende midler.)
☐ Nei ☐ Ja

55. Hvis ja, oppgi navn på medisin(e) og når du har tatt dem. (Ta med alle typer medisiner også naturmedisiner, både faste og fke-faste.)

Navn på medisinen (feks. Valium, Rohypnol, Paracet)	Siste del av svangerskapet		0-3 måneder etter fødselen		Antall dager etter fødselen 4-6 måneder etter fødselen
	Brukt medisin	Antall dager	Brukt medisin	Antall dager	
_____	☐	<div><div></div><div></div></div>	☐	<div><div></div><div></div></div>	<div><div></div><div></div></div>
_____	☐	<div><div></div><div></div></div>	☐	<div><div></div><div></div></div>	<div><div></div><div></div></div>
_____	☐	<div><div></div><div></div></div>	☐	<div><div></div><div></div></div>	<div><div></div><div></div></div>

56. Bruker du, eller har du brukt, tren, vitaminer eller annet kosttilskudd siden forrige spørreskjema?

Nei

Ja

+

57. Hvis ja, hvilket preparat, når brukte du det og hvor ofte? (En inge for hvert preparat.)

Navn på preparatet	Når brukte du preparatet		Hvor ofte?	
	Siste del av svangerskapet	0-3 måneder etter fødselen	Brukt daglig	Brukt av og til
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

58. Har du hatt smerter i ryggen eller bekkenet etter at du fylte ut forrige spørreskjema? +

☐ Nei	☐ Ja
------------------------------	-----------------------------

59. Hvis ja, sett kryss for hvor du var plaget, når du var plaget og hvor mye.

	Siste del av svangerskapet	En del plaget	Serkt plaget
Hvor satt smertene?			
I korsryggen	☐	☐	☐
Over det ene bekleleddet bak	☐	☐	☐
Over begge bekleleddene bak	☐	☐	☐
Over halleleinet	☐	☐	☐
I selbalene	☐	☐	☐
Foran i bekkenet	☐	☐	☐
I lysken	☐	☐	☐
Andre rygsmerter	☐	☐	☐

60. Våkner du om natten på grunn av bekkensmerter nå for tiden?

☐ Nei, aldri	☐ Ja, en sjelden gang
☐ Ja, ofte	

61. Har du så store vansker med å gå på grunn av bekkensmerter at du må bruke stokk eller krykker nå for tiden?

☐ Nei, aldri	☐ Ja, men ikke hver dag
☐ Ja, hver dag	

62. Har du noen gang fått behandling for bekkensmerter?

☐ Nei	☐ Ja
------------------------------	-----------------------------

63. Hvis ja, kryss av for hvilken type behandling og når det var:

	For dette svanger-skapet	I dette svanger-skapet	Etter denne fødselen
Fysioterapi	☐	☐	☐
Kiropraktikk	☐	☐	☐
Medisiner	☐	☐	☐
Annet, beskriv: _____	☐	☐	☐

64. Hvor lang tid tok det før du gjennomtok det seksuelle samlivet etter fødselen?

	uker
☐ Har ikke hatt samleie	

65. Har du nå for tiden noen av følgende plager, i så fall hvor ofte og hvor mye? (Kryss av for hver linje.)

	1-4 ganger pr måned	Aldri	Mer enn 4 ganger pr dag	1 gang pr dag	Mer enn 4 ganger pr dag	Hvor mye om gangen?
Plager						
Urinneklasje ved hosting, nyzing eller latter.	☐	☐	☐	☐	☐	Sierne mangler
Urinneklasje ved fysisk aktivitet (top/hopp)	☐	☐	☐	☐	☐	
Urinneklasje ved sterk trang til vannlating	☐	☐	☐	☐	☐	
Problemer med å holde på ardning	☐	☐	☐	☐	☐	
Problemer med å holde på luft	☐	☐	☐	☐	☐	

66. Hvor mange ganger var du til ultralydundersøkelse i svangerskapet?

	ganger
--	--------

67. Var alt i orden ved ultralydundersøkelsen(e)?

☐ Ja	☐ Nei
-----------------------------	------------------------------

68. Hvis nei, hva var problemet?

☐ Barnet vokste for lite	☐ Mistanke om misdannelse, beskriv: _____
☐ Annet, beskriv: _____	

69. Hvor mye veide du ved slutten av svangerskapet og hvor mye veier du nå?

Ved slutten av svangerskapet
 _____ kg

Nå
 _____ kg

+ +

70. Vor du helt eller delvis sykemeldt etter svangerskapsuke 30? (Regn ikke med fødselspermisjon)

☐ Nei

☐ Ja, delvis sykemeldt

☐ Ja, helt sykemeldt

+

Var sykemeldt i svangerskapsuker		Antall dager	% sykemeldt
30-33	34-37		
☐	☒	10	50
☐	☐	<input type="text"/>	<input type="text"/>
☐	☐	<input type="text"/>	<input type="text"/>
☐	☐	<input type="text"/>	<input type="text"/>
☐	☐	<input type="text"/>	<input type="text"/>

71. Hvis du har vært sykemeldt etter svangerskapsuke 30, fylt ut i tabellen nedenfor med en linje for hver sykemelding. Angi årsaken og kryss av i hvilke svangerskapsuker du var sykemeldt. Oppgi hvor mange dager og hvor mange prosent du var sykemeldt hver gang.

Årsak til sykemelding: _____

Eksempel: bekkenløsning _____

72. Er økonomien slik at du/dere vil ha mulighet til å klare en uførtsett regning på kr. 10.000,- til f. eks. tanlegge eller en reparasjon?

☐ Nei

☐ Ja

☐ Vel ikke

+

☐ Hund

☐ Katt

☐ Marsvin, kanin, mus, rotte eller lign.

☐ Undulær, annen fugl

Annet dyr: _____

73. Har det i løpet av de siste 6 måneder hendt at du/dere har hatt vansker med å klare løpende utgifter til mat, transport, husleie og lignende?

☐ Nei, aldri

☐ Ja, en sjelden gang

☐ Ja, av og til

☐ Ja, ofte

+

74. Er det dyr i barnets hjem?

☐ Nei

☐ Ja

75. Hvis ja, hvilket(ø) dyr? (Sett eventuelt flere kryss.)

☐ Hund

☐ Katt

☐ Marsvin, kanin, mus, rotte eller lign.

☐ Undulær, annen fugl

Annet dyr: _____

76. Har dere oppvarming med elektriske varmeledninger i gulvet i rom hvor barnet oppholder seg? (Ta ikke med vannbåren varme)

☐ Nei

☐ Ja

+

77. Hvis ja, i hvilke rom? (Sett eventuelt flere kryss.)

☐ Stue

☐ Kjøkken

☐ Bad

☐ Andre rom

78. Hvor ofte gjør du øvelser for disse muskelgruppene hjemme eller på trening nå for tiden? (Kryss av for hver linje.)

	1-3 ganger pr. uke	1 gang pr. uke	2 ganger pr. uke	3 ganger eller mer pr. uke
Magemuskler	☐	☐	☐	☐
Ryggmuskler	☐	☐	☐	☐
Bekkenbunnsmuskler (muskler rundt skjeden, urinrør, endetarm)	☐	☐	☐	☐

Økonomi - livsstil

88. Hvis ja, hvor enig er du i disse beskrivelsene? (Sett kun ett kryss for hver linje.)

	Svært enig	Enig	Litt enig	Litt uenig	Uenig	Svært uenig
Dat er et nært samhold mellom meg og min ektefelle/samboer/partner.	☐	☐	☐	☐	☐	☐
Min partner og jeg har problemer i forholdet	☐	☐	☐	☐	☐	☐
Jeg er svært lykkelig mitt forhold	☐	☐	☐	☐	☐	☐
Min partner er generelt fornøyd.	☐	☐	☐	☐	☐	☐
Jeg tenker ofte på å avslutte vårt forhold	☐	☐	☐	☐	☐	☐
Jeg er fornøyd med forholdet til min partner	☐	☐	☐	☐	☐	☐
Vi er ofte uenige om viktige avgjørelser	☐	☐	☐	☐	☐	☐
Jeg har vært heldig med valg av partner	☐	☐	☐	☐	☐	☐
Vi er enige om hvordan barn bør oppdras	☐	☐	☐	☐	☐	☐
Jeg tror min partner er fornøyd med forholdet	☐	☐	☐	☐	☐	☐

+

89. Hvor ofte opplever du følgende i ditt daglige liv? (Sett kun ett kryss for hver linje.)

	Svært sjelden/ aldri	Nokså sjelden	Noen ganger	Oftre	Veldig ofte
Føler deg glad for noe	☐	☐	☐	☐	☐
Føler deg lykkelig	☐	☐	☐	☐	☐
Føler deg optimist, som om alt legger seg til rette for deg	☐	☐	☐	☐	☐
Føler at du vil skikke til noen eller slå løs på ting	☐	☐	☐	☐	☐
Føler deg stolt, triktert eller ergerlig	☐	☐	☐	☐	☐
Føler deg rasende på noen	☐	☐	☐	☐	☐

+

90. Kryss av om du er enig eller uenig i de følgende påstandene.
(Sett kun ett kryss for hver linje.)

	Heilt uenig	Uenig	Litt uenig	Litt enig	Enig	Heilt enig
På de fleste måter er livet mitt nær idealt mitt	☐	☐	☐	☐	☐	☐
Livsbetingelsene mine er svært gode	☐	☐	☐	☐	☐	☐
Jeg er fornøyd med livet mitt	☐	☐	☐	☐	☐	☐
Så langt har jeg oppnådd det som er viktig for meg i livet	☐	☐	☐	☐	☐	☐
Hadde jeg kunnet leve livet på nytt, ville jeg nesten ikke forandret noe	☐	☐	☐	☐	☐	☐

+

91. Har du opplevd noe av det følgende siden forrige spørreskjema? Hvis ja, hvor vondt eller vanskelig var dette for deg?
(Kryss av for hver linje.)

	Nei	Ja	Hvis ja Ikke så lite	Vondt/ vanskelig
Har du hatt problemer på arbeidsplassen eller der du utdanner deg	☐	☐	☐	☐
Har du hatt økonomiske problemer	☐	☐	☐	☐
Ble du skilt, separert eller avbrøt samlivet	☐	☐	☐	☐
Har du hatt problemer eller konflikter med familie, venner eller naboer	☐	☐	☐	☐
Har du vært alvorlig bekymret for om det er noe galt med barnet	☐	☐	☐	☐
Har du vært alvorlig syk eller skadet	☐	☐	☐	☐
Har en av dine nærmeste vært alvorlig syk eller skadet	☐	☐	☐	☐
Har du vært utsatt for alvorlig ulykke, brann eller grovt tyveri	☐	☐	☐	☐
Har du mistet en som du deg nær	☐	☐	☐	☐
Har du blitt presset til seksuelle handlinger	☐	☐	☐	☐
Annet	☐	☐	☐	☐

16

92. Har du i løpet av den siste uken hatt noen av disse følelsene? (Sett kun ett kryss for hver linje.)

	Ja, nesten hele tiden	Ja, av og til	Ikke særlig ofte	Nei, aldri
Bedredt deg selv uten grunn når noe gikk galt	☐	☐	☐	☐
Vært nervøs eller bekymret uten grunn	☐	☐	☐	☐
Vært redd eller fått panikk uten grunn	☐	☐	☐	☐
Vært så u lykkelig at du har hatt vanskeligheter med å sove	☐	☐	☐	☐
Følt deg nedbrøt eller u lykkelig	☐	☐	☐	☐
Vært så u lykkelig at du har grått	☐	☐	☐	☐

+

93. Hva slags oppblåsing har du av deg selv? (Sett kun ett kryss for hver linje.)

	Svært enig	Enig	Uenig	Svært uenig
Jeg har en positiv holdning til meg selv	☐	☐	☐	☐
Jeg føler meg virkelig ubrukelig til tider	☐	☐	☐	☐
Jeg føler at jeg ikke har mye å være stolt av	☐	☐	☐	☐
Jeg føler at jeg er en verdifull person, i alle fall på lik linje med andre	☐	☐	☐	☐

+

94. Har du i løpet av de 2 siste ukene vært plaget med noe av det følgende? (Sett kun ett kryss for hver linje.)

	Ikke plaget	Litt plaget	Ganske mye plaget	Veldig mye plaget
Stadig redd eller engstelig	☐	☐	☐	☐
Nervøsitet, indre uro	☐	☐	☐	☐
Følelse av tapshet med hensyn til fremtiden	☐	☐	☐	☐
Nedtrykt, tungsinndig	☐	☐	☐	☐
Mye bekymret eller urolig	☐	☐	☐	☐
Følelse av at alt er et slit	☐	☐	☐	☐
Føler deg anspekt eller oppslått	☐	☐	☐	☐
Plutselig frykt uten grunn	☐	☐	☐	☐

+

Tusen takk for hjelpen!

Legg det utfylte skjemaet i den frankerte returkonvolutten.

+

den norske Mor & barn undersøkelsen

+ Spørreskjema 5 – Når barnet er 18 måneder

I dette spørreskjemaet stiller vi en del spørsmål som du kanskje vil kjenne igjen fra tidligere spørreskjemaer. Vi gjør dette fordi vi ønsker å følge din og barnets utvikling videre. Det er fint om du finner frem barnets Helsekort, slik at du kan benytte opplysningene som står der. Hvis du synes at et spørsmål er for ubehagelig eller vanskelig å svare på kan du la være å svare på det spørsmålet og gå videre til det neste.

Skjemaet skal leses av en maskin. Det er derfor viktig at du legger vekt på følgende ved utfyllingen:

- Bruk blå eller sort kulepenn.
- I de små avkrypsjangboksene setter du et kryss for det svaret som du mener passer best, slik: ☒
- Hvis du mener at du har satt kryss i feil boks, kan du rite det ved å fylle boksen helt, slik: ☐
- I de store, grønne boksene skriver du tall.

Det er viktig at du bare skriver i det hvite feltet i boksene, slik:

Tall: **1 2 3 4 5 6 7 8 9 0**

- Tallboksene har to eller flere ruter. Når du skriver et ett-sifret tall bruker du den høyre ruten. Eksempel: 5 skrives slik:

5	
---	--

- Spesielle opplysninger som f.eks. medisinerte skiver du fyller på de åpne linjene.
- Fjernlagt skriv jodelig med STORE BOKSTAVER.
- Husk å fylle ut dato for utfylling av skjemaet

Så snart du har fylt ut dette skjemaet, ber vi om at du sender det tilbake til oss i den vedlagte frankerte svarkonvolutten.

Oppgi dag, måned og år for utfylling av skjemaet

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
dag		måned		år	

(Skriv årstall med 4 tall, f.eks. 2003)

OM BARNET

Mat og drikke

1. Hvilken type melk har barnet fått siden hun/han var 6 måneder gammel?

(Du kan sette flere kryss.)

Melketype	Barnets alder i måneder				
	6 - 8	9 - 11	12 - 14	15 - 18	
1. Bystemk	☐	☐	☐	☐	
2. Mornmelsteratning	☐	☐	☐	☐	
3. Mornmelsteratning ved meikentolnase	☐	☐	☐	☐	
4. Heimeik (set)	☐	☐	☐	☐	
5. Lettmek vanlig (set)	☐	☐	☐	☐	
6. Ekstra lett meik (set)	☐	☐	☐	☐	
7. Skummet meik (set)	☐	☐	☐	☐	
8. Bida – alle typer	☐	☐	☐	☐	
9. Annen yoghurt	☐	☐	☐	☐	
10. Andre surmek typer	☐	☐	☐	☐	

+

2. Hvor ofte får barnet følgende drikke, nå ved ca. 18 måneders alder? Velg den hyppighet som i gjennomsnitt passer best. (Sett ett kryss for hver type.)

	Aldri	Mindre enn 1 g. per uke	1-3 g. per uke	4-6 g. per uke	1-2 g. per dag	3-4 g. per dag	5 el. flere g. per dag
1. Bystemk	☐	☐	☐	☐	☐	☐	☐
2. Mornmelsteratning	☐	☐	☐	☐	☐	☐	☐
3. H-mek	☐	☐	☐	☐	☐	☐	☐
4. Lettmek	☐	☐	☐	☐	☐	☐	☐
5. Ekstra lett meik	☐	☐	☐	☐	☐	☐	☐
6. Skummet meik	☐	☐	☐	☐	☐	☐	☐
7. Bida, alle typer	☐	☐	☐	☐	☐	☐	☐
8. Yoghurt naturell	☐	☐	☐	☐	☐	☐	☐
9. Yoghurt med frukt	☐	☐	☐	☐	☐	☐	☐
10. Andre surmektyper	☐	☐	☐	☐	☐	☐	☐
11. Vann fra springen	☐	☐	☐	☐	☐	☐	☐
12. Vann kjøpt på flaske	☐	☐	☐	☐	☐	☐	☐
13. Satt, suket	☐	☐	☐	☐	☐	☐	☐
14. Juice	☐	☐	☐	☐	☐	☐	☐
15. Brus	☐	☐	☐	☐	☐	☐	☐
16. Lettbrus	☐	☐	☐	☐	☐	☐	☐
17. Annet:	☐	☐	☐	☐	☐	☐	☐

3. Får barnet følgende å drikke om natten nå ved ca. 18 måneders alder? (Sett ett kryss for hver type.)

	Aldri/ sjelden	Av og til	Ja, de fleste netter	
1. Vann	☐	☐	☐	
2. Meik eller satt fra kopp	☐	☐	☐	
3. Meik eller satt fra flaske	☐	☐	☐	
4. Annen	☐	☐	☐	+

4. Hvor ofte får barnet følgende mat, nå ved ca. 18 måneders alder? Velg den hyppighet som i gjennomsnitt passer best. (Sett ett kryss for hver type.)

	Aldri	Mindre enn 1 g. per uke	1-3 g. per uke	4-6 g. per uke	1-2 g. per dag	3 g. el. mer per dag
1. Brød med leverpostei	☐	☐	☐	☐	☐	☐
2. Brød med kjøttlegg	☐	☐	☐	☐	☐	☐
3. Brød med fisk (f.eks. sardin, makrell)	☐	☐	☐	☐	☐	☐
4. Brød med ost	☐	☐	☐	☐	☐	☐
5. Brød med syltetøy/honning	☐	☐	☐	☐	☐	☐
6. Brød med annet pålegg	☐	☐	☐	☐	☐	☐
7. Industriefremstalt barnegrøt (pulver)	☐	☐	☐	☐	☐	☐
8. Hjemmelaget grøt	☐	☐	☐	☐	☐	☐
9. Kjøtt, pasta, kjøttboller o.l.	☐	☐	☐	☐	☐	☐
10. Fisk, fiskeboller, fiskepudding o.l.	☐	☐	☐	☐	☐	☐
11. Pannekaker	☐	☐	☐	☐	☐	☐
12. Poteter	☐	☐	☐	☐	☐	☐
13. Pasta	☐	☐	☐	☐	☐	☐
14. Ris	☐	☐	☐	☐	☐	☐
15. Erver, bønner	☐	☐	☐	☐	☐	☐
16. Andre løkke grønnsaker	☐	☐	☐	☐	☐	☐
17. RA grønnsaker	☐	☐	☐	☐	☐	☐
18. Frukt	☐	☐	☐	☐	☐	☐
19. Kaker/vaffler/satt kjeks	☐	☐	☐	☐	☐	☐
20. Deserteris	☐	☐	☐	☐	☐	☐
21. Smågodt	☐	☐	☐	☐	☐	☐
22. Smågodt, seigmann, annet godteri	☐	☐	☐	☐	☐	☐

+

5. Får barnet hjemmelaget middagsmat eller ferdigkjøpt (indufryssett) barmemat på glass?

☐ Bare hjemmelaget	☐ Nesten alltid
☐ Mest hjemmelaget	☐
☐ Omrent halvparten av hvert	☐
☐ Mest ferdigkjøpt	☐
☐ Bare ferdigkjøpt	☐

+

7. Reagerer barnet på visse matvarer?

☐ Nei	☐
☐ Ja	☐
☐ Vet ikke	☐

+

8. Hvis ja, hvilken type mat reagerer barnet på? (Du kan sette flere kryss.)

1. ☐ H-mælk	14. ☐ Fukt, bør
2. ☐ Skummet melk/lettmeik	15. ☐ Grønnsaker/poteter
3. ☐ Flete	16. ☐ Spikade
4. ☐ Yoghurt/sur mælk	17. ☐ Andre godterier
5. ☐ Iskrem	18. ☐ Sukker
6. ☐ Ost	19. ☐ Annet:
7. ☐ Rått egg (fisks eggedosis)	

+

9. Er det noen matvarer du bevistst umngår å gi barnet?

☐ Nei	☐
☐ Ja	☐

+

10. Hvis ja, hvilke matvarer prøver du å unngå, og hvor streng er dietten?

Nær redusert bruk i forhold til vanlig kosthold	Bruker ikke i ublandet form, men tillater litt i forskjellige matreiter	Ungår all bruk (også "sekurr" i matreiter)
1. Meik	☐	☐
2. Egg	☐	☐
3. Fisk/fiskeprodukter	☐	☐
4. Kjøtt/kjøttprodukter	☐	☐
5. Hele	☐	☐
6. Sukker	☐	☐
7. Annet:	☐	☐

+

11. Får barnet tran, vitaminer, jern eller annet kosttilskudd?

☐ Nei	☐
☐ Ja	☐

[illegible]

		Hvis ja, er barnet henvist til spesialistundersøkelse?		
		Nei	Ja	
Helseproblem				
4. Forsinket motorisk utvikling (f.eks etter/går sent)		☐	☐	
5. For liten vektøkning		☐	☐	
6. For stor vekstøking		☐	☐	
7. Avvikende hudkompleks		☐	☐	
8. Hjerteefeil		☐	☐	+
9. Testiklene ikke kommet ned i pungen		☐	☐	
10. Astma		☐	☐	
11. Atopisk (barn)eksem		☐	☐	
12. Elveblett		☐	☐	
13. Metallergi/intoleranse		☐	☐	
14. Forsinnet eller avvikende språkutvikling		☐	☐	
15. Svaneproblemer		☐	☐	
16. Allergiproblemer		☐	☐	
17. Kontaktproblemer		☐	☐	
18. (Annen) misdiagnose: _____		☐	☐	
19. Annet: _____		☐	☐	
17. Hvis barnet ble henvist videre, hva viste denne undersøkelsen?				
☐ Alt var orden				
☐ Fortsett vil undersøkes videre				
☐ Har ikke vært til undersøkelse ennå				
☐ Diagnose I: _____				
☐ Diagnose II: _____				
☐ Diagnose III: _____				
18. Har barnet blitt behandlet med "pute" for hofteleider?				
☐ Nei				
☐ Ja				
		Hvor lenge? <input type="text"/> måneder		
19. Har barnet hatt noen av følgende sykdom/helseproblem ved 6-11 måneders alder, og/eller ved 12-18 måneders alder? Oppgi hvor mange ganger, og om barnet har vært innlagt på sykehus for dette problemet. (Kryss av for hver linje.)				
Sykdom/helseproblem	Ved 6-11 måneders alder Ganger Nei Ja	Ved 12-18 måneders alder Ganger Nei Ja	Vært innlagt på sykehus for dette? Nei Ja	
1. Forkjølelse	☐	☐	☐	☐
2. Halsbetennelse med påviste streptokokker	☐	☐	☐	☐
3. Annen halsbetennelse	☐	☐	☐	☐
4. Ørebetennelse	☐	☐	☐	☐
5. Falak kupp	☐	☐	☐	☐
6. Bronkitt/RS-viruslungebetennelse	☐	☐	☐	☐
7. Omgangssyke/diare	☐	☐	☐	☐
8. Urinveisinfeksjon	☐	☐	☐	☐
9. Øyekatar	☐	☐	☐	☐
				+ + + + + (forts.)

Sykdom/helseproblem		Ved 6 - 11 måneders alder		Antall ganger		Ved 12-18 måneders alder		Antall ganger		Vært innlagt på sykehus for dette?	
		Nei	Ja	Nei	Ja	Nei	Ja	Nei	Ja	Nei	Ja
10.	Feber/kramper	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11.	Anore kramper (uten feber)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12.	Vannkopper	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13.	Saude eller ulykke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14.	Annet: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

20. Har barnet vært til lege eller på sykehus ved 6-11 måneders alder og/eller ved 12-18 måneders alder? Hvis ja, oppgi hvor mange ganger. (Kryss av for hver tinge.)

		Ved 6 - 11 måneders alder		Ved 12 - 18 måneders alder	
		Nei	Ja	Nei	Ja
Almennlege (utenom helsestasjonen)		☐	☐	☐	☐
Legesvaldige		☐	☐	☐	☐
Privatpraktiserende spesialist		☐	☐	☐	☐
Poliklinikk på sykehus		☐	☐	☐	☐
Innlagt på sykehus		☐	☐	☐	☐

21. Har barnet vært henvist til følgende instanser?

	Nei	Ja
Habiliteringsinstansen	☐	☐
PP-tjenesten	☐	☐
Barnspsykiatrik poliklinikkavdeling	☐	☐

22. Hvis barnet har vært undersøkt eller innlagt på sykehus, oppgi navn på sykehus.

Navn på sykehus: _____

Navn på sykehus: _____

Navn på sykehus: _____

+

23. Har barnet hatt noen av følgende symptomer siden 6 måneders alder? Hvis ja, ved hvilken alder? (Kryss av for hver tinge.)

	Hatt symptomene?		
	Nei	Ja	
1. Piping/hvesing i brystet	☐	☐	
2. Tøtthet i brystet	☐	☐	
3. Natlig hoste	☐	☐	
4. Rennende nese uten forkjølelse	☐	☐	
5. Forstoppelse	☐	☐	
6. Diare	☐	☐	
7. Klesende utslett som kommer og går	☐	☐	

24. Har barnet vært allergitestet?

Nei

Ja

+

25. Hvis ja, hva ble barnet testet på og slo testen ut?

(Du kan sette flere kryss.)

Slo testen ut?

Nei

Ja

Vet ikke

1. Melk

2. Egg

3. Fisk

4. Muggopp

5. Melld

6. Dyr

7. Pollen

8. Annet:

26. Har dere oppsøkt såkalt alternativt medisin for barnet siden hun/han var 6 måneder??

Nei

Ja

27. Hvis ja, hva slags alternativt medisin?

ganger

28. Har barnet fått medisiner siden 6 måneders alder? (Dette gjelder alle typer medisiner, også naturmedisiner og urtepreparater)

Nei

Ja

29. Hvis ja, oppgi navn på medisinene og barnets alder ved medisinbruk. (Ta med alle typer medisiner også naturmedisiner)

Navn på medisin
(f.eks. Apocilin, Paracet)

Hvor gammelt var barnet ved medisinbruk?

6-8 mnd

9-11 mnd

12-14 mnd

15-18 mnd

30. Hva var barnets lengde, vekt og hodoomkrets når barnet var omtrent 8 måneder, ca 1 år og ved siste måling (15-18 måneder)?

(Se barnets historikk)

+

Ca 8 mnd

Ca. 1 år

15 - 18 mnd

Dato for måling

dag

måned

år

Vekt

Lengde

Hodoomkrets

31. Kan barnet gå uten støtte?

Nei

Ja

Hvis ja, hvor gammelt var barnet når det først kunne gå uten støtte?

Antall: måneder.

28. Har dere oppsøkt såkalt alternativt medisin for barnet siden hun/han var 6 måneder??

Nei

Ja

27. Hvis ja, hva slags alternativt medisin?

ganger

29. Hvis ja, oppgi navn på medisinene og barnets alder ved medisinbruk. (Ta med alle typer medisiner også naturmedisiner)

Navn på medisin
(f.eks. Apocilin, Paracet)

Hvor gammelt var barnet ved medisinbruk?

6-8 mnd

9-11 mnd

12-14 mnd

15-18 mnd

30. Hva var barnets lengde, vekt og hodoomkrets når barnet var omtrent 8 måneder, ca 1 år og ved siste måling (15-18 måneder)?

(Se barnets historikk)

+

Ca 8 mnd

Ca. 1 år

15 - 18 mnd

Dato for måling

dag

måned

år

Vekt

Lengde

Hodoomkrets

31. Kan barnet gå uten støtte?

Nei

Ja

Hvis ja, hvor gammelt var barnet når det først kunne gå uten støtte?

Antall: måneder.

32. Nedentfor følger spørsmål om barnets utvikling ved ca. 18 måneders alder. (Sett ett kryss for hver linje.)

+

+

+

+

33. Mer om barnets utvikling. (Sett ett kryss for hver linje.)

+

+

+

34. Hvor typisk er følgende atferd for ditt barn? (Sett ett kryss for hver linje.)

+

+

+

8

+		Passer ltt/ noen ganger		Passer godt/ ofte	
5.	Barnet er stort sett bld og grøt.	☐	☐	☐	☐
6.	Barnet klenger på voksne, eller er for anhengig	☐	☐	☐	☐
7.	Barnet blir for urolig når addsett fra foreldre	☐	☐	☐	☐
8.	Barnet kommer ofte opp i krangel	☐	☐	☐	☐
9.	Barnet slå andre	☐	☐	☐	☐
10.	Barnet er trassig	☐	☐	☐	☐
11.	Det merkes ikke på barnet når hun/han har gjort noe galt	☐	☐	☐	☐
12.	Grimasetting endrer ikke barnets atferd	☐	☐	☐	☐
13.	Barnet spiser dårlig	☐	☐	☐	☐
14.	Barnet liker nesten all slags mat	☐	☐	☐	☐
15.	Barnet motsetter seg å legge seg om kvelden	☐	☐	☐	☐
16.	Barnet vil ikke sove alene	☐	☐	☐	☐
17.	Barnet er redd for å prøve nye ting	☐	☐	☐	☐
18.	Barnet blir urolig av enhver forandring i faste rutiner	☐	☐	☐	☐
19.	Barnet er for mod og engstelig	☐	☐	☐	☐

+		Passer ltt/ noen ganger		Passer godt/ ofte	
38.	Hvor ofte hender det at barnet våkner om natten?	☐	☐	☐	☐
	☐ 3 eller flere ganger hver natt	☐	☐	☐	☐
	☐ 1-2 ganger hver natt	☐	☐	☐	☐
	☐ Noen ganger i uken	☐	☐	☐	☐
	☐ Sjelden eller aldri	☐	☐	☐	☐

+		Passer ltt/ noen ganger		Passer godt/ ofte	
39.	Hvor mange timer sover barnet til sammen pr. døgn?	☐	☐	☐	☐
	☐ 10 timer eller mindre	☐	☐	☐	☐
	☐ 11 - 12 timer	☐	☐	☐	☐
	☐ 13 - 14 timer	☐	☐	☐	☐
	☐ 15 timer eller mer	☐	☐	☐	☐

+		Passer ltt/ noen ganger		Passer godt/ ofte	
40.	Om bekymringer. (Skriv ett kryss for hver frite)	☐	☐	☐	☐
	1. Er du bekymret for barnets fysiske utvikling?	☐	☐	☐	☐
	2. Er du bekymret for barnets værenstet?	☐	☐	☐	☐
	3. Er du bekymret fordi barnet er krevende og vanskelig å ha med å gjøre?	☐	☐	☐	☐
	4. Er du bekymret fordi barnet er så lite interessert i andre barn?	☐	☐	☐	☐
	5. Har du annen bekymring for barnets helse?	☐	☐	☐	☐
	Hva	☐	☐	☐	☐

(Benytt gjerne siste siden til ekstra skneplasse)

45. Hvis barnet ikke bor sammen med sin far, hvor mye er barnet sammen med ham?

Minst halvparten av tiden

Minst en gang i uken

Minst en gang i måneden

Sjeldnere enn en gang i måneden

Aldri

+

46. Hvor mange ganger har dere flyttet siden barnet ble født?

ganger

47. Omrent hvor stort boareal har din nåværende bolig?

m²

48. Har dere oppvarming med elektriske varmekabler i gulvet i rom hvor barnet oppholder seg?

Nei

Ja

49. Hvis ja, hvilke rom? (Slett eventuelt flere kryss)

☐ Stue

☐ Gang

☐ Kjøkken

☐ Bad

☐ Barnesom

☐ Andre rom

☐ Soverom

50. Har det vært luktskader, synlig sopp-/muggvekst eller mugglukt i boligen i løpet av siste år? (Du kan sette flere kryss.)

☐ Nei

☐ Ja, luktskader

☐ Ja, synlig sopp-/muggvekst

☐ Ja, mugglukt

+

51. Hva slags drikkevann er det dere bor?

☐ Vann fra offentlig eller privat vannverk

☐ Vann fra egen vannforsyning (f.eks egen brønn)

☐ Vel ikke

52. Bor dere i nærheten av en høyspenningsledning?

☐ Nei

☐ Ja, nærmere enn 50 meter

☐ Ja, 50-100 meter unna

☐ Ja, men mer enn 100 meter fra

53. Er det dyr i barnets hjem, eller hos dagmamma?

☐ Nei

☐ Ja, i hjemmet

☐ Ja, hos dagmamma

+

54. Hvis ja, hva slags dyr? (Slett eventuelt flere kryss.)

☐ Hund

☐ Katt

☐ Marsvin, kanin, mus, rotte eller lignende

☐ Ukultet, annen fugl

☐ Annet dyr:.....

55. Oppholder barnet seg i rom hvor noen røyker?

☐ Ja, daglig.

☐ Ja, flere ganger i uken

☐ Ja, av og til

☐ Usikkert

☐ Nei

+

56. Hvor ofte børstes barnets tærner?

☐ 2 ganger pr. dag eller oftere

☐ En gang pr. dag

☐ Av og til

☐ Aldri

57. Brukes fluorertannkrem på børstene?

☐ Nei

☐ Av og til

☐ Ja, vanligvis

58. Hvor mye er barnet utendørs nå for tiden?

☐ Sjelden

☐ Ofte, men gjennomsnittlig mindre enn en time daglig

☐ Gjennomsnittlig 1-3 timer daglig

☐ Mer enn 3 timer daglig

59. Hvor mange timer gjennomsnittlig sitter barnet daglig foran TV/video?

☐ 4 timer

☐ 3 timer

☐ 1-2 timer

☐ Mindre enn 1 time

☐ Sjeldn/aldri

60. Deltar eller har barnet deltatt i babytysvenning?

☐ Nei

☐ Ja.

Hvis ja. Hvor lenge har barnet deltatt?

61. Bruker barnet narresmøkk nå ved 18 måneders alder?

☐ Sjelden eller aldri

☐ Bare når hushjelp skal sove

☐ Ganske ofte

☐ Mesteparten av tiden

62. Bor dere i nærheten av en høyspenningsledning?

☐ Nei

☐ Ja, nærmere enn 50 meter

☐ Ja, 50-100 meter unna

☐ Ja, men mer enn 100 meter fra

63. Er det dyr i barnets hjem, eller hos dagmamma?

☐ Nei

☐ Ja, i hjemmet

☐ Ja, hos dagmamma

+

64. Hvis ja, hva slags dyr? (Slett eventuelt flere kryss.)

☐ Hund

☐ Katt

☐ Marsvin, kanin, mus, rotte eller lignende

☐ Ukultet, annen fugl

☐ Annet dyr:.....

12

OM DEG SELV

Helse, sykdom og medisnbruk

+

62. Hvilken sivilstand har du nå?

☐ Gift

☐ Separert/skilt

☐ Samboer

☐ Enke

☐ Enslig

☐ Annet

63. Er du gravid nå?

☐ Nei

☐ Ja

Hvis ja, hvor mange uker?

64. Har du en langvarig sykdom som har oppstått de siste 12 månedene?

☐ Nei

☐ Ja, hvilken?

65. Har du selv vært innlagt på sykehus de siste 12 månedene?

☐ Nei

☐ Ja, hvilket sykehus?

66. Bruker du nå for tiden tran, vitaminer eller annet kosttilskudd?

☐ Nei

☐ Ja, hvilket?

67. Hvor mye veier du nå for tiden?

kg

68. Har det i løpet av de siste 6 månedene eller noen gang tidligere i livet hendt at (Kryss av for hver rye.)

Siste 6 måneder

Tidligere

Ja

Kanskje

Nei

Ja

Kanskje

Nei

1. Du selv syntes at du var for tykk?

☐

☐

☐

☐

☐

☐

☐

☐

☐

2. Du var veldig redd for å legge på deg eller bli for tykk?

☐

☐

☐

☐

☐

☐

☐

☐

☐

3. Andre sa du var for tynn, mens du selv syntes du var for tykk?

☐

☐

☐

☐

☐

☐

☐

☐

☐

4. Du syntes det var svært viktig for synet på deg selv at du holdt en bestemt vekt?

☐

☐

☐

☐

☐

☐

☐

☐

☐

69. Har det hendt i løpet av de siste 6 månedene eller tidligere i livet - i en periode på minst 3 måneders varighet - at du har opplevd noe av det følgende, og i så fall når hvor hyppig var det? (Veg den perioden som du var mest plagt.) (Kryss av for hver rye.)

Siste 6 måneder

Tidligere

Minst 2 g. i uken

1-4 g. i uken

mind. 1 g. i uken

aldri

Minst 2 g. i uken

1-4 g. i uken

mind. 1 g. i uken

aldri

1. Følt at du mistet kontrollen mens du spiste, og ikke klarte å stoppe før du hadde spist alt for mye?

☐

☐

☐

☐

☐

☐

☐

☐

☐

2. Brukt oppkast for å kontrollere vekten?

☐

☐

☐

☐

☐

☐

☐

☐

☐

3. Brukt avføringsmidler for å kontrollere vekten?

☐

☐

☐

☐

☐

☐

☐

☐

☐

4. Brukt taskeur for å kontrollere vekten?

☐

☐

☐

☐

☐

☐

☐

☐

☐

5. Brukt hard fysisk trening for å kontrollere vekten?

☐

☐

☐

☐

☐

☐

☐

☐

☐

70. Har det hendt de siste 6 månedene, eller tidligere i livet at det har gått minst tre måneder uten menstruasjon (uten at du har vært gravid eller i barse/ammepriode)? (Utkrysning til en periode med spiseproblemer)

☐ Nei, aldri

☐ Ja, de siste 6 måneder

☐ Ja, tidligere

+

71. Har du de siste 12 månedene hatt smerter noen av følgende steder? (Satt ett kryss for hver linje)

	Sjelden/aldri	Litt plaget	En del plaget	Sterkt plaget
1. Magen	☐	☐	☐	☐
2. Armer/bein	☐	☐	☐	☐
3. Nakke/skuldre	☐	☐	☐	☐
4. Hodet	☐	☐	☐	☐
5. Ryggen	☐	☐	☐	☐
6. Bekkenet (bækkelassning)	☐	☐	☐	☐

72. Hvis du har hatt smerter i ryggen eller bekken de siste 12 måneder, kryss av for hvor mye du var plaget på ulike steder:

	Sjelden/aldri	Litt plaget	En del plaget	Sterkt plaget
1. I leversengen	☐	☐	☐	☐
2. Over det ene bekenleddet bak	☐	☐	☐	☐
3. Over begge bekenleddene bak	☐	☐	☐	☐
4. Over halvbakken	☐	☐	☐	☐
5. I seteløstolen	☐	☐	☐	☐
6. Foran over kjørstolen	☐	☐	☐	☐
7. I lysken	☐	☐	☐	☐
8. Andre ryggsmarter	☐	☐	☐	☐
9. Andre smerter	☐	☐	☐	☐

73. Våkner du om natten pga. bekkensmerter nå for tiden?

☐ Nei, aldri

☐ Ja, en sjelden gang

☐ Ja, ofte

74. Har du nå for tiden så store vansker med å gå pga. bekkensmerter at du må bruke stokk eller krykker?

☐ Nei, aldri

☐ Ja, men ikke hver dag - smerter varierer fra dag til dag

☐ Ja, må bruke stokk eller krykker hver dag

75. Har du fått behandling for bekkensmerter etter siste bodset?

☐ Nei

☐ Ja

76. Hvis ja, hvilken type behandling har du fått?
(Set eventuelt flere kryss.)

☐ Fysioterapi

☐ Kiropraktikk

☐ Medikamenter

☐ Annet:

77. Har du nå for tiden noen av følgende plager? (Kryss av for hver linje.)

Plager:	1-4 gjeng pr. uke	5-6 gjeng pr. uke	7-8 gjeng pr. uke	9-10 gjeng pr. uke
1. Urnæklekasje ved hosting, nyring eller latter	☐	☐	☐	☐
2. Urnæklekasje ved fysisk aktivitet (leikhop)	☐	☐	☐	☐
3. Urnæklekasje ved sterk tungt til venning	☐	☐	☐	☐
4. Problemer med å holde på avføring	☐	☐	☐	☐
5. Problemer med å holde på lutt	☐	☐	☐	☐

78. Bruker du medisiner i løvning? (Dette gjelder alle typer medisiner, også naturmedisiner.)

☐ Nei

☐ Ja

79. Hvis ja, oppgi navn på medisinene og hvor ofte du bruker dem. (Ta med alle typer medisin, også naturmedisiner)

Navn på medisin

+

Hvor ofte bruker du dem?

(f.eks. Aspirin, Paraset)

Daglig / perioder

Av og til

80. Hvor lang permisjon tok du/dere etter fødselen? Oppgi enten antall måneder eller uker

Månader

Uker

Dag selv

eller

Barnets far

81. Har du nå inntektsgivende arbeid?

☐ Nei
 ☐ Ja

82. Hvis ja, hvor mange timer arbeider du pr. uke?

timer

+

83. Hvis du er i lønnet arbeid, har du vært sykemeldt siden du begynte å arbeide igjen? Hvis ja, oppgi hvor mange dager du var sykemeldt

☐ Nei
 ☐ Ja

84. Hvor ofte er du så fysisk aktiv (i fritid eller på arbeid) at du blir andpusten eller svett?

1. Aldri

2. Mindre enn 1 gang pr. uke

3. 1 gang pr. uke

4. 2 ganger pr. uke

5. 3-4 ganger pr. uke

6. 5 ganger eller mer pr. uke

I fritiden

På arbeid

85. Har det i løpet av det siste halve året hendt at du/dere har hatt vansker med å klare løpende utgifter til mat, transport, husleie og lignende?

☐ Nei
 ☐ Nei aldri
 ☐ Ja, en sjelden gang
 ☐ Ja, av og til
 ☐ Ja, ofte

86. Hvor ofte driver du fysisk aktivitet nå for hver fjerde...

1. Aldri

2. Mindre enn 1 gang pr. uke

3. 1 gang pr. uke

4. 2 ganger pr. uke

5. 3-4 ganger pr. uke

6. 5 ganger eller mer pr. uke

1 gang pr. uke

2 ganger pr. uke

3 ganger eller mer pr. uke

87. Hvor ofte driver du fysisk aktivitet nå for tiden? (Sett ett kryss for hver fjerde...)

1-3 ganger pr. mnd

1 gang pr. uke

2 ganger pr. uke

3 ganger eller mer pr. uke

88. Hvordan er rykevennene i hjemmet nå?

Din samboer/ektefelle	Dag selv
1. Røyker ikke	☐
2. Røyker av og til	☐
3. Røyker daglig	☐
4. Hvis daglig, antall sigaretter per dag	<input type="text"/>

89. Hvor ofte drikker du alkohol nå for tiden?

☐ Omrent 6-7 ganger pr. uke	+
☐ Omrent 4-5 ganger pr.uke	
☐ Omrent 2-3 ganger pr.uke	
☐ Omrent 1 gang pr.uke	
☐ Omrent 1-3 ganger pr.måned	
☐ Spjendrer enn 1 gang pr. måned	
☐ Aldri	

Betyr alkohol

For å sammenligne ulike typer alkohol, spes. vi etter det vi kaller alkoholenhet (= 1,50 ren alkohol). I praksis betyr dette følgende:

- 1 glass (10 cl) øl = 1 enhet
- 1 glass (10 cl) vin = 1 enhet
- 1 helnaglass, sherry eller annen hvin = 1 enhet
- 1 drammeglass brennvin eller likør = 1 enhet
- 1 flaske brennvin/likør

Litt mer om deg selv og hvordan du har det nå

91. Hvis du har en ektefelle/samboer/partner, hvor enig er du i disse beskrivelsene? (Sett ett kryss for hver linje.)

	Svært enig	Enig	Litt enig	Litt uenig	Uenig	Svært uenig
1. Det er et nært samhold mellom meg og min ektefelle/samboer/partner	☐	☐	☐	☐	☐	☐
2. Min partner og jeg har problemer i parforholdet	☐	☐	☐	☐	☐	☐
3. Jeg er svært lykkelig i mitt parforhold	☐	☐	☐	☐	☐	☐
4. Min partner er generelt forståelsefull	☐	☐	☐	☐	☐	☐
5. Jeg tenker ofte på å avslutte vårt parforhold	☐	☐	☐	☐	☐	☐
6. Jeg er fornøyd med forholdet til min partner	☐	☐	☐	☐	☐	☐
7. Vi er ofte uenige om viktige avgjørelser	☐	☐	☐	☐	☐	☐
8. Jeg har vært heldig med valg av partner	☐	☐	☐	☐	☐	☐
9. Vi er enige om hvordan barn bør oppdras	☐	☐	☐	☐	☐	☐
10. Jeg tror min partner er fornøyd med forholdet	☐	☐	☐	☐	☐	☐

92. Har du noen utenom din ektefelle/samboer/partner som du kan snakke råd hos i en vanskelig situasjon?

☐ Nei	+
☐ Ja, 1-2 personer	
☐ Ja, flere enn 2 personer	

93. Hvor ofte treffer du eller snakker i telefonen med familie (utenom husholdningen) eller nære venner?

☐ 1 gang i måneden eller sjeldnere
☐ 2-8 ganger i måneden
☐ Mer enn 2 ganger i uken

95. Hvor riktig er disse utsagnene for deg? (Sett ett kryss for hver linje.)

	Ikke riktig	Litt riktig	Nesten riktig	Helt riktig
1. Jeg klær alltid å løse vanskelige problemer hvis jeg prøver hardt nok	☐	☐	☐	☐
2. Hvis noen motarbeider meg, finner jeg en måte å oppnå det jeg vil på	☐	☐	☐	☐
3. Jeg er sikker på at jeg kan mestre uventede hendelser	☐	☐	☐	☐
4. Jeg er rolig når jeg møter vanskeligheter fordi jeg stoler på min evne til å klare meg	☐	☐	☐	☐
5. Dersom jeg er i en knipe, finner jeg vanligvis en løsning	☐	☐	☐	☐

96. Hvor ofte opplever du følgende i ditt daglige liv? (Sett ett kryss for hver linje.)

	Spelden/aldri	Nokså sjelden	Noen ganger	Ofta	Veldig ofte
1. Føler deg glad for noe	☐	☐	☐	☐	☐
2. Føler deg lykkelig	☐	☐	☐	☐	☐
3. Føler deg opptatt, som om at legger seg til rørt for deg	☐	☐	☐	☐	☐
4. Føler at du vil skrike til noen eller slå løs på ting	☐	☐	☐	☐	☐
5. Føler deg sint, irritert eller ergerlig	☐	☐	☐	☐	☐
6. Føler deg rasende på noen	☐	☐	☐	☐	☐

97. Hva slags oppfatning har du av deg selv? (Sett ett kryss for hver linje.)

	Svært enig	Enig	Uenig	Svært uenig
1. Jeg har en positiv holdning til meg selv	☐	☐	☐	☐
2. Jeg føler meg virkelig ubrukelig til tider	☐	☐	☐	☐
3. Jeg føler at jeg ikke har mye å være stolt av	☐	☐	☐	☐
4. Jeg føler at jeg er en verdiløs person, iallfall på lik linje med andre	☐	☐	☐	☐

98. Har du i løpet av de 2 siste ukene vært plaget med noe av det følgende? (Sett ett kryss for hver linje.)

	Ikke plaget	Litt plaget	Ganske mye plaget	Veldig mye plaget
1. Stadig redd eller engstelig	☐	☐	☐	☐
2. Nervøsitet, indre uro	☐	☐	☐	☐
3. Følelse av tungsnet med hensyn til fremtiden	☐	☐	☐	☐
4. Nedtrykt, tungsind	☐	☐	☐	☐
5. Mye bekymret eller urolig	☐	☐	☐	☐
6. Følelse av at alt er slit	☐	☐	☐	☐
7. Føler deg angstet eller oppgitt	☐	☐	☐	☐
8. Plutselig frykt uten grunn	☐	☐	☐	☐

99. Har du opplevd noe av det følgende det siste året (siden forrige spørreskjema)? Hvis ja, hvor vondt eller vanskelig var dette for deg? (Kryss av for hver linje.)

	Nei	Ja	Ikke så lite	Hvis ja	Vondt/ vanskelig	Veldig vondt/ vanskelig
1. Problemer på arbeidsplassen eller der du utdanner deg	☐	☐	☐	☐	☐	☐
2. Økonomiske problemer	☐	☐	☐	☐	☐	☐
3. Bli skilt, separert eller abrupt samvitt	☐	☐	☐	☐	☐	☐
4. Problemer eller konflikter med familie, venner eller naboer	☐	☐	☐	☐	☐	☐
5. Avorlig bekymring for om det er noe galt med barnet	☐	☐	☐	☐	☐	☐
6. Avorlig sykdom eller skade (deg selv)	☐	☐	☐	☐	☐	☐
7. En av de nærmeste har vært alvorlig syk eller skadet	☐	☐	☐	☐	☐	☐
8. Avorlig trafikkukke, boligbrann eller grovt tyveri	☐	☐	☐	☐	☐	☐
9. Misset en som sto deg nær	☐	☐	☐	☐	☐	☐
10. Bli tvunget til seksuelle handlinger	☐	☐	☐	☐	☐	☐
11. Annet	☐	☐	☐	☐	☐	☐

+

100. Hvordan vil du vurdere kvaliteten på livet ditt?

☐ Svært dårlig

☐ Dårlig

☐ Verken god eller dårlig

☐ God

☐ Svært god

101. Hvor tilfreds er du med helsen din?

☐ Svært utilfreds

☐ Utilfreds

☐ Verken tilfreds eller utilfreds

☐ Tilfreds

☐ Svært tilfreds

102. De følgende spørsmålene spør etter hvor mye du har opplevd av bestemte ting i de siste to ukene. (Sett ett kryss for hver linje.)

Ikke i det hele tatt

Litt

Til en viss grad

Svært i høy grad

1. I hvilken grad føler du at smerte hindrer deg i å gjøre det du må?

☐

☐

☐

☐

2. I hvilken grad trenger du medisinsk behandling for å kunne fungere til daglig?

☐

☐

☐

☐

3. Hvor mye gleder du deg over livet?

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4. I hvilken grad føler du at livet ditt er meningsfullt?

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5. Hvor godt kan du konsentrere deg?

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6. Hvor trygg føler du deg til daglig?

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7. Hvor samme er dine fysiske omgivelser?

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103. De følgende spørsmålene spør etter hvor fullstendig du opplevde eller kunne utføre bestemte ting i løpet av de siste to ukene. (Sett ett kryss for hver linje.)

Ikke i det hele tatt

Litt

Til en viss grad

Fullstendig

1. Har du nok energi til dine daglige gjøremål?

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2. Kan du akseptere utseende ditt?

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3. Har du nok penger til å dekke dine behov?

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4. Hvor tilgjengelig er den informasjonen som du trenger dagliglivet?

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5. I hvilken grad har du mulighet for å delta i fritidsaktiviteter?

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104. Hvor godt er du i stand til å komme deg ditt du vil?

☐ Svært dårlig

☐ Dårlig

☐ Verken godt eller dårlig

☐ Godt

☐ Svært godt

105. De følgende spørsmålene spør etter hvor glad eller tilfreds du har følt deg over bestemte sider ved livet i de siste to ukene. (Sett ett kryss for hver linje.)

Svært utilfreds

Utilfreds

Verken tilfreds eller utilfreds

Tilfreds

Svært tilfreds

1. Hvor tilfreds er du med hvordan du sover?

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2. Hvor tilfreds er du med din evne til å utføre dine daglige gjøremål?

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3. Hvor tilfreds er du med din arbeidskapasitet?

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4. Hvor tilfreds er du med deg selv?

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5. Hvor tilfreds er du med ditt forhold til andre mennesker?

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6. Hvor tilfreds er du med ditt seksualliv?

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7. Hvor tilfreds er du med den støtten du får fra dine venner?

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8. Hvor tilfreds er du med forholdene der du bor?

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9. Hvor tilfreds er du med din tilgang til helsejenester?

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10. Hvor tilfreds er du med transportmulighetene dine?

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18

106. Det følgende spørsmålet refererer seg til hvor ofte du har opplevd eller følt negative følelser i løpet av de siste to ukene?
Hvor ofte har du opplevd negative følelser, som f.eks. at du er trist, nervøst, engstelig eller deprimeret?

+

KOMMENTARER:

BARNETS MÅL OG VEKT

107. Hvis noen av målene i spørsmål 30 mangler i barnets helsekort, kan vi da ta kontakt med helsestasjonen for å få disse?

☐ Nei

☐ Ja

Namn på helsestasjonen: _____

Poststed eller kommune: _____

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den norske Mor & barn undersøkelsen

+ Spørreskjema 6 – Når barnet er 36 måneder

I dette spørreskjemaet stiller vi en del spørsmål som du kanskje vil kjenne igjen fra tidligere spørreskjemaer. Vi gjør dette fordi vi ønsker å følge din og barnets utvikling videre. Det er fint om du finner frem barnets Helsekort, slik at du kan benytte opplysningene som står der.

Hvis du synes at et spørsmål er for ubehagelig eller vanskelig å svare på kan du la være å svare på det spørsmålet og gå videre til det neste.

Skjemaet skal leses av en maskin. Det er derfor viktig at du legger vekt på følgende ved utfyllingen:

- Bruk blå eller sort kulepenn.
- Les små avkrypsningsboksene etter du er ferdig for det svaret som du mener passer best, slik: ☒
- Hvis du mener at du har satt kryss i feil boks, kan du rette det ved å fylle boksen helt, slik: ☒
- Les store bokstaver skrivet du får.

Det er viktig at du bare skriver i det hvite feltet i boksene, slik:

Tall:

Tall:

- Tallboksene har to eller flere rader. Når du skriver et ett-sifret tall, bruk du den høyre raden. Eksempel: 5 skrives slik:

- Spesielle opplysninger som f.eks. medikamenter skriver du inn på de åpne linjene.
- Følg nøye instruksjonene som står på forsiden av skjemaet.

- Husk å fylle ut dato for utfylling av skjemaet

Så snart du har fylt ut dette skjemaet, ber vi om at du sender det tilbake til oss i den vedlagte frankerte svarkonvolutten.

Oppgi dag, måned og år for utfylling av skjemaet

dag måned år

(Skriv årstall med 4 tall, f.eks. 2005)

+

Utvikling, sykdom og helse hos barnet

1. Hva er barnets høyde og vekt (uten klær) nå ved 3 år? Deresom du vet barnets høyde og vekt ved 2 år og 15-18 måneders alder, oppgi disse målingene også. (Hvis ikke du vet disse, gå videre til neste spørsmål.) Oppgi dato for målingene om du har foretatt målingene slik.

	Dato for måling		Lengde		Vekt		Mål selv
Ca. 3 år	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Ca. 2 år	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Ca. 15-18 mnd.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

2. Hvor mange måneder var barnet da det tok sine første skritt uten støtte.

mnd

☐ Går ikke ennå uten støtte.

+

+

Nå følger spørsmål om sykdom og helseproblemer hos barnet. Først spør vi om mer langvarige plager, og deretter om sykdommer og plager av mer forbigående type.

3. Har barnet hatt langvarig sykdom eller helseproblemer siden barnet var 18 måneder?

Helseproblem	+	Nei	Ja, hadde tidligere	Hvis ja, er barnet henvisst til spesialist
1. Nedsett hørsel	☐	☐	☐	Nei ☐ Ja ☐
2. Nedsett syn	☐	☐	☐	☐
3. Forsatt motorisk utvikling (f.eks. sletter/går sønn)	☐	☐	☐	☐
4. Cerebralt parase	☐	☐	☐	☐
5. Leddproblemer	☐	☐	☐	☐
6. Diabestes	☐	☐	☐	☐
7. For liten vekstning	☐	☐	☐	☐
8. For stor vekstning	☐	☐	☐	☐
9. Hjertefeil	☐	☐	☐	☐
10. Testiklene ikke kommet ned i pungen	☐	☐	☐	☐
11. Astma	☐	☐	☐	☐
12. Allergi i øyne eller nese, f.eks. høysnue	☐	☐	☐	☐
13. Atopisk eksem (barneeksem)	☐	☐	☐	☐
14. Annen eksem	☐	☐	☐	☐
15. Ofte diare	☐	☐	☐	☐
16. Ofte magesmærter	☐	☐	☐	☐
17. Matallergi/intoleranse	☐	☐	☐	☐
18. Andre mage- tarm problemer	☐	☐	☐	☐
19. Forsatt eller avvikende språkutvikling	☐	☐	☐	☐
20. Svaneproblemer	☐	☐	☐	☐
21. Kontaktbarstær	☐	☐	☐	☐
22. Hyperaktivitet	☐	☐	☐	☐
23. Autistiske trekk	☐	☐	☐	☐
24. Andre atferdsproblemer	☐	☐	☐	☐
25. Annen langvarig sykdom/tilstand	☐	☐	☐	☐

Hvilken dag?

+

4. Hvis barnet har vært hos spesialist eller på sykehus, hva viste undersøkelsen?

- ☐ Alt var i orden
☐ Forsatt tvi/ utredet videre
☐ Har ikke vært til undersøkelse ennå
☐ Fikk diagnose I: _____
☐ Fikk diagnose II: _____
☐ Fikk diagnose III: _____

5. Hvis barnet har en alvorlig eller langvarig sykdom, beskriv eventuelt navnet:

6. Har barnet ditt vært utsatt for eller vært involvert i en alvorlig hendelse?

- ☐ Nei ☐ Ja

7. Hvis ja, beskriv:

8. Synes du det har påvirket barnets væremåte eller utvikling?

- ☐ Nei ☐ Ja

+

13. Hvis ja, oppgi navn på medisinene, hvor lange barnet til sammen har brukt disse medisinene og om det braker dem nå.

Navn på medisin:	Varighet av bruk				Brukes medisinene nå?		
	0-2 uker	3-4 uker	1-2 mnd	3-6 mnd	7-12 mnd	J	N
_____	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐

14. Har barnet fått noen vaksiner siden du fylte ut forrige skjema (ved ca 18 mnd, evt. ca 6 mnd)? ☐ Ja ☐ Nei

15. Hvis ja, oppgi hvilken vaksine og dår barnet fikk den.

Type vaksine: _____

Dato gitt: _____

16. Får barnet nå for tiden tran, vitaminer eller annet kosttilskudd? ☐ Ja, daglig ☐ Av og til ☐ Nei

	Dato gitt:			
	dag	måned	år	
1. Tran	☐	☐	☐	☐
2. Fluoridtabletter	☐	☐	☐	☐
3. Vitaminpreparat, hvilke?	☐	☐	☐	☐
4. Jerntilskudd, hvilke?	☐	☐	☐	☐
5. Annet kost tilskudd, hvilke?	☐	☐	☐	☐

Utvikling og mestring hos barnet

I denne delen vil du finne noen spørsmål i tillegg. Dette gjør vi slik at vi kan sammenlikne barns utvikling med andre liknende undersøkelser, og prøve ut den beste måten å spørre på. Spørsmålene skal dekke barn som har kommet ulikt langt i utviklingen. Vi ber deg svare på alle spørsmålene så godt du kan, selv om ikke alt passer så godt for ditt barn.

17. Om barnets motoriske utvikling. (Kryss av for hver linje.)

	Ja	Noen ganger	Ikke ennå
1. Uten å holde seg i noe får du få støtte, kan barnet spørre en ball ved å svinge benet framover?	☐	☐	☐
2. Kan barnet ta mot en stor ball med begge hendene?	☐	☐	☐
3. Når barnet tegner, holder det blyanten eller fingerstiften mellom fingrene og tarmelen slik voksne gjør?	☐	☐	☐
4. Kan barnet knuppe opp en eller flere knapper?	☐	☐	☐

18. Om barnets språkfærdigheter. (Kryss av for det alternativet som best beskriver barnets vanlige bruk av språk.)

☐ Snakker ikke ennå	☐ Snakker, men jeg forstår ikke hva han/hun sier
☐ Snakker i ett-ords setninger, f.eks. «Mek» eller «Ned»	☐ Snakker i 2-3 ords setninger, f.eks. «Jeg få ball» eller «Spise mat»
☐ Snakker i nokså fullstendige setninger, f.eks. «Jeg har en dukke» eller «Kan jeg få gå ut?»	☐ Snakker i lange og sammensatte setninger, f.eks. «Når jeg var i parken så lekte jeg» eller «Jeg så en gutt som sto på hjomet»

19. Om barnets kroppspråk. (Kryss av på hver linje for det svar du synes passer best for barnet)

+

Ja, vanligvis

Svært sjelden

Ikke ennå

1. Når du oppmuntrernde sier «Hvor er hansen (eller armen leie)?» vil barnet da peke mot leken selv om den er over 1 meter unna?

☐

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2. Når du ser ut i rommet og oppsluttet og forbausert sier «Neimen, hva skjær?» snur han/hun anskuet i samme retning som deg med en gang?

☐

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3. Bruker barnet lyder eller ord samtidig med at han/hun bruker gester (f.eks. når han/hun peker eller streker hånden mot en ting) .

☐

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4. Viser barnet deg en leke ved å se på deg og holde leken opp mot anskuet ditt? (f.eks. fra avstand eller leken mot deg slik at du kan se på den) .

☐

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20. Om barnets sosiale mestring. (Kryss av for hvert utsagn og ang om du synes det stemmer eller ikke.)

Stemmer ikke

Stemmer delvis

Stemmer helt

1. Barnet deler gjerne med andre barn (godteri, leker, fargepenn og lignende)

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2. Barnet er hjelpsomt hvis noen har slitt seg, er lei seg eller føler seg dårlig

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3. Barnet er omtenkamt, tar hensyn til andre menneskers følelser

☐

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4. Barnet er snill mot yngre barn

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☐

5. Barnet tilbyr seg ofte å hjelpe andre (veninder, andre barn, i barnehagen)

☐

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6. Barnet er svært opptatt/interessert når du prøver å lære han/henne noe nytt.

☐

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21. Om å forstå hva andre sier og selv kunne formidle seg. (Kryss av på hver linje for det svar du synes passer best for barnet.)

+

Ja

Noen ganger

Ikke ennå

1. Uten at du først viser, peker barnet på riktig bilde når du sier «Vis meg kattungen» eller spør «Hvor er hunden»? Barnet trenger bare å peke på ett riktig bilde.

☐

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2. Når du ber barnet peke på øye, nese, hår, tetter, ører og så videre, peker det da riktig på minst sju kroppsdeler? (Barnet kan peke enten på seg selv, på deg eller på en dukke.)

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3. Bruker barnet setninger som består av tre eller fire ord?

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4. Uten at du gir hjelp ved å peke eller vise, hvis du ber barnet «Lugg boken på bordet» og «Sitt skoenne under stolen», gjør barnet begge deler riktig?

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5. Når den ser i en bildebok, forteller barnet om hva som skjer eller hva noen gjør på bildet? (For eksempel: Sier barnet «Bjelle», «ape», «sagie» og «gråflue»?)

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6. Kan barnet fortelle deg minst to ting om en kjent gjestend? Hvis du leke sier «Fortell meg om bilen din», vil du barnet svare noe slikt som «Den er rød, jeg kan kjøre den, den er stor»?

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22. Om kroppspråk og andre måter å formidle seg til andre. (Må spør hvordan barnet vanligvis er. Hvis noe skjer sjelden, f.eks. du bare har sett det skje en eller to ganger, kryss av for nei.)

+

Ja

Nei

1. Reagerer barnet en av de to første gangene du sier navnet hans/hennes?

☐

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☐

2. Hendes/det at barnet kommer bort til deg med ting for å vise deg noe?

☐

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3. Hennes barnet etter deg, for eksempel når du gjør grimsaker?

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4. Hendes/det noen gang at barnet bruker pakkeringen og peker for å vise sin interesse for noe?

☐

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5. Er barnet interessert i andre barn?

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6. Hvis du peker på en leke på den andre siden av rommet, ser barnet på den?

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7. Er det lett å få øyekontakt med barnet?

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8. Når noen snakker til barnet, reagerer han/hun da med å se opp, lytte, smile, snakke eller bable?

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9. Vriker det noen gang som om barnet er overentusiast for lyder (f.eks. holder seg for ørene)?

☐

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10. Velger barnet bare noen svært få, bestemte leker eller ting selv om du prøver å få han/henne interessert i flere ting?

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11. Vriker barnet til noen for å huse eller si ade?

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12. Tåler barnet å stå seg mye uten at det ser ut til at han/hun bryr seg (har en høy smertestøise)?

☐

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6

23. Om bruk av språk sammen med andre. (Kryss av for hvert spørsmål om du synes det stemmer for barnet eller ikke.)

+

Ja

Nei

1. Snakker barnet ved å kombinere ord eller bruke setninger?

☐

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2. Kan du ha en «samtale» med barnet nå som innebarer at dere har hver deres tur eller barnet ser noe som bygger videre på det du har sagt?

☐

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3. Har barnet noen gang brukt merkelige setninger eller sagt det samme om og om igjen på nesten nøyaktig samme måte? (Det vil si bruke setninger barnet har hørt andre bruke eller noe barnet har funnet på selv)

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4. Har barnet noen gang kommet med spørsmål eller utslag som var enkle? F.eks. har barnet still personlige spørsmål eller kommet med kommentarer om andre på upassende tidspunkter?

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5. Foretrekker barnet noen gang pronomenene (dvs. sier «du» eller «han/ hun» i stedet for «jeg»)?

☐

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6. Bruker barnet noen ord svært mye og som det virker som om det har funnet på selv, eller uttrykker barnet ting på en merkelig, indrekket eller på en bliddelig måte? F.eks. det si «varmt regn» i stedet for «damp»?

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7. Har barnet noen gang sagt samme ting igjen og igjen på nøyaktig samme måte, eller insistert på at du skal si det samme om og om igjen?

☐

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8. Har barnet noen gang hatt ting det virker som om det må gjøres på en helt spesiell måte eller i en bestemt rekkefølge, eller ritualer barnet må få deg til å følge?

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24. Om væremåte og spesielle ting barn kan finne på å gjøre. (Kryss av for hvert spørsmål om du synes det stemmer for barnet eller ikke.)

+

Ja

Nei

9. Vriker armbaktrykket til barnet vanligvis som å passe til den enkelte situasjon, så langt du kan bedømme det?

☐

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10. Har barnet noen gang brukt hånden din som et redskap, eller som den var en del av hans/hennes egen kropp (f.eks. pekt med din finger, lagt hånden din på dorkenken for å få deg til å åpne døren)?

☐

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11. Har barnet noen gang hatt noen interesser som oppstår det og som kan virke merkelige for andre (f.eks. talkkøys, ledninger eller blader med mye teket i)?

☐

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12. Har barnet noen gang virket mer interessert i enkelte deler av en leke eller en gjendstand heller enn i å bruke gjendstanden slik den er ment å brukes (f.eks. glimtar i snurre hjulene på en bil heller enn å kjøre med bilen)?

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13. Har barnet noen gang hatt spesielle interesser som har vært uvanlig intense, selv om de forøvrig har passet for hans/hennes alder og gruppe (f.eks. trikker, dinosaurer/ plasttyr)?

☐

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14. Har barnet noen gang virket uvanlig interessert i å se eller føle på, høre på lyden av, smake eller lukte på ting eller andre personer?

☐

☐

☐

15. Har barnet noen gang hatt særheter eller merkelige måter å bevege hendes eller fingre på slik som å vite med eller bevege fingrene foran øynene?

☐

☐

☐

16. Har barnet noen gang gjort kompliserte bevegelser med hele kroppen, slik som å snurre rundt i ring eller stå og hoppe opp og ned?

☐

☐

☐

17. Steder barnet noen gang seg selv med vif, slik som å bite seg i armen eller dunke hodet?

☐

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☐

18. Har barnet noen gang gjendstander som det må bare rundt på? (noe annet enn en myk leke eller et koseleppe)

☐

☐

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25. Om sosial utvikling og interesse for andre. Kryss av for hvert spørsmål om du synes det stemmer for barnet eller ikke.)

+

Ja

Nei

19. Har barnet en spesiell venn eller en bestevenn?

☐

☐

☐

20. Snakker barnet noen ganger til deg bare for å fortelle noe hyggelig (snarere enn for å få noe av deg)?

☐

☐

☐

21. Hendes/det barnet spontant etterligner deg (eller andre) eller herner eller noe du holder på med (f.eks. som å prøve å leie, snakke eller hjerne det å reparere ting)?

☐

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22. Piker barnet noen gang spontant på ting rundt seg bare for å vise deg dem (ikke fordi det vil ha dem)?

☐

☐

☐

23. Bruker barnet noen gang gester, uttenom å peke eller dra deg i hånden, for å la deg få vite hva det vil?

☐

☐

☐

24. Nikker barnet når det mener «ja»?

☐

☐

☐

25. Reiter barnet på hodet når det mener «nei»?

☐

☐

☐

26. Ser barnet vanligvis opp i anskuet ditt når det gjør ting sammen med deg eller snakker med deg?

☐

☐

☐

27. Smiler barnet tilbake hvis noen sniler til det?

☐

☐

☐

28. Vriker barnet deg noen gang ting som interesserer det for å vekke din oppmerksomhet?

☐

☐

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[illegible]

36. Oppholder barnet seg i rom hvor noen ryker?

☐ Ja, daglig	Anslå timer per dag:	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>
☐ Ja, flere ganger i uken		
☐ Ja, av og til		
☐ Utslukt		
☐ Nei		

+

37. Hvor mye er barnet utendørs nå for tiden?

☐ Spilten	
☐ Ofte, men gjennomsnittlig mindre enn 1 time per dag	
☐ Gjennomsnittlig 1-3 timer per dag	
☐ Mer enn 3 timer daglig	

+

38. Hvor mange timer gjennomsnittlig sitter barnet daglig foran TV/video?

☐ 4 timer eller mer	☐ Mindre enn 1 time
☐ 3 timer	☐ Spilten aldri
☐ 1-2 timer	

+

39. Hvor passeres barnet på dagtid nå for tiden?
(Du kan sette flere kryss.)

☐ Hjemme med mor	
☐ Hjemme med far	
☐ Hjemme med datter/mamma / praktkant	
☐ Hos datter/mamma / familiebarnehage	
☐ I parken	
☐ I barnehagen	

40. Hvor mange timer per uke passes barnet på dagtid av andre enn mor eller far?

<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>
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Kosthold

41. Hvor ofte drikker eller spiser barnet følgende, nå for tiden? (Velg den hyppigheten som i gjennomsnitt passer best.)
(Sett ett kryss for hver frøye.)

	Sjelden/ mindre enn 1 g per uke	1-3 ganger per uke	4-6 ganger per uke	1 gang per dag	2 ganger per dag	3 ganger per dag	4 el. flere ganger per dag
1. H-melk, søt / sur	☐	☐	☐	☐	☐	☐	☐
2. Lett, elektrifisert skummet melk, søt / sur	☐	☐	☐	☐	☐	☐	☐
3. Yoghurt, naturell	☐	☐	☐	☐	☐	☐	☐
4. Yoghurt / drøkesyoghurt med fyll	☐	☐	☐	☐	☐	☐	☐
5. Boda, alle typer	☐	☐	☐	☐	☐	☐	☐
6. Juice	☐	☐	☐	☐	☐	☐	☐
7. Saft / nektar / lekedrikk / brus, sukker	☐	☐	☐	☐	☐	☐	☐
8. Saft / lekedrikk / brus, kunstig søtet	☐	☐	☐	☐	☐	☐	☐
9. Kjøttdeilig (leverpostei, skinke, o)	☐	☐	☐	☐	☐	☐	☐
10. Friskepållegg (makrel, kaviar o)	☐	☐	☐	☐	☐	☐	☐
11. Brunost, prim	☐	☐	☐	☐	☐	☐	☐
12. Ost ost og annen ost	☐	☐	☐	☐	☐	☐	☐
13. Syltetøy, honning, sjokoladepållegg, annet søtt pålegg	☐	☐	☐	☐	☐	☐	☐
14. Egg, kokt, stekt, eggerøre	☐	☐	☐	☐	☐	☐	☐
15. Annelt pålegg	☐	☐	☐	☐	☐	☐	☐
16. Frukt	☐	☐	☐	☐	☐	☐	☐
17. Rosiner	☐	☐	☐	☐	☐	☐	☐
18. Is, lulleis	☐	☐	☐	☐	☐	☐	☐
19. Is, saftis	☐	☐	☐	☐	☐	☐	☐
20. Satt kjeks	☐	☐	☐	☐	☐	☐	☐
21. Boller, kakor, vafler	☐	☐	☐	☐	☐	☐	☐
22. Spokede	☐	☐	☐	☐	☐	☐	☐
23. Smågodt, seigmann o)	☐	☐	☐	☐	☐	☐	☐
24. Chips, potetgul	☐	☐	☐	☐	☐	☐	☐

+

42. Hvor mange skiver brød / knekkebrød spiser barnet daglig?

<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>
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Hvor mange av disse er fiberrikt brød / knekkebrød (eks. rugbrød, Fedose brød)

[illegible]

Spørsmål om deg selv

48. Hva var årsaken? (Satt eventuelt flere kryss.)

☐ Permisjon
☐ Egen sykdom, hvilken _____
☐ Sykt barn
☐ Annet

49. Føler du deg ofte ensom?

☐ Nesten aldri
☐ Sjelden
☐ Av og til
☐ Som regel
☐ Nesten alltid

50. Har du noen utenom din ektefelle/samboer/partner som du kan søke råd hos i en vanskelig situasjon?

☐ Nei
☐ Ja, 1-2 personer
☐ Ja, flere enn 2 personer

51. Hvor ofte treffer du eller snakker i telefon med familie (utenom husholdningen) eller nære venner?

☐ 1 gang i måneden eller sjeldnere
☐ 2-8 ganger i måneden
☐ Mer enn 2 ganger i uken

+

44. Hvilken skilstand har du nå?

☐ Gift
☐ Separert/ekkt
☐ Samboer
☐ Enlig
☐ Annet

45. Er du i lønnet arbeid nå for tiden?

☐ Nei (gå til spørsmål 48)
☐ Ja

Antall timer vanligvis per uke:

46. Hvilken arbeidsordning har du? (Satt eventuelt flere kryss.)

☐ Fast dagarbeid
☐ Skiftarbeid/turnusordning
☐ Fast ettermiddags/vektarbeid
☐ Ingen fast (elstømhelp, ekstravakt, vikar ol)
☐ Fast nattarbeid

47. Hvor mange dager har du til sammen vært borte fra arbeidet siste år (se bort fra ferie og avspasering)?

dager

52. Har du noen ganger siden du ble gravid med dette barnet i en sammenhengende periode på to uker eller mer.....
(Sett et kryss for hver linje.)

	Ja, i svanger- skapet	Ja, i siste åre etter fødselen	Ja, i siste åre etter 2 år
+			
1. Fall deg depriment, trist, nedfor?	☐	☐	☐
2. Har problemer med matlysten eller spisi for mye?	☐	☐	☐
3. Vært plaget av kvaliteter eller mangel på overskudd?	☐	☐	☐
4. Vrikelig breibredt deg selv og følt deg verdiløs?	☐	☐	☐
5. Har problemer med å konsentrere deg eller hatt vanskelg med å ta beslutninger?	☐	☐	☐
6. Hatt minst 3 av problemene som er nevnt ovenfor samtidig?	☐	☐	☐

53. Er du gravid nå? ☐ Nei ☐ Ja

+

54. Har du hatt langvarig sykdom eller helseplage som har oppstått de siste 3 årene?

Fysisk plage:

☐ Nei ☐ Ja, for beskriv: _____

☐ Ja, nå, beskriv: _____

Psykisk plage:

☐ Nei ☐ Ja, for beskriv: _____

☐ Ja, nå, beskriv: _____

55. Har du selv vært til undersøkelse på sykehus de siste 3 årene?

☐ Nei ☐ Ja, hvilken sykdom?

[illegible]

Værdi af aktivitet der du blir anspændt eller svært	Hvor ofte				
	Mindre enn 1 gang per uke	1 gang per uke	2 ganger per uke	3-4 ganger per uke	5 ganger eller mer per uke
Altri	☐	☐	☐	☐	☐
Mindre enn 30 minutter	☐	☐	☐	☐	☐
Mellom 30-60 minutter	☐	☐	☐	☐	☐
Mer enn 60 minutter	☐	☐	☐	☐	☐

58. Alt i alt, hvordan vil du karakterisere din fysiske helbelse?

☐ Mægtig god
☐ God
☐ Dårlig
☐ Svært dårlig

+

60. Bruger du:

☐ Skid/lyggebakke/ anus
☐ Nicotinryggsgummi
☐ Nicotiplaster
☐ Nicotinhalator

61. Hvor ofte drikker du alkohol nå for tiden?

☐ Omrent 6-7 gange pr. uke
☐ Omrent 4-5 gange pr. uke
☐ Omrent 2-3 gange pr. uke
☐ Omrent 1 gang pr. uke
☐ Omrent 1-3 gange pr. måned
☐ Sjældnere end 1 gang pr. måned
☐ Aldri

59. Røyker du nå for tiden?

☐ Røyker ikke
☐ Røyker av til -
 antall sigaretter per uke:
☐ Røyker daglig -
 antall sigaretter daglig:

62. Hvor mange alkoholenheter drikker du vanligvis når du nyter alkohol? (Kryss av både for helgen og hverdager) (Se forklaring nedenfor om enheter alkohol.)

	I helgen	Hverdager
10 eller flere	☐	☐
7-9	☐	☐
5-6	☐	☐
3-4	☐	☐
1-2	☐	☐
Færre enn 1	☐	☐

Enheter alkohol

For å sammenligne ulike typer alkohol, spør vi etter det vi kaller alkoholenheter (= 1,5cl ren alkohol). Enkelt betyr:

- 1 glass (13 liter) øl = 1 enhet
- 1 vinflaske rød eller hvit vin = 1 enhet
- 1 helnagels, sherry eller annen hvetin = 1 enhet
- 1 øl eller annen øl uten eller med = 1 enhet
- 1 flaske substarbutor = 1 enhet

65. Har det de siste 18 måneder - i en periode på minst 3 måneders varighet - hendt at du har opplevd noe av det følgende, og i så fall hvor hyppig var det? (Slett ett kryss for hver linje.)

	Minst 2 ganger i uken	1-4 ganger i mid	Spelden/ aldri
1. Følt at du mistet kontrollen mens du spiste, og ikke klarte å stoppe før du hadde spist alt for mye?	☐	☐	☐
2. Brukt oppkast for å kontrollere vekten?	☐	☐	☐
3. Brukt avføringsmiddel for å kontrollere vekten?	☐	☐	☐
4. Brukt fasteure for å kontrollere vekten?	☐	☐	☐
5. Brukt hard fysisk trening for å kontrollere vekten?	☐	☐	☐

66. Har det det siste 18 måneder hendt at det har gått minst tre måneder uten menstusasjon i tilknytning til en periode med spiseproblemer? (uten at du har vært gravid)

☐ Nei ☐ Ja

67. Hvor mye veier du nå?

kg

Hvor høy er du?

cm

68. Følelse av uro og rastløshet. (Kryss av for det som passer best for deg de siste 6 månedene.)

	Aldri	Spelden	Av og til	Oftre	Veldig ofte
1. Hvor ofte har du ønsket med å få gjort ting de siste dagene av en oppgave, når den utfordrende delen er gjennomført?	☐	☐	☐	☐	☐
2. Hvor ofte har du ønsket med å få plassert saker i riktig rekkefølge når du arbeider med oppgaver som krever organisering?	☐	☐	☐	☐	☐
3. Når du har en oppgave som krever mye gjennomtenking, hvor ofte unngår eller utsetter du å begynne med den?	☐	☐	☐	☐	☐
4. Hvor ofte har du vanskeligheter med å huske avtaler eller forpliktelser?	☐	☐	☐	☐	☐
5. Når du må sitte stille over en lengre tid, hvor ofte beveger du hender og føtter på en urolig og rastløs måte?	☐	☐	☐	☐	☐
6. Hvor ofte føler du deg overaktv og tungtet til å gjøre ting, som om du er drevet av en motor?	☐	☐	☐	☐	☐

+

+

69. Hvis du har en ektefelle/ samboer/ partner, hvor enige er du i disse beskrivelsene? (Slett ett kryss for hver linje.)

	Støtt enig	Enig	Litt enig	Litt uenig	Støtt uenig
1. Min partner og jeg har problemer i parforholdet	☐	☐	☐	☐	☐
2. Jeg er svært lykkelig i mitt parforhold	☐	☐	☐	☐	☐
3. Min partner er generelt trøstelsesfull	☐	☐	☐	☐	☐
4. Jeg er fornøyd med forholdet til min partner	☐	☐	☐	☐	☐
5. Vi er enige om hvordan barn bør oppdras	☐	☐	☐	☐	☐

70. Har du i løpet av de siste 2 ukene vært plaget med noe av det følgende? (Slett ett kryss for hver linje.)

	Ikke plaget	Litt plaget	Ganske mye plaget	Veldig mye plaget
1. Stadig redd eller engstelig	☐	☐	☐	☐
2. Nervøsitet, indre uro	☐	☐	☐	☐
3. Følelse av hjelpeløshet med hensyn til framtiden	☐	☐	☐	☐
4. Nedtrykt, tungendig	☐	☐	☐	☐
5. Mye bekymret eller urolig	☐	☐	☐	☐
6. Følelse av at alt er et slit	☐	☐	☐	☐
7. Føler deg anspent eller oppgitt	☐	☐	☐	☐
8. Plutselig frykt uten grunn	☐	☐	☐	☐

71. Har du det siste 18 måneder opplevd noe av det følgende? Hvis ja, hvor vondt og vanskelig var dette for deg? (Slett ett kryss for hver linje.)

	Nei	Ja	Ikke så ille	Vondt/ vanskelig
1. Har du hatt problemer på arbeidsplassen eller der du utdanner deg	☐	☐	☐	☐
2. Har du hatt økonomiske problemer	☐	☐	☐	☐
3. Ble du skilt, separert eller avbrøt samlivet	☐	☐	☐	☐
4. Har du hatt problemer eller konflikter med familie, venner eller naboer	☐	☐	☐	☐
5. Har du vært alvorlig bekymret for om det er noe galt med barnet	☐	☐	☐	☐
6. Har du vært alvorlig syk eller skadet	☐	☐	☐	☐
7. Har en av dine nærmeste vært alvorlig syk eller skadet	☐	☐	☐	☐
8. Har du vært utsatt for alvorlig ulykke, brann eller grovt tyveri	☐	☐	☐	☐
9. Har du mistet en som sto deg nær	☐	☐	☐	☐
10. Annet	☐	☐	☐	☐

72. Hvor ofte opplever du følgende i ditt daglige liv? (Slett ett kryss for hver linje.)

	Spelden/ aldri	Noen ganger	Oftre	Veldig ofte
1. Føler deg glad for noe	☐	☐	☐	☐
2. Føler deg lykkelig	☐	☐	☐	☐
3. Føler deg oppstamt som om alt legger seg til rette for deg	☐	☐	☐	☐
4. Føler at du vil skille til noen eller slåss på ting	☐	☐	☐	☐
5. Føler deg sint, irrtet eller engstelig	☐	☐	☐	☐
6. Føler deg rasende på noen	☐	☐	☐	☐

+

+