Gebelerin Psikososyal Sağlık Durumları İle Annelik Rolü Algısı Arasındaki İlişki

The Relationship Between Psychosocial Health Status of Pregnants and Perception of Maternal Role

Hülya UÇAR [1 C,D,E,F,G], Hava ÖZKAN [2 A,B,D,F,G]

[1]Şehit Burak Tatar Vocational and Technical Anatolian High School, Erzurum, Turkey

[2]Atatürk University, Faculty of Health Sciences, Erzurum, Turkey

ÖZ

Amaç: Araştırma, gebelerin psikososyal sağlık durumları ile annelik rolü algısı arasındaki ilişkiyi değerlendirmek amacıyla tanımlayıcı olarak yapılmıştır.

Yöntem: Araştırma, Erzurum il merkezinde bulunan Nenehatun Kadın Doğum Hastanesi polikliniklerine Eylül 2013-Haziran 2014 tarihleri arasında antenatal kontrolleri için gelen 420 gebe ile yürütülmüştür. Veriler, 'Kişisel Bilgi Formu', 'Gebelikte Psikososyal Sağlığı Değerlendirme Ölçeği (GPSDÖ)' ve 'Anlamsal Farklılık Ölçeği-Anne Olarak Ben (AOB) ölçeği' kullanılarak toplanmıştır. Verilerin değerlendirilmesinde; sayı, yüzde ve ortalama ortalama gibi tanımlayıcı istatistikler, t-testi, Tek Yönlü Varyans analizi, Kruskall- Wallis H, Mann Whitney-U testi ve Pearson Korelasyon analizi kullanılmıştır.

Bulgular: Gebelerin, GPSDÖ'den aldıkları toplam puan ortalamasının 4.33±0.37 olduğu, AOB ölçeğinden alınan toplam puan ortalamasının ise 60.5±9.9 olduğu saptanmıştır. Gebelerin gelir durumu algısı, gebelik sayısı, gebeliğin planlanma durumu ve eşin gebeliği istemesi durumuna göre GPSDÖ puan ortalamaları arasında fark olduğu belirlenmiştir (p<0.05). Gebelerin; gebelik haftası, gebeliğin planlanma durumu ve eşin gebeliği istemesi durumuna AOB ölçek puan ortalamaları arasında fark olduğu saptanmıştır (p<0.05). GPSDÖ ile AOB ölçeği puan ortalamaları arasında pozitif yönde zayıf ilişki olduğu bulunmuştur (p<0.01, r= .162).

Sonuç: Bu çalışmada, gebelerin, psikososyal sağlık ile annelik rolü algısının iyi düzeyde olduğu saptanmıştır. Psikososyal sağlık düzeyi arttıkça kendilerini anne olarak daha olumlu algıladıkları belirlenmiştir.

Anahtar Kelimeler: Annelik rolü, Gebelik, Psikososyal sağlık.

ABSTRACT

Objective: The research was carried out as a descriptive study to evaluate the relationship between the psychosocial health status of pregnant women and the perception of motherhood role.

Methods: The study was conducted with 420 pregnant women who went to the polyclinics of Nenehatun Maternity Hospital in the center of Erzurum city for their antenatal controls between September 2013 and June 2014. The data were collected by using the 'Personal Information Form', 'Pregnancy Psychosocial Health Assessment Scale (PPHAS)' and 'Semantic Differential Scale- Myself as a Mother (MaM)'scale. In the evaluation of the data; Descriptive statistics such as number, percentage and mean mean, t-test, One-Way Analysis of Variance, Kruskall-Wallis H, Mann Whitney-U test and Pearson Correlation analysis were used.

Results: It was determined that the total mean score of the pregnant women from the GPSSS was 4.33±0.37, and the total mean score from the AOB scale was 60.5±9.9. It was determined that there was a difference between the GPSSS mean scores according to the perception of income status, number of pregnancies, planning of pregnancy and the spouse's desire for

pregnancy (p<0.05). It was determined that there was a difference between the mean AOB scale scores in terms of gestational week, planning status of pregnancy and the spouse's desire for pregnancy (p<0.05). It was found that there was a weak positive correlation between GPSDS and AOB scale mean scores (p<0.01, r= .162).
Conclusion: In this study, it was determined that pregnant women had a good level of perception of psychosocial health and the perception of motherhood role. It was determined that as the level of psychosocial health increased, they perceived themselves more positively as mothers.

Key words: Perception of motherhood role, Pregnancy, Psychosocial health.

1. INTRODUCTION

Pregnancy is one of the important transitional processes in a woman's life (1). Pregnancy is a vital crisis period where the bio-psychosocial balance and the family and workplace roles of women change, and a parental relationship is established between the mother and the infant (1-3). Thus, the mood and life of women affect the course of pregnancy and the pregnancy itself creates important reflections on both mental and emotional experiences (2,4).

The existence of infant in womb, pregnancy-specific physiological changes and the differences occurring in the family and social life constitute the basis of the psychosocial reactions in this process. Comprising of three trimesters of three months, the process of pregnancy is a long period for mothers and gives sufficient time for them to accept the infant and prepare for birth (5).

Pregnancy is a natural event in the lives of women. However, the neuroendocrine and psychosocial changes caused by pregnancy and birth periods are considerably greater than other periods of life. Thus, pregnancy is a period where there is a high risk of encountering with many factors that may create anxiety and stress and is often combined with anxiety and depression (5-7).

Since motherhood is the developmental combination of social roles, behaviors and attitudes, the process of becoming a mother requires an intensive psychological, social, and physical effort (8). The psychosocial problems experienced in pregnancy have a negative effect on not only the mental health of mother, but also the health of mother, fetus and infant, as well as the family and society. Thus, it is important to conduct not only the physical assessment, but also the psychosocial evaluation and the evaluation of risk factors while conducting the medical evaluation during the follow-ups of a pregnant woman, in terms of an integrated approach (5-9). Besides, considering the fact that the process of pregnancy has a direct effect on the health of child, family and consequently the society, it is very important for healthcare professionals to know the psychosocial problems regarding this period, plan protective interventions aimed at these problems and perform the convenient approaches when necessary. Psychosocial health and maternal role perception during pregnancy were studied as separate studies (1,2,6,7,8). However, no study has been found that evaluates the perception of psychosocial health and the role of motherhood together during pregnancy. Psychosocial health during pregnancy can affect women's the perception of motherhood role.

The purpose of this study was to evaluate the relationship between the psychosocial health status of pregnant women and the perception of motherhood role.

Research Questions

Q1: What is the psychosocial health level of pregnant women?

Q2: What is the perception of motherhood role of pregnant women?

Q3: Do socio-demographic and obstetric characteristics affect the psychosocial health of pregnant women and their perception of maternal role?

Q4: There is a relationship between the psychosocial health status of pregnant women and the perception of motherhood role.

2. METHOD

This descriptive study was conducted with 420 pregnant women who applied to the Polyclinics of Nenehatun Maternity Hospital in the province of Erzurum between September 2013/June 2014 in order to evaluate the relationship between the psychosocial health conditions of pregnant women and the role of motherhood.

Data Collection Tools

The data of study were obtained using the Personal Information Form, Pregnancy Psychosocial Health Assessment Scale (PPHAS) and the Semantic Differential Scale-Myself as Mother (MaM).

Personal Information Form: The form was prepared by the researcher in order to determine the demographic and obstetrical features of pregnant women (2,4,8).

Pregnancy Psychosocial Health Assessment Scale (PPHAS): Being developed by Yıldız in order to assess the psychosocial health in pregnancy, the scale involves 46 items. Pregnancy Psychosocial Health Assessment Scale (PPHAS) is a 5-point likert scale. Each item in the scale is scored from 1 to 5. The scale involves six subscales. Thirteen items in the first subscale of the scale involve "Features regarding the relationship of pregnancy and husband", eight items in the second subscale "Features regarding anxiety and stress", seven items in the third subscale "Features regarding domestic violence", seven items in the fourth subscale "Features regarding the need for a psychosocial support", four items in the fifth subscale "Family features" and six items in the sixth subscale involve "Features regarding the physical-psychosocial changes caused by pregnancy" (6).

Mean scores of items are determined by dividing the total score obtained from the assessment of the scale into the number of items and the result is between 1 and 5. When the total score diverges from 5 to 1, it signifies a problem in the psychosocial health during pregnancy. 1 point obtained from the scale signifies that the psychosocial health is very bad.

The same assessment is also made in the subscales and as the score approaches 1, it signifies a problem in that subscale. While the minimum value to be obtained from the scale is 1, the maximum value is 5. The Cronbach Alpha reliability coefficient of the PPHAS was determined as 0.93 (6). In this study, on the other hand, the Cronbach Alpha reliability coefficient was determined as 0.87.

Semantic Differential Scale-Myself as Mother (MaM): Evaluating the concept of "Myself as Mother", the scale involves 22 items, seven-point semantic and 11 opposite adjective pairs.

In the study that was conducted by Çalışır (10) for the validity and reliability of the scale, the assessment dimension of scale items was described by Walker (1986) through conducting a factor analysis for the answers given by 104 mothers (11). Walker determined the

internal consistency reliability of the "Semantic Differential Scale-Myself as Mother" as 0.81-0.85 (11). High total scores obtained from the scale signify a positive self-assessment of motherhood. While the lowest score to be obtained from the scale of "Myself as Mother" is 11, the highest score is 77. The Cronbach Alpha reliability coefficient of the "Semantic Differential Scale-Myself as Mother" was determined as 0.73-0.74 (10). In this study, on the other hand, the Cronbach Alpha reliability coefficient was found as 0.84.

Ethical Principles of the Study: Before starting the study, an approval was received from the Ethics Committee of Erzurum Atatürk University Faculty of Health Sciences and an application approval was taken from Erzurum Nenehatun Maternity Hospital. In the data collection process, verbal consents were received from the pregnant women after informing them about the study. The data were collected by using the technique of face-to-face interview with pregnant women, who accepted to participate in the study.

Assessment of Data: The analyses were carried out using the SPSS Statistics Package Program, Version 18.0. Data analysis was performed using descriptive statistics (mean, percentage, standard deviation, ect.) t-test, One Way Analysis of Variance, Kruskall-Wallis H, Mann Whitney-U test, and Pearson Correlation analysis. A p-value of <0.05 was considered statistically.

3. RESULTS

While the lowest score to be obtained by pregnant women from PPHAS is 1, the highest score is 5. Examining PPHAS scores obtained by pregnant women in the study; the minimum score was determined as 3, maximum score 5 and total mean score 4.33±0.37 (Table 1).

While the lowest score to be obtained by pregnant women from the MaM is 11, the highest score is 77. Examining the MaM scores obtained by pregnant women in the study; the minimum score was determined as 21, maximum score 77 and total mean score 60.5±9.9. (Table 1).

Table 1. Scores obtained and to be obtained by pregnant women from PPHAS and MaM and their total mean scores

Scale	Lowest and highest scores to be obtained from the scale	lowest and highest scores to be obtained from the scale	Mean score obtained from the scale $\overline{X} \pm SD$
PPHAS	1-5	3-5	4.33±0.37
MAM	11-77	21-77	60.5±9.9

It was determined to be insignificant the difference between mean scores of PPHAS according to age, duration of marriage, education, working condition and family type of pregnant women. No difference was determined between mean scores of the PPHAS according to the education and working condition of husbands (p>0.05, Table 2).

It was determined that the difference between the PPHAS score averages according to the income status of the pregnant women was statistically significant (p<0.05, Table 2). As a result of the advanced analysis, the difference was determined to be caused by groups that had less income than expense.

No difference was determined between mean scores of PPHAS according to the trimesters of pregnant women and the gender of infant (p>0.05, Table 3).

It was determined that the difference between mean scores of PPHAS according to the number of pregnancies was statistically significant (p<0.05, Table 3). As a result of the advanced analysis, the difference was found to be caused by groups that had four pregnancies and above. Comparing mean scores of PPHAS according to the state of pregnant women to intend the pregnancy; the difference between mean scores was statistically significant (p<0.05, Table 3). As a result of the advanced analysis, the difference was determined to be caused by groups who intended and planned the pregnancy. Comparing mean scores of PPHAS according to the state of the husbands to intend the pregnancy; the difference between mean scores was statistically significant (p<0.05, Table 3).As a result of the advanced analysis, the difference was determined to be caused by groups who intended and planned the pregnancy.

Table 2. Comparing the socio-demographic characteristics of pregnant women with mean scores of PPHAS

Socio-Demographic Characteristics (n=420)	n	%	$\overline{X} \pm$ SD	Test and p value
Age Group				
19 years and below	38	0.9	4.35±0.38	
20-24 years	117	27.9	4.32 ±0.35	
25-29 years	143	34.0	4.38±0.36	F=2.27 p>0.05
30-34 years	82	19.5	4.22 ±0.39	
35 years and above	40	9.6	4.35±0.39	
Duration of Marriage				
0-1 year	155	36.9	4.39±0.34	
2-4 years	95	22.6	4.35±0.35	F=2.61 p>0.05
5-9 years	98	23.3	4.29±0.41	
10 years and above	72	17.2	4.26±0.38	
Education				
Primary School	148	35.2	4.28 ±0.40	
Secondary School	128	30.5	4.37±0.36	F=2.30 p>0.05
High School	84	20.0	4.33±0.32	
Graduate school	60	14.3	4.41±0.31	
Working Condition				
Employed	51	12.1	4.37±0.35	t=0.92
Unemployed	369	87.9	4.32±0.37	p>0.05
Education of Husband				
Primary School	83	19.8	4.59±0.38	
Secondary School	80	19.0	4.30±0.34	F=0.57 p>0.05
High School	142	33.8	4.35 ±0.39	
Graduate school	115	27.4	4.34±0.36	
Working Condition of Husband				
Employed	396	94.3	4.34±0.36	t=2.38
Unemployed	24	5.7	4.15±0.48	p>0.05
Perception of income status*				
Less income than expense	81	19.3	4.08±0.40	
Equal income and expense	22	5.2	4.41±0.23	F=24.3 **p<0.05**
More income than expense	317	75.5	4.38±0.35	
Family Type				
Nuclear Family	310	73.8	4.33±0.37	t=0.42
Extended Family	110	26.2	4.31±0.38	p>0.05

* According to pregnant women's own statements

There was no difference between the mean scores of MaM according to the socio-demographic characteristics of the pregnant women (p>0.05, Table 4).

There was a statistically significant difference between the mean MaM scores of the pregnant women according to their trimester characteristics (p<0.05, Table 5). As a result of the advanced analysis, the difference was associated with pregnant women in the third trimester. There was a statistically significant difference between the mean scores of MaM of the pregnant women according to their pregnancy planning status (p<0.05, Table 5). As a result of the advanced analysis, the difference was associated with groups that intended and planned the pregnancy. It was determined that the difference between mean scores of MaM according to the state of the husband to intend the pregnancy was statistically significant (p<0.05, Table 5). As a result of the advanced analysis, the difference was associated with groups that intended and planned the pregnancy.

Table 3. Comparing the obstetrical characteristics of pregnant women with mean scores of PPHAS

Obstetrical Characteristics (n=420)	n	%	$\overline{X} \pm SD$	Test and p value
Trimesters				
1st Trimester	140	33.3	4.30±0.39	F=2.42 p>0.05
2nd Trimester	140	33.3	4.38±0.35	
3rd Trimester	140	33.4	4.29±0.37	
Number of Pregnancies				
1	211	50.2	4.39±0.33	F=7.18 **p<0.05**
2	84	20.1	4.31±0.43	
3	74	17.6	4.29±0.35	
4 and above	51	12.1	4.13±0.42	
Gender of Infant				
Female	206	49.0	4.31±0.36	t=-0.95 p>0.05
Male	214	51.0	4.34±0.38	
State of Intending the Pregnancy				
I was intending and planning the pregnancy	327	77.9	4.41±0.32	KW=65.53 **p<0.05**
I was intending the pregnancy, but for another time in the future	60	14.3	4.03± 0.42	
I was intending the pregnancy neither for the present time nor the future	10	2.4	3.96± 0.22	
I was not intending the pregnancy; but, when I conceived, I accepted it	23	5.4	4.05±0.40	
State of the Husband to Intend the Pregnancy				
He wanted me to conceive and planned the pregnancy	362	86.2	4.38±0.34	KW=44.63 **p<0.05**
He wanted me to conceive, but for another time in the future	31	7.4	3.93±0.42	
He wanted me to conceive neither for the present time nor the future	8	1.9	3.98±0.27	
He did not want me to conceive; but when I did, he accepted it	18	4.5	4.07±0.41	

The difference was not statistically significant in terms of mean scores of MaM according to the number of pregnancies and the gender of infant (p>0.05, Table 5).

Table 4. Comparing the socio-demographic characteristics of pregnant women with mean scores of MaM

Socio-Demographic Characteristics (n=420)	n	%	$\overline{X} \pm$ SD	Test and p value
Age Group				
19 years and below	38	9	57.7±10.5	KW=8.97 p>0.05
20-24 years	117	27.9	59.6±10.6	
25-29 years	143	34.0	61.3±9.7	
30-34 years	82	19.5	59.8±10.0	
35 years and above	40	9.6	64.2±7.1	
Duration of Marriage				
0-1 year	155	36.9	59.9±9.6	F=1.35 p>0.05
2-4 years	95	22.6	59.5±11.2	
5-9 years	98	23.3	31.3±9.6	
10 years and above	72	17.2	62.1±9.1	
Education				
Primary School	148	35.2	60.0±10.4	KW=0.42 p>0.05
Secondary School	128	30.5	61.2± 9.01	
High School	84	20.0	60.8±9.6	
Graduate school	60	14.3	59.9±11.1	
Working Condition				
Employed	51	12.1	62.1±9.4	t=1.24 p>0.05
Unemployed	369	87.9	60.3±9.9	
Education of Husband				
Primary School	83	19.8	59.8±9.9	F=1.01 p>0.05
Secondary School	80	19.0	59.1±10.8	
High School	142	33.8	61.2±9.4	
Graduate school	115	27.4	61.1±9.9	
Working Condition of Husband				
Employed	396	94.3	60.5±10.1	M-WU=.3.18 p>0.05
Unemployed	24	5.7	59.7±7.8	
Perception of income status*				
Less income than expense	81	19.3	58.5±9.6	KW=5.92 p>0.05
Equal income and expense	22	5.2	58.9± 12.9	
More income than expense	317	75.5	61.1±9.7	
Family Type				
Nuclear Family	310	73.8	60.5±10.0	t=.08 p>0.05
Extended Family	110	26.2	60.4±9.9	

* According to pregnant women's own statements

Table 6 illustrates the relationship between mean scores of PPHAS and mean scores of MaM. As a result of the correlation analysis, a positive and significant relationship was determined between mean scores of the Psychosocial Health Assessment Scale and mean scores of MaM. Examining the relationship between mean scores of the subscales of the Psychosocial Health Assessment Scale and mean scores of MaM; there was a positive and significant relationship between mean scores of the relationship of pregnancy and husband, anxiety and

stress, physical-psychosocial changes caused by pregnancy and mean scores of MaM, and a negative and significant relationship between the need for a psychosocial support and mean score of MaM ($p < 0.001$, $p < 0.05$). The difference between the subscales of domestic violence and family features and mean scores of MaM was statistically insignificant ($p > 0.05$, Table 6).

Table 5. Comparing the obstetrical characteristics of pregnant women with mean scores of MaM

Obstetrical Characteristics (n=420)	n	%	$\overline{X} \pm$ SD	Test and p value
Trimesters				
1st Trimester	140	33.3	59.3±9.9	F=6.72
2nd Trimester	140	33.3	59.5±9.9	**p<0.05**
3rd Trimester	140	33.4	63.0±9.6	
Number of Pregnancies				
1	211	50.2	59.5±11.0	
2	84	20.1	60.8±8.7	F=2.05
3	74	17.6	61.4±8.6	p>0.05
4 and above	51	12.1	63.0 ±8.6	
Gender of Infant				
Female	206	49.0	59.7±10.7	t=-1.64
Male	214	51.0	61.3±9.1	p>0.05
State of Intending the Pregnancy				
I was intending and planning the pregnancy	327	77.9	60.9±9.8	
I was intending the pregnancy, but for another time in the future	60	14.3	58.3±9.7	KW=6.30
I was intending the pregnancy neither for the present time nor the future	10	2.4	58.3±7.7	**p<0.05**
I was not intending the pregnancy; but, when I conceived, I accepted it	23	5.4	61.5±12.2	
State of the Husband to Intend the Pregnancy				
He wanted me to conceive and planned the pregnancy	362	86.2	60.7±10.0	
He wanted me to conceive, but for another time in the future	31	7.4	57.9±8.5	KW=4.16
He wanted me to conceive neither for the present time nor the future	8	1.9	61.6±5.0	**p<0.05**
He did not want me to conceive; but when I did, he accepted it	18	4.5	60.9±11.3	

4. DISCUSSION

In this study, the relationship between the psychosocial health status of pregnant women and the perception of motherhood role was evaluated. Considering the fact that the highest score to be obtained from PPHAS is 5 and from MAM 77, the psychosocial health of pregnant women and their adjustment with the perception role of motherhood were positively good. It was determined that the psychosocial health and perceptions of maternal role the pregnant women were at a good level, and these results answered the research questions (Q1 and Q2).

It was determined that the income status of pregnant women was effective on their psychosocial health conditions and the difference between groups was statistically significant. In a study that was conducted by Sequin et al. (12), it was indicated that depressive symptoms

Table 6. The relationship between mean score of PPHAS and mean score of MaM

Scales			Myself as Mother
Pregnancy Psychosocial Health Assessment Scale	Relationship of pregnancy and husband	r	**0.099***
		p	0.044
	Anxiety and stress	r	**0.196****
		p	0.001
	Domestic violence	r	0.018
		p	0.713
	Need for a psychosocial support	r	**-0.178****
		p	0.000
	Family features	r	0.043
		p	0.380
	Pregnancy-related Physical-psychosocial changes	r	0.289**
		p	0.001
	Evaluation of the psychosocial health	**r**	**0.162**
		p	**0.001**

*p<0.05 **p<0.001

were more common especially among women with lower socio-economic conditions during pregnancy, and these symptoms were usually associated with environmental factors. Income status is a nonignorable fact in adapting to changes in today's life conditions and providing the care and future of the infant. The study results comply with the results of the study that was conducted by Sequin et al. (12). In another study, it was stated that there was a statistically significant difference between the perceived income status of pregnant women and their psychosocial health (2).

The difference between the number of pregnancies and the PPHAS mean score was found to be statistically significant. Özşahin et al. (2) also reported that there was a significant difference between the number of pregnancies and the PPHAS score averages.

Comparing mean scores of PPHAS according to the state of pregnant women to intend the pregnancy; the difference between mean scores of those who intended and planned the pregnancy was statistically significant. In their study examining the stressors throughout pregnancy, Sequin et al. (12), determined that unintended pregnancies caused pregnant women to get depressed. The results of this study show a parallelism with the results of Sequin et al. (12).

Comparing mean scores of PPHAS according to the state of the husband to intend the pregnancy; the difference between mean scores of those who intended and planned the pregnancy was statistically significant. Affonso (13) associates the main reason of depression with the weakening of marriage relationship and men's high indifference after birth. It is indicated that women who have problems in their marriages and do not receive sufficient support from their husbands have higher risks of developing postpartum depressive symptoms and a good social support positively affects the health of the infant (14). In her study, Gözüyeşil (15) determined a statistically significant difference between mean scores of depression and concordance with husband. The results of Affonso (13) and Gözüyeşil (15) comply with the results of this study.

The psychosocial health scores of the pregnant women in the third trimester were higher than the pregnant women in the other trimesters. Women's psychosocial reaction against and

adaptation with pregnancy are evaluated within the scope of different developmental duties to be accomplished in each passing trimester (8). It is reported that ambivalent emotions experienced by pregnant women in the first period of pregnancy are also experienced in the final period. In this period, expectant mothers hate the pregnancy on one hand and want the baby, but experience negative emotions like fear, anger and despair due to the birth on the other (5). It is thought that even though some views about how the birth would occur and whether the infant would be healthy or not affect the fear levels of pregnant women in each trimester, the approach of pregnant women towards the happy ending positively affects the perception of maternal role.

It has been observed that the perception of income status, the number of pregnancies, the desire of the spouse to become pregnant, and state of the husband to intend the pregnancy affect the psychosocial health status of the pregnant women (Q 3).

We found that the mean MaM scores of the pregnant women who were planning a pregnancy were higher than the women who conceived without planning. The preparation of women planning their pregnancies for the role of motherhood may have affected their perceptions about infants. Büyükkoca (16) stated that the intention of pregnancy was associated with mother's readiness for the infant and the role of motherhood, as well as her power for coping with possible problems and expressed that the desire of pregnancy affects the readiness for motherhood. In their different studies, Özkan (17) and Gager et al. (18), indicated that individuals planning the pregnancy got ready for their responsibilities and the desire of becoming a mother positively affected the acquisition of the perception of maternal role. The study results show a parallelism with the results of this study.

Comparing mean scores of MaM according to the state of the husband to intend the pregnancy; those who intended and planned the pregnancy had a mean score of 60.7 ± 10.0 and the difference between the groups was statistically significant. The most important factors affecting the mental health of pregnant women involve her husband's attitude and the psychosocial environment. The support received from important persons in the social environment has a positive effect on the pregnancy experience of women. It is indicated that women whose role of motherhood is approved by their husbands and who are able to share their responsibilities with them experience less problems (5,8).

It was observed that trimester n, the number of pregnancies, the spouse's desire to conceive, and the spouse's intention to become pregnant affect the perception of the role of motherhood in pregnant women (Q 3).

Examining the relationship between mean scores of the subscales of PPHAS and mean scores of MaM; there was a positive and significant relationship between mean scores of the relationship of pregnancy and husband, anxiety and stress, pregnancy-related physical-psychosocial changes and mean scores of MAM, and a negative and significant relationship between the need for a psychosocial support and mean score of MaM. In stressful conditions, individuals in the lives of pregnant women actively participate in the solution of problems with their support. Social supports received from other people affect the ways of coping and thus, they could change the connection between the stressful event and the result. The most important resource of support for pregnant women is the close family members and especially their husbands (5,19,20). When the husbands support the pregnancy, this enables women to get adapted to the pregnancy and the presence of supportive systems makes the pregnant women

feel better (5,21). It has been proven that there is a positive significant relationship between the psychosocial health of pregnant women the perception of maternal role (Q 4).

5. CONCLUSION

It was determined that pregnant women had a good level of psychosocial health and the perception of motherhood role. It was determined that as the level of psychosocial health increased, they perceived themselves more positively as mothers.

While performing the medical evaluation of a pregnant woman, it could be recommended to have an integrated approach by considering not only the physical assessment, but also the psychiatric and socio-demographic characteristics; enable the pregnant woman to get adapted to their new role by training primarily the husband of the pregnant woman, as well as her family regarding the psychosocial changes experienced by women during pregnancy and their need for support in this period; enable midwives/nurses to offer training to expectant mothers to support acquiring the role of motherhood for their transition to parental roles before and after birth and developing successful motherhood behaviors at gynecology and obstetrics clinics; provide materials such as relevant booklet, brochure etc and make these practices routine.

Ethical Consideration of the Study

This study was approved by the ethics board of Erzurum Atatürk University Faculty of Health Sciences (Date 05.08.2013) with 2013/4 session numbered.

Conflict of Interest Statement

The authors declare no conflict of interest..

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