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Perceived Social Support and Comfort Level of Turkish Pregnant Women: A Correlational Study

Türk Gebe Kadınların Algıladıkları Sosyal Destek ve Konfor Düzeyi: Korelasyonel Bir Çalışma

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ABSTRACT

Aim: Social support and comfort level during pregnancy are essential for pregnant women to have a healthy pregnancy process for themselves and their babies. This study aimed to determine the factors affecting perceived social support and comfort level and the relationship between perceived social support and comfort level in pregnant women.
Methods: The research was a descriptive and correlational type. The study was conducted with 272 pregnant women who came to the obstetrics policlinic between September 2022 and February 2023. Data were collected using the Individual Identification Form, the Multidimensionel Scale of Perceived Social Support (MSPSS), and the Prenatal Comfort Scale (PCS).
Results: The mean age of the pregnant women was 28.81±4.74 years. The MSPSS score averaged 69.03±6.95, while the PCS score was 65.31±3.80. Significant differences were found in education level, employment status, family type, income, marriage duration, marriage age, number of living children, desired gender, and perceived social support and comfort levels (p<0.05). Additionally, trimester, number of pregnancies, and satisfaction with the baby's sex significantly influenced PCS scores(p<0.05). There was a moderate positive correlation between MSPSS and PCS scores (r=0.609; p=0.000). Comfort level increased perceived social support by 1.1 units (B=1.113; R2=0.371).
Conclusions: Perceived social support and comfort level were affected by each other in pregnant women. Healthcare providers, especially nurses, should assess and integrate social support and comfort levels into prenatal care for pregnant women.

Keywords: Perceived social support, Pregnancy, comfort, Prenatal comfort scale, Women.

ÖZ

Amaç: Gebelik döneminde sosyal destek ve konfor düzeyi gebe kadınların kendileri ve bebekleri için sağlıklı bir gebelik süreci geçirmeleri açısından çok önemlidir. Bu çalışmanın amacı, gebelerde algılanan sosyal destek ve konfor düzeyini etkileyen faktörleri ve algılanan sosyal destek ile konfor düzeyi arasındaki ilişkiyi belirlemektir.
Gereç ve Yöntemler: Araştırma tanımlayıcı ve korelasyonel tiptedir. Çalışma kadın doğum polikliniğine gelen 272 gebe ile Eylül 2022 ve Şubat 2023 tarihleri arasında yürütülmüştür. Veriler Birey Tanımlama Formu, Çok Boyutlu Algılanan Sosyal Destek Ölçeği (ÇBASDÖ) ve Prenatal Konfor Ölçeği (PKÖ) kullanılarak toplanmıştır.
Bulgular: Gebelerin yaş ortalaması 28.81±4.74'dir. ÇBASDÖ puan ortalaması 69,03±6,95 iken, PKÖ puan ortalaması 65,31±3,80'dir. Eğitim düzeyi, çalışma durumu, aile tipi, gelir, evlilik süresi, evlilik yaşı, yaşayan çocuk sayısı, istenen cinsiyet, algılanan sosyal destek ve konfor düzeylerinde anlamlı farklılıklar bulunmuştur (p<0.05). Ayrıca, trimester, gebelik sayısı ve bebeğin cinsiyetinden duyulan memnuniyet PKÖ puanlarını anlamlı şekilde etkilemiştir (p<0.05). ÇBASDÖ ve PKÖ puanları arasında orta düzeyde pozitif yönde anlamlı bir korelasyon vardır (r=0,609; p=0.000). Konfor düzeyinin 1 birim artması algılanan sosyal desteği 1,1 birim artırmaktadır (B=1,113; R2=0,371).
Sonuçlar: Gebe kadınlarda algılanan sosyal destek ve konfor düzeyi birbirinden etkilenmektedir. Sağlık hizmeti sağlayıcıları, özellikle de hemşireler, sosyal destek ve konfor düzeylerini değerlendirmeli ve gebe kadınların doğum öncesi bakımına entegre etmelidir.

Anahtar Kelimeler: Algılanan sosyal destek, Gebelik, konfor, Prenatal konfor ölçeği, Kadınlar.

Introduction

Pregnancy is a crucial period in a woman's life, during which perceived social support (PSS) can significantly influence her emotional and physical health. PSS in pregnant women generally consists of various sources such as spouses, family, friends, health professionals, other pregnant women, and colleagues (1,2,3). Every pregnant woman has different social support needs and this support is important at every stage of pregnancy. PSS in pregnant women can vary from help in daily life to emotional support (1,4,5). As PSS increased in pregnant women, mood disorders such as anxiety, depression and fear of childbirth in pregnancy decreased (3,4,6-9) and psychosocial health status was improving (3,8) and the mother-baby bond was strengthened (10,11).

Comfort in pregnancy refers to a pregnant woman's ability to fulfill her physical, emotional, and social needs, to relax, and to feel a general state of well-being. Given the range of changes and difficulties experienced by women during this period, comfort involves a broad perspective and may differ from individual to individual (12,13). Comfort during pregnancy was affected by many factors such as physical discomfort, emotional balance, nutrition, physical activity, sleep,

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work, working life, level of knowledge, preparation, prenatal care, and social support (14-16). Increased comfort level in pregnant women was reported to reduce anxiety symptoms and positively affect fetal health (17). Pregnant women needed social support to feel good, relax, and get through this period more easily. Pregnant women with social support had fewer physical and psychological symptoms during pregnancy (3,4,8). The comfort level of pregnant women who spent their pregnancies in a healthier physical and psychological way also increased. The good comfort level of pregnant women enabled them to have healthier pregnancies (12,13,14,17). In this context, an increase in PSS in pregnant women may help women to feel safer and healthier, physically and psychologically more comfortable during pregnancy. This can positively affect the comfort level of pregnant women. This study aimed to determine the factors affecting PSS and comfort level and the relationship between PSS and comfort level in pregnant women.

Materials and Methods

A descriptive and correlational study was undertaken involving 272 pregnant women, each at 19 to 39 weeks of gestation, who attended the obstetrics clinic of a training and research hospital in Izmir, located in western Türkiye, for routine prenatal care. The study period extended from September 2022 to February 2023. Izmir was a cosmopolitan city and the hospital was located in the center of Izmir, accessible and provided care and services to women from a wide range of sociocultural backgrounds.

The population of the study consisted of 975 women who applied to the obstetrics outpatient clinic of the hospital where the study was conducted in 2022. The sample of the study was calculated with a margin of error of 5% and a 95% confidence interval with the known sampling method (n=Nt2pq/d2(N-1)+t2pq) and was determined as 276 pregnant women (18). The sample of the study consisted of a total of 420 pregnant women who applied to the obstetrics outpatient clinic of a training and research hospital between September 2022 and February 2023 and came for routine control. All of these women were extended an invitation to participate in the study. Among those invited, 28 were not included in the study because they had risky pregnancies, 9 were single parents, 8 had a psychiatric illness, 18 were not spontaneously pregnant, 8 had multiple pregnancies, 16 were illiterate, 22 could not speak Turkish and 39 were unwilling to participate in the research study.

Ultimately, a sample of the study finally comprised 272 pregnant women. The participation rate in the study was 65%. At the end of the study, post hoc power analysis showed that the power obtained with a correlation coefficient of 0.609 and a 5% margin of error between social support and the comfort level of pregnant women was 99.9% (18).

Inclusion criteria;

• No risky pregnancy,

• Not a single parent,

• No psychiatric illness,

• Failure to conceive as a result of infertility treatment,

• No multiple pregnancies,

• Literate,

• Turkish speaking.

The study protocol received approval from the Izmir Katip Çelebi University Non-Interventional Clinical Research Ethics Committee (IRB: 0256, Date: 26 May 2022) and obtained the necessary authorization from the hospital where the study was conducted (IRB: 2022/84, Date: 8 September 2022) and informed consent was signed by all pregnant women. Pregnant women were informed that they could withdraw from the study at any time. After signing the consent forms, the recruited pregnant women completed an individual identification form, the Turkish version of the MSPSS, and the PCS. The process of filling out these forms took approximately 20 minutes. Data were collected by the researchers every weekday. Researchers were available to address any questions the pregnant women had. All forms were collected through face-to-face interviews and were completed by the pregnant women themselves. Data were collected individually with pregnant women in a quiet and calm room of the obstetrics outpatient clinic. It was stated that all information provided by pregnant women would be used by the researchers for scientific purposes only and would only be shared with the institution where the study was conducted, if necessary. The research was conducted in accordance with the Principles of the Declaration of Helsinki.

Instruments

Pregnant women were asked to complete three instruments. These instruments were the "Individual Identification Form", "Multidimensional Scale of Perceived Social Support (MSPSS)" and "Prenatal

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Comfort Scale (PCS)".

Individual Introduction Form

The form was developed by the researchers, drawing on previous studies (8,12,13,19). This form comprises 16 questions, addressing socio-demographic factors (8 questions), obstetric history (6 questions), and characteristics of the baby (2 questions).

The MSPSS

The MSPSS was developed by Zimet et al. in 1988 to evaluate social support (20). The Turkish version of the scale underwent validity and reliability testing by Eker and Arkar in 1995 (21). The MSPSS includes 12 items arranged on a seven-point Likert scale, encompassing three dimensions: family support (Items 3, 4, 8, and 11), friend support (Items 6, 7, 9, and 12), and significant other support (Items 1, 2, 5, and 10). The total possible score on the scale ranges from 12 to 84, with higher scores reflecting greater perceived social support (PSS). Each dimension can yield scores between 4 and 28. The scale demonstrates a Cronbach's alpha ranging from 0.77 to 0.92 for its total score and individual dimensions (21). In the present study, the Cronbach's alpha was determined to be 0.85. The McDonald'ın w coefficient for the MSPSS was computed as 0.87. According to the confirmatory factor analysis, the KMO and Bartlett's Test value was 0.82 (p<.001).

The PCS

The PCS, devised by Takeishi et al. in 2011, aims to gauge positive affect among pregnant women. This instrument comprises 35 items distributed across five subscales, as outlined by Takeishi et al. (13). While the first version of the scale was 34 items, it was later revised and shortened to 15 items (12). The Turkish validity and reliability of the scale were performed by Şenol et al. in 2021 (19). The scale consists of 15 items and 5 sub-dimensions. The sub-dimensions and items are as follows: "deepening relationships with husband growing to father" [HUSBAND] (3,4,7,9), "interactions by moving of fetüs" [FETUS] (13,14), "support from communications with the people around" [PEOPLE] (11,12,15), "realization of becoming a mother and attachment to the baby" [MOTHER] (1,5,8), and "changes in myself during the pregnancy life" [MYSELF] (2,6,10). The scale was a six-point Likert type. Each item was scored between 0-5. The scale was evaluated over a total of 75 points. The higher the score, the higher the comfort level was interpreted. The scale had no reverse-scored items and no cut-off

point. The Cronbach Alpha (α) value of the scale was 0.95 (12,13). The Turkish validity and reliability of the scale were reported to be Cronbach alpha 0.82 (19). In the current study, the Cronbach's alpha coefficient for the PCS was computed as 0.78. The McDonald'ın w coefficient for the PCS was computed as 0.79. According to the confirmatory factor analysis, the KMO and Bartlett's Test value was 0.71 (p<.001).

Statistical Analysis

The data analysis was conducted using the SPSS 25.0 statistical software package. Categorical variables were expressed as frequencies (n) and percentages (%), while continuous variables were summarized using means and standard deviations (SD) with the range (min-max) provided. The normality of data distribution was assessed using the Kolmogorov–Smirnov test. Group differences in scale scores were assessed using the t-test for two groups and One-Way ANOVA for three or more groups. Bonferroni test was used to find the group that made a difference. The association between MSPSS and PCS scores was examined using Spearman correlation analysis. Correlation coefficients were interpreted as follows: below 0.40 indicating a low correlation, 0.40-0.69 indicating a moderate correlation, and above 0.70 indicating a strong correlation (18,22). Linear regression analysis was conducted to ascertain the predictive impact of comfort level on perceived social support. The coefficient of determination (R^2) was employed to calculate effect sizes in the regression models. Results were interpreted at a 95% confidence interval, with statistical significance set at p<0.05.

Women were evaluated after approval was obtained Izmir Katip Çelebi University Non-Interventional Clinical Research Ethics Committee (Decision No: 0256-26 May 2022) and obtained the necessary authorization from the hospital where the study was conducted (IRB: 2022/84, Date: 8 September 2022) and informed consent was signed by all pregnant women.The study was conducted under the principles of the Declaration of Helsinki.

Results

Characteristics of Population

A total of 272 pregnant women were included in this study. The socio-demographic, obstetric, and baby-related characteristics of the participants are presented in Table 1. The mean age of the pregnant women was 28.81±4.74 (18-41) years and was duration

Table 1. Population Characteristics and Comparison of MSPSS and PCS Total Score According to These Characteristics

			MSPSS		PCS	
	Mean ±SD		Mean ±SD	Test/p	Mean ±SD	Test/p
Age	28.81±4.74 (18-41)			-0.028*/0.650	28.81±4.74	-0.019*/0.754
Age of marriage	24.51±3.48 (17-32)			0.140*/**0.020**	28.81±4.74	0.239*/**<0.001**
Week of pregnancy	30.10±3.48 (19-39)			-0.007*/0.912		0.129*/**0.033**
	n	%				
Education						
Under high school	106	39.0	67.01±5.61	t=-4.191/	63.33±3.47	t=-7.465/
High school and above	166	61.0	70.33±7.41	**<0.001**	66.56±3.46	**<0.001**
Partner' Education						
Under high school	62	22.8	67.27±3.93	t=-2.541/	62.79±3.93	t=-5.884/
High school and above	210	77.2	69.55±7.16	**0.012**	66.04±3.43	**<0.001**
Work						
Working	56	20.6	71.61±5.71	t=3.583/	67.05±2.71	t=4.892/
Not working	216	79.4	68.37±7.09	**0.001**	64.85±3.91	**<0.001**
Family type						
Nuclear	219	80.5	69.73±6.98	t=3.753/	65.96±3.76	t=7.754/
Extended	53	19.5	66.15±6.04	**<0.001**	62.58±2.57	**<0.001**
Income						
Low[a]	89	32.7	66.04±5.42	F=13.810/	63.61±3.08	F=15.188/
Middle[b]	174	64.0	70.59 ±7.25	**<0.001**	66.06±3.88	**<0.001**
High[c]	9	3.3	68.55±4.66	***b>a, b>c	67.44±3.08	***a>b, a>c
Duration of marriage (year)						
1-5[a]	191	70.2	69.94±6.76	F=5.996/	65.91±3.55	F=8.625/
6-10[b]	62	22.8	66.54±6.99	**0.003**	63.93 ±3.67	**<0.001**
11 and above[c]	19	7.0	68.05±6.85	***a>b, a>c	63.68 ±5.07	***a>b=c
Trimester of pregnancy						
2nd trimester	51	18.8	68.84±7.05	t=-0.218/	64.07±3.08	t=-2.987/
3rd trimester	221	81.3	69.08±6.94	0.828	65.58±3.91	**0.004**
Pregnancy						
Primiparous	158	58.1	69.52±6.63	t=1.344/	66.15±3.31	t=4.471/
Multiparous	114	41.9	68.35±7.34	0.180	64.13±4.14	**<0.001**
Number of living children						
None[a]	175	64.3	69.71±6.76		66.12±3.51	
1[b]	58	21.3	68.65±6.49	F=3.238/	63.84±3.50	F=8.676/
2[c]	20	7.4	68.35±6.05	**0.023**	63.10±5.48	**<0.001**
3[d]	19	7.0	64.68±8.36	***a>d	64.57±2.94	***a>b, a>c
Time between pregnancies*						
24 months and under	25	21.9	70.32±8.11	t=1.404/	64.20±4.98	t=0.081/
25 months and above	89	78.1	67.81±7.06	0.169	64.11±3.91	0.936
Planning pregnancy						
Yes	262	96.3	69.14±6.95	t=-1.462/	65.38±3.75	t=-1.495/
No	10	3.7	66.10±6.45	0.175	63.20±4.56	0.168
Desired pregnancy						
Yes	265	97.4	69.13±6.87	t=-1.129/	65.33±3.77	t=-0.642/
No	7	2.6	65.14±9.29	0.301	64.14±4.87	0.544
Desired gender						
Girl[a]	74	27.2	71.05±7.83	F=4.518/	66.55±3.56	F=5.667/
Boy[b]	30	11.0	67.70±7.36	**0.012**	64.83±4.32	**0.004**
Does not matter[c]	168	61.8	68.38±6.29	***a>c	64.84±3.70	***a>c
Satisfaction with the baby's gender						
Yes	264	97.1	69.09±7.02	t=-1.397/	65.41±3.80	t=-3.786/
No	8	2.9	67.12±3.79	0.198	62.12±2.35	**0.005**

MSPSS: Multidimensional Scale of Perceived Social Support. PCS: Prenatal Comfort Scale. SD: Standard deviation. Independent two sample 't' test. F: One-Way Anova Test. p<0.05. *Spearman correlation test.**Calculated over:n=114. *** Bonferronni test

of marriage between 1-5 years (70.2%). The majority of the women had a high educational level (61%), were nonworking (79.4%), lived in a nuclear family (80.5%), and had a middle-income level (64%). The majority of the participants were in the third trimester (81.3%), were primiparous (58.1%), had no living children (64.3%), had planned pregnancy (96.3%), had wanted pregnancy (97.4%), and were not important the gender of the baby (61.8%) (Table 1).

Affecting Factors and PSS

In the study, the MSPSS score was 69.03±6.95 (Min: 12; Max: 84). The highest scores of the MSPSS were for a special person and the family sub-dimensions. Detailed information about the sub-dimensions of the MSPSS is given in Table 2. Women with a higher level of education (p<0.001), and their partners (p=0.012), working (p<0.001), living in nuclear families (p<0.001), middle level of income (p<0.001), in the first five years of marriage (p=0.003), age of marriage (p=0.020), living without children (p=0.023), desire a baby girl (p=0.012) had a significantly higher MSPSS score (Table 1).

Table 2. MSPSS and PCS Sub-dimension and Total Scores

Scales	Mean±SD	Min-Max	Scale Min-Max
MSPSS			
Special person	23.24±2.77	9-28	7-28
Family	23.52±2.14	17-28	7-28
Friends	21.83±3.65	6-28	7-28
Total score	69.03±6.95	43-84	12-84
PCS			
Husband "deepening relationships with the husband growing to father"	17.63±1.27	14-20	0-20
Fetus "interacting with fetal movements"	9.06±0.81	6-10	0-10
People "social support from people around"	12.81±1.42	7-15	0-15
Mother "realization of becoming a mother and attachment with the baby"	13.27±1.11	10-15	0-15
Myself "recognizing changes in pregnancy"	12.52±1.42	8-15	0-15
Total score	65.31±3.80	56-75	0-75

MSPSS: Multidimensional Scale of Perceived Social Support. PCS: Prenatal Comfort Scale.
SD: Standard deviation.

Affecting Factors and Prenatal Comfort Level

In the study, the PCS score was 65.31±3.80 (Min: 0; Max: 75). The highest scores of the PCS were the husband, fetus, and mother sub-dimensions. A detailed description of the sub-dimensions of the PCS is given in Table 2. Women with a higher level of education (p<0.001), and their partners (p<0.001), working (p<0.001), living in nuclear families (p<0.001), high level of income (p<0.001), in the first five years of marriage (p<0.001), age of marriage (p<0.001), 3rd trimester (p=0.004), primiparous (p<0.001), living without children (p<0.001), desire a baby girl (p=0.004), and were satisfaction with the sex of the baby (p=0.005) had a significantly higher PCS score (Table 1).

Correlation Between MSPSS and Prenatal Comfort Level

The correlation between MSPSS and PCS total scores and their sub-dimensions is detailed in Table 3. There was a moderate positive correlation between MSPSS and PCS total scores (r= 0.609; p<0.001). It was found that there was a weak positive significant correlation between the PCS total score and the "special person" sub-dimension of MSPSS (r=0.300; p<0.001), a moderate positive significant correlation between the "family" sub-dimension of MSPSS (r=0.657; p<0.001) and a moderate positive significant correlation between the "friend" sub-dimension of MSPSS (r=0.580; p<0.001) (Table 3).

Linear Regression Analysis to Examine the Effect of Predictors on Perceived Social Support

Finally, linear regression analysis was used to detect any variation independently associated with the PSS domains (dependent variables). In the study, it was found that a one-unit increase in comfort level among pregnant women resulted in a 1.1-fold increase in perceived social support (B=1.113, p<0.001) and accounted for 37% of the variance (R2=0.371) (Table 4). The best-fit regression model revealed six variables that explained 42% of the variance in PSS in pregnancy (R2:0.416). Linear regression analysis results showed that age (B:-0.361, p:0.010), age of marriage (B:0.345, p:0.055), education level (B:-2.982, p:0.009), income level (B:-3.795, p<0.001), number of pregnancies (B:-1.967, p:0.029), PCS total score (B:1.130, p<0.001) were associated with the PSS (Table 4).

Table 3. Correlation Between MSPSS and PCS Sub-Dimension and Total Scores

PCS	MSPSS							
	Special person		Family		Friend		Total score	
	r	p	r	p	r	p	r	p
Husband "deepening relationships with the husband growing to father"	0.047	0.443	0.232	**<0.001**	0.118	0.052	0.175	**0.004**
Fetus "interacting with fetal movements"	0.068	0.264	0.421	**<0.001**	0.054	0.376	0.182	**0.003**
People "social support from people around"	0.221	**<0.001**	0.535	**<0.001**	0.540	**<0.001**	0.517	**<0.001**
Mother "realization of becoming a mother and attachment with the baby"	0.262	**<0.001**	0.495	**<0.001**	0.457	**<0.001**	0.476	**<0.001**
Myself "recognizing changes in pregnancy"	0.296	**<0.001**	0.389	**<0.001**	0.518	**<0.001**	0.480	**<0.001**
PCS total score	0.300	**<0.001**	0.657	**<0.001**	0.580	**<0.001**	0.609	**<0.001**

MSPSS: Multidimensional Scale of Perceived Social Support. PCS: Prenatal Comfort Scale. r: Spearman correlation test. p<0.05.

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Table 4. Linear regression analysis to examine the effect of comfort level on perceived social support

Independent Variables	B	Standard Error	β	t	CI 95%		R	R²	Adjusted R²	Durbin-Watson	p
Constant	-3.633	5.771	-	-0.630	-14,996	7,729	0.609	0.371	0.368	1.767	0.530
PCS total score	1.113	0.088	0.609	12.613	0.939	1.286					**<0.001**
Predictors of perceived social support in pregnant women											
Constant	1.383	6.373	-	0.217	-11.165	13.930					0.828
Age	-0.361	0.139	-0.246	-2.599	-0.634	-0.087					**0.010**
Age of marriage	0.345	0.179	0.173	1.925	-0.008	0.698	0.645	0.416	0.403	1.851	0.055
Education (Under high school)	-2.982	1.136	-0.210	-2.624	-5.219	-0.745					**0.009**
Income (Low)	-3.795	0.996	-0.257	-3.809	-5.757	-1.833					<0.001
Number of pregnancies (Multiparous)	-1.967	0.896	-0.140	-2.197	-3.730	-0.204					0.029
PCS total score	1.130	0.095	0.618	11.833	0.942	1.318					<0.001

B: Unstandardized Coefficient. β:Standardized Coefficient. CI: Confidence Interval. PCS: Prenatal Comfort Scale. R2: Coefficient of determination, p<0.05.

Backward selected. Excluded Variables: Family type, work, partner' education level, duration of marriage and number of living children

Discussion

The study aimed to determine the factors affecting PSS and comfort level and the relationship between PSS and comfort level in pregnant women. In the study, the MSPSS total score of pregnant women was 69.03±6.95 (61% of them had high school and above). In studies conducted with Turkish pregnant women, the MSPSS total score was 50.53±14.18 in 2020 (32.1% of them had high school and above), 61.68±20.05 in 2016 (27.3% of them had high school and above), 60.28±15.72 in 2015 (57.5% of them had high school and above), and 64.3±17.9 in 2014 study (40.7% of them had high school and above) (5,6,8,23). The PSS of Turkish pregnant women in our study was better than previous studies in Turkey. We would like to draw attention to the level of education of women in the studies. The majority of pregnant women in our study had a high school education or higher, which was higher than in other studies. Education level positively affected PSS. Moreover, in our study, we found that MSPSS total scores of pregnant women with high school education levels and above were significantly higher, which was consistent with the results of studies conducted in 2015 and 2020 (6,8). In the study conducted with Chinese pregnant women, the MSPSS total score was 72.12±10.25 and 56.2% of these pregnant women had a high school education or higher (3). In a study of Iranian pregnant women, the MSPSS total score was 93.85±11.69 and 94.7% of these pregnant women had a high level of education (2). Social support constitutes the social environment together with spouse, family, and friends and improves the social interactions of individuals (24). Therefore, we think that sociocultural structure affects PSS.

In this study, it was determined that increasing age in pregnant women negatively affected perceived social support (B:-0.361) and this was consistent with the results of studies in 2020 (7,8). The reasons for this may include the shrinkage of extended family structures with increasing age, shrinkage of the social environment, and differences in the individual's access to support mechanisms. In particular, women who experience pregnancy at a young age benefit more from family, friends, and social support systems, whereas these supports may decrease over time in older pregnant women. This may be related to the individual's life experience and level of independence, but may also be influenced by environmental and cultural factors. However, in a study, it was determined that there was no relationship between the age of pregnant women and the social support they perceived (2). In this context, the relationship between age and perceived social support during pregnancy should be evaluated in the context of individual and environmental factors.

In the study, PSS was higher in working pregnant women compared to non-working pregnant women. This finding was consistent with the results of previous studies (2,3,6,8). These results showed that working pregnant women were able to provide a more social environment compared to non-working pregnant women. In addition, employment was an important factor in improving socio-economic status and well-being (24). In our study, Turkish pregnant women with middle income had higher levels of PSS, which was consistent with the results of a study in 2020 (8). In parallel with our study, Chinese pregnant women with middle income had a higher perception of social support (3). In Iranian pregnant women, increasing socioeconomic status increased social support scores by 1.6 units (most of the medium socioeconomic class) (2). In our study, low-income level negatively affected perceived social support (B:-3.795). Pregnant women living in nuclear families had higher PSS, which was consistent with the results of studies in 2020 (7,8). We think that the husbands of pregnant women living in nuclear families provide more support to them.

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Because spousal support and positive relationships with the partner increase the PSS of pregnant women (4-6). The fact that the pregnant women in our study had a high mean of a special person sub-dimension confirmed this result. In addition, the higher educational level of the majority of the spouses of pregnant women in our study significantly increased the PSS of pregnant women (p<0.05). The high level of education of the spouses of pregnant women may have a positive effect on their PSS, which was parallel to Nazari et al. (2). Similarly, in our study, pregnant women with higher educational levels had better perceived social support.

In our study, PSS was better in pregnant women with a marriage duration of 1-5 years. Based on the parallel relationship between the duration of marriage and living children, the majority of the women in our study (64.3%) had no living children. This result suggested that the pregnant woman's husband, family, and friends directed all their support to the pregnant woman. In our study, a higher number of living children decreased PSS, which was consistent with the results of a study in 2020 (8). In addition, multiparity was found to negatively affect perceived social support in the study (B:-1.967). However, surprisingly, pregnant women who wanted to have a baby girl had a better level of PSS. This result suggested that the husbands of the pregnant women also agreed on the sex of the baby and were supported by their husbands. Besides, the fact that almost all pregnant women in our study were satisfied with the sex of the baby may have increased PSS.

The comfort level of pregnant women who participated in our study was good (65.31±3.80) (mean of gestational week; 30.10±3.48), which was consistent with the results of studies in 2015 and 2021 (12,19). In the study conducted by İbici Akca et al. (17), the comfort level of pregnant women was lower than our study (50.56±15.78) (mean of gestational week 23.47±2.35). We would like to draw attention to the mean of gestational weeks of pregnant women. In addition, in the comparison between trimesters in our study, the comfort level of pregnant women in the 3rd trimester was significantly higher than pregnant women in the 2nd trimester (64.07±3.08; 65.58±3.91, respectively) (p<0.05), which was parallel to the study in 2020 (14). Therefore, we can say that the gestational week affects the comfort level of women and the comfort level of pregnant women in our study was better.

In our study, the comfort level was higher in pregnant women with higher education levels, without living children, and primiparous women, which was consistent with the results of a study in 2020 (14). Besides, in studies in 2013 and 2015, the comfort level of primiparous pregnant women was higher compared to multiparous pregnant women (12,25). In our study, pregnant women who were employed and had a high-income level had a better level of comfort. Employment was an important factor that increased socioeconomic status (24). In previous studies, it was stated that prenatal mother-baby attachment of working pregnant women was at a better level (26), it was easier to adapt to pregnancy (16), and quality of life was positively affected (15). Considering that the level of comfort is affected by many factors such as the fetus, motherhood, and relationships with the partner, it can be said that working pregnant women have a better level of comfort (13,19). A study conducted by Aydın Özkan et al. (14) stated that the comfort of working with pregnant women was better. Therefore, we think that pregnant women who work and have a high-income level have a better comfort level.

Pregnant women living in nuclear families and with a marriage duration of 1-5 years had a better level of comfort. We would like to emphasize again that the majority of pregnant women in our study were primiparous (58.1%). Because primiparity was an important factor that increased comfort (12,14,25). The majority of the pregnant women in our study (64.3%) had no living children. When the duration of marriage increases, both the number of living children, the risk of pregnancy, and the number of children in the family may increase. Therefore, it can be said that the comfort of pregnant women living in a nuclear family and within the first five years of marriage is better. Pregnant women who wanted to have a baby girl and were satisfied with the gender of the baby had a better level of comfort. The satisfaction experienced by the pregnant woman about the baby positively affects the woman's interaction with her baby, the feeling of motherhood, and the father's interaction with the baby (27-29).

One of the important main results of our study was the moderate positive correlation between PSS and comfort level in Turkish pregnant women. Additionally, the study revealed that a one-unit increase in comfort level led to a 1.1-unit increase in perceived social support. Our study was the first study to shed light on the relationship between PSS and the comfort

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level of pregnant women in Türkiye. Increased PSS improved the comfort level in pregnant women and vice versa. Pregnancy is an important period in which not only physical but also emotional symptoms are experienced (1). In this period, it was stated that the increase in PSS from pregnant women's social environment such as spouses, family, and friends had a positive effect on both the physical and emotional process of pregnancy (1,8). It was reported that pregnant women with high PSS had lower levels of anxiety and depression during pregnancy (3,4,6,7) and reduced fear of childbirth (23). In addition, it was reported that pregnant women with high PSS experienced fewer physical symptoms, were healthier during pregnancy, and spent their pregnancies more satisfied and happy (1,3). It was also found that these women received more social support from their husbands during pregnancy (4). In this context, it can be said that pregnant women with high PSS feel better both physically and psychologically. Besides, pregnant women with high PSS had better interactions with themselves, their infants their partners, and other people, and these pregnant women were more aware of motherhood and infant attachment (9-11). In our study, the higher scores of the spouse, fetus, and motherhood sub-dimensions of the PCS confirmed this result. Therefore, it can be said that there is a positive relationship between the PSS of pregnant women and their comfort level.

Conclusion

In conclusion, this study determined the PSS and comfort level of pregnant women and the relationship between them. According to these results, the PSS and comfort level of pregnant women were at a good level and there was a moderate positive relationship between them. Some sociodemographic and obstetric characteristics affected the PSS and comfort level in pregnant women. Healthcare providers and especially nurses need to determine, follow up, and know the factors affecting PSS in pregnant women. Healthcare providers, and especially nurses, should identify the level of comfort in pregnant women during each trimester and the factors that affect the level of comfort. To strengthen the social support networks of pregnant women and increase their comfort level, it is necessary to raise awareness of family members and the immediate environment, establish pregnancy support groups, encourage spousal support, increase access to prenatal care services, develop supportive policies and technology-based practices, and increase social awareness. Healthcare providers and especially nurses should improve pregnant women's social support networks, increase their access to health, and follow-up from pregnancy to the postnatal period, which will enable pregnant women to have a healthier pregnancy and increase maternal and child health.

The sample of our study consisted of pregnant women admitted to the obstetrics and gynecology outpatient clinic of a single hospital in western Türkiye. Therefore, the results cannot be generalized and are limited to the data of pregnant women admitted to the hospital. In addition, the fact that the sample of our study was conducted in western Türkiye and the majority of the pregnant women were primiparous seems to have affected the results of the study. It is recommended that future studies should be conducted in different regions of Türkiye with multicenter, large populations, and pregnant women with different descriptive characteristics.

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