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Maternal Ambivalence and Related Factors: The Case of Şanlıurfa

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ABSTRACT

Introduction: Maternal ambivalence refers to both positive and negative emotions associated with mothering. It is an essential factor that may affect maternal and infant health.
Objective: This study aimed to determine maternal ambivalence and related factors among women living in Şanlıurfa province.
Method: The population of this descriptive study consisted of pregnant women over 18 and mothers with children in the 0-2 age group. The sample size was calculated as 172 people according to the values obtained from the pilot study. The data were collected by face-to-face interviews between October and December 2024 using a personal information form, the Maternal Ambivalence Scale (MAS) and the Psychological Distress Scale (PDS). In evaluating the data, percentage, mean, and standard deviation from descriptive statistics, t-test, one way ANOVA test and Pearson Correlation analysis from univariate analysis were used.
Results: In the study, the mean age of the women was 26.3±5.4 years, and 60.4% had primary education or less. 20.9% of the women stated that they did not receive any spousal support during pregnancy, labour and postpartum periods. The mean MAS score was 29.8±0.2, and the mean PDS score was 38.7±0.4. Maternal ambivalence was higher in women without spousal support, and maternal ambivalence decreased as psychological distress increased ($p<0.05$).
Conclusion: As a result of this study, it was determined that women in Şanlıurfa have a moderate level of maternal ambivalence and that spousal support and psychological distress are factors affecting maternal ambivalence.

Keywords: Pregnant, Mother, Ambivalence, Psychological Distress, Spousal Support.

INTRODUCTION

Becoming a mother is a significant life goal for women (1). Although having a child is generally regarded as a situation that brings happiness and positive emotions, this experience does not always unfold as expected for mothers (1,2). This process, which starts with adding a new member to the family, is a challenging and stressful process that requires reorganisation of family dynamics because it brings new roles and responsibilities for the mother (3). Therefore, the decision to have a child may not always be easy for women of reproductive age (4). In this situation, both positive and negative emotions associated with being a mother coexist and are defined as “maternal ambivalence” (5). In its broader definition, maternal ambivalence is the mother's experience of mixed positive and negative emotions, thoughts and behaviours towards the maternal role or the baby (6). Maternal ambivalence can affect women in many ways. Studies show that when maternal ambivalence is not adequately addressed (ignored, suppressed, etc.), it may cause significant consequences on women's mental health (1,7). In particular, they may experience loss of self-esteem and self-confidence, body imagedissatisfaction, decreased quality of life, difficulties in social relationships, work life and leisure time utilization, and problems such as anhedonia, anger and stress (8,9).

In the literature, it is reported that there are many factors affecting maternal ambivalence. Some of these factors include partner presence and relationship quality (10), family and spouse support (11), influence of social environment (12), socio-economic status (13), mental health problems (14) and depression (1). Another important factor affecting maternal ambivalence is psychological distress (14). Psychological distress is defined as a state of emotional suffering characterized by symptoms of depression and anxiety (15). It is a factor that may negatively affect the mother-infant relationship and the cognitive and emotional development of the infant during pregnancy, delivery and postnatal period (16).

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It is essential to identify maternal ambivalence and the factors affecting it early and develop solutions for them to protect and improve maternal-infant health. Şanlıurfa is a province with the highest fertility rate in Turkey (17), where women gain status with their fertility (18) and where individuals with different ethnic origins and cultures live together (19). Taking these factors into account, it is believed that research focusing on identifying the elements that influence mother-baby health, particularly maternal ambivalence and psychological distress, will significantly improve the field. Therefore, this study was conducted to determine women's maternal ambivalence and related factors in Şanlıurfa.

METHOD

Type of Study

The study is of descriptive type.

Place and Date of Conduct of the Study

The study was conducted between October 20 and December 7, 2024, in a training and research hospital in Şanlıurfa city centre.

Population and Sample of the Study

The study population consisted of pregnant women and mothers with at least one child aged 0-2 years who applied to the Obstetrics Outpatient Clinics and Postpartum Services of a training and research hospital in Şanlıurfa city centre for any reason. For the sample size, a pilot study was conducted with 53 women who applied to the hospital. From the data obtained as a result of the pilot study, the sample size was calculated considering the variable of planned pregnancy. Maternal ambivalence was 26.6 (±5.1) in unplanned and 24.55 (±3.67) in planned pregnancies and the typical standard deviation of both measurements was 3.36, and the effect size between the two groups was calculated as 0.61. However, to reduce the probability of error, the effect size was increased by 0.5. Accordingly, the total sample size was calculated as 172 people by taking the effect size 0.5, alpha error 0.05 and power 0.9.

Inclusion criteria;

- 18 years of age or older,

- Being pregnant or having at least one child aged 0-2 years,

- To know Turkish and not to have communication problems.

Data Collection Tools

The study's data were collected using the face-to-face interview technique through the Personal Information Form, which the researchers created (1,5,9,13,18). The form included questions about the participants' socio-demographic and obstetric characteristics, the Maternal Ambivalence Scale, and the Psychological Distress Scale. Each interview lasted approximately 10-15 minutes.

Personal Information Form: Participants' socio-demographic (age, education level, language spoken, employment status, economic status, spouse's education level, spouse's employment status, family type, place of residence, chronic disease status) and obstetric (age at marriage, duration of the marriage, order of pregnancy, gestational week, whether the pregnancy was planned or not, the total number of pregnancies, abortion experience, the reason for abortion, number of living children, gender of children, any disability in living children, health problems during pregnancy, type of termination of previous pregnancy, problems experienced in the last birth, previous birth experience, spousal support during pregnancy, birth and postpartum period) consisted of 27 questions.

Maternal Ambivalence Scale (MAS): The Turkish adaptation of the scale developed by Martín-Sánchez et al. (5) in 2022 was conducted by Ünal and Yağmur (13) in 2024. The scale is Likert-type and consists of 14 items in total. Each item on the scale is scored between 1and 4 (1= Strongly disagree; 4= Strongly agree). Items 1,4,6,8,11,12, and 13 are reverse coded. The scale has three sub-dimensions: Doubts sub-dimension (2,3,5,7,9,10 items), Denial sub-dimension (1,4,6,8 items) and Suppression sub-dimension

(11,12,13,14 items). Higher scores in the sub-dimensions of the scale indicate more suspicion for the first sub-dimension, more insecurity for the second sub-dimension and more tendency to suppress ambivalence towards others for the third sub-dimension. The minimum score that can be obtained from the scale is 14, and the maximum score is 56. An increase in the total score obtained from the scale indicates a high level of maternal ambivalence. Cronbach's alpha coefficient of the scale was calculated as 0.752. In this study, the Cronbach alpha value of the scale was calculated as 0.618.

Psychological Distress Scale (PDS): The Turkish validity and reliability study of the scale developed by Kessler et al. (20) in 2002 was conducted by Altun et al. (21) in 2019. The lowest score that can be obtained from the five-point Likert scale is 10, the highest score is 50, and the scale consists of a total of 10 items. cut-off point of the scale is >20. Higher scores on the scale indicate more psychological distress. Cronbach's alpha coefficient of the scale was calculated as 0.95. In this study, the Cronbach's alpha value of the scale was calculated as 0.809.

Ethical Dimension of the Research

For the Maternal Ambivalence and Psychological Distress Scale used in the study, permission was obtained from the authors of the scale. Written permissions were obtained from the Harran University Clinical Research Ethics Committee (dated 22.07.2024 and numbered HRÜ/24.10.22) and Şanlıurfa Provincial Health Directorate (dated 01.10.2024 and numbered 375143), and informed consent was obtained from the participants. The Principles of the Declaration of Helsinki conducted each stage of the study.

Definitions

In the survey, the variable “the language spoken most at home” was asked to determine ethnic origin.

Variables of the Study

The dependent variable of the study is the mean scores of the participants on the Maternal Ambivalence Scale. The independent variables of the study were the participants' socio-demographic and obstetric characteristics and the mean scores of the Psychological Distress Scale.

Evaluation of Data

The data were evaluated with the statistical package program (SPSS 25.0). In the evaluation of the data, percentage, mean, and standard deviation from descriptive statistics, a T-test was used to compare the mean of two groups in categorical variables and a One way ANOVA test to compare the mean of three groups from univariate analysis; Pearson correlation analysis was used in continuous variables. The findings were interpreted at a significance level of $p < 0.05$ at 95% confidence interval.

RESULTS

The mean age of the women was 26.3±5.4 years. 54.6% of the women use a language other than Turkish at home (21.5% Kurdish, 33.1% Arabic). 60.4% of the women had primary education or less, and 48.3% lived in the city centre. 87.2% of the women were unemployed, and 42.4 % perceived their income level as low. The difference between the mean MAS scores of women and socio-demographic characteristics was not statistically significant ($p>0.05$) (Table 1).

80.2% of women had a planned pregnancy. 23.3% of women had a history of abortion (0.6% on demand and 22.7% for medical reasons), 4.7% had a history of having a disabled child, and 1.2% had a history of problems with previous births. 16.3% of mothers had a daughter, and 66.9% found their child's gender to align with their expectations. 16.3% of pregnant women experienced health problems during pregnancy. 20.9% of the women stated that they did not receive any spousal support during pregnancy, delivery and postpartum. While the difference between the groups was statistically significant ($p<0.05$) in terms of spousal support, it was not significant in terms of other obstetric characteristics ($p>0.05$). Accordingly, maternal ambivalence increased in women who did not have spousal support (Table 2).

Table 1. Distribution of Mean MAS Scores of Women According to Socio-Demographic Characteristics

			MAS Score		
Characteristics	**n**	**%***	**Mean ±SD**	**Test**	**P value**
Education Level					
Primary education and below	104	60.4	26.0±3.8		
Secondary education	48	27.9	26.7±4.3	1.932 **	0.148
University	20	11.6	27.8±4.4		
Most Spoken Language at Home					
Turkish	78	45.3	26.7±4.1		
Kurdish	37	21.5	25.9±4.2	0.519 **	0.596
Arabic	57	33.1	26.3±4.0		
Employment Status					
Yes	22	12.8	26.7±4.2		
No	150	87.2	26.3±4.0	0.378 ***	0.706
Perceived Economic Status					
High	10	5.8	25.5±4.3		
Medium	89	51.7	26.3±4.4	0.306 **	0.737
Low	73	42.4	26.5±3.5		
Spouse's Education Level					
Primary education and below	84	48.8	25.7±4.0		
Secondary education	59	34.3	26.7±4.0	2.369 **	0.097
University	29	16.8	27.5±4.0		
Spouse's Employment Status					
Yes	157	91.3	26.2±3.9		
No	15	8.7	27.8±5.1	-1.441 ***	0.151
Family Type					
Nuclear family	115	66.9	26.3±4.0		
Extended family	57	33.1	26.6±4.2	-0.401 ***	0.689
Place of Residence					
Provincal center	83	48.3	26.6±4.4		
District	63	36.6	26.3±3.5	0.210 **	0.811
Village	26	15.1	26.0±4.1		
Chronic Disease Status					
Yes	16	9.3	27.0±5.1		
No	156	90.7	26.3±3.9	0.596 ***	0.552
Total	172	100.0			

* Column Percentage, **Oneway ANOVA test, ***Independent samples test, MAS: Maternal Ambivalence Scale, SD:Standard Deviation.

Table 2. Distribution of Mean MAS Scores According to Obstetric Characteristics of Women

			MAS Score		
Characteristics	**n**	**% ***	**Mean ±SD**	**Test**	**P value**
Planned/Willing Pregnancy Status					
Yes	138	80.2	26.3±4.0	-0.410 ***	0.682
No	34	19.8	26.6±4.2		
Abortion Experience					
Yes	40	23.3	26.9±4.1	0.983 ***	0.327
No	132	76.7	26.2±4.0		
Gender of Children**					
Girl	55	43.3	26.9±3.0	-0.234 ***	0.793
Boy	72	56.7	27.2±5.4		
Expectation Conformity of Child Gender**					
Yes	115	90.6	26.6±3.8	-0.146 ***	0.884
No	12	9.4	26.8±5.7		
Disabled Child**					
Yes	8	6.3	27.2±4.2	0.415 ***	0.679
No	119	93.7	26.6±4.0		
Health Problems in Pregnancy					
Yes	28	16.3	26.0±2.8	-0.591 ***	0.439
No	144	83.7	26.5±4.2		
Previous Problems in Childbirth**					
Yes	2	1.6	27.0±2.8	0.115 ***	0.908
No	125	98.4	26.6±4.1		
Spousal Support during Pregnancy, Childbirth and Postpartum					
Supporting	136	79.1	26.1±4.1	**-2.033*** **	**0.044**
No support	36	20.9	27.6±3.6		
Total	172	100			

* Column Percentage, **This is the answer of those who answered the relevant question, ***Independent samples test, MAS: Maternal Ambivalence Scale, SD: Standard Deviation.

The mean age at marriage was 21.0± 3.9 years, the mean duration of marriage was 5.2±4.3 years, the mean number of pregnancies was 2.9±1.9, the mean number of living children was 1.9±1.6, the mean gestational order was 2.6±1.7 and mean gestational week was 35±3.8 weeks (Table 3).

Table 3. Distribution of Some Descriptive Characteristics of Women

Characteristics	Mean±SD	Median (min-max)
Age	26.3±5.4	25(17-49)
Marriage age	21.0± 3.9	20(15-38)
Duration of marriage	5.2±4.3	4.0(1-20)
Number of pregnancies	2.9±1.9	2.5(1-10)
Number of living children	1.9±1.6	2.0(0-8)
How many pregnancies	2.6±1.7	2.0(1-10)
Gestational week	35±3.8	36(10-41)

SD: Standard Deviation.

The mean MAS score of the women was 29.8±0.2, and it was 9.0±0.1 for the doubt subscale, 12±0.1 for the denial subscale and 8.7±0.1 for the suppression subscale. The mean PDS score was 38.7±0.4 (Table 4).

Table 4. Distribution of Women's Mean Scores on MAS and PDS

Mean Scale Score	Mean±SD	Median (min-max)
MAS	29.8±0.2	30(21-39)
Suspicions Subdimension	9.0±0.1	9(6-18)
Rejection Subdimension	12±0.1	12(7-16)
Suppression Subscale	8.7±0.1	9(6-11)
PDS	38.7±0.4	39(14-50)

SD: Standard Deviation, MAS: Maternal Ambivalence Scale, PDS: Psychological Distress Scale.

While there was a weak negative correlation between women's MAS scores and PDS scores (r:-0.255, $p<0.05$), no significant correlation was found in terms of other socio-demographic and obstetric characteristics ($p>0.05$). Accordingly, as maternal ambivalence increases, psychological distress decreases (Table 5).

Table 5. Correlation of Women's MAS Scores with PDS Scores and Some Descriptive Characteristics

Variable	r value	p value
PDS Score	**-0.255**	**0.001**
Age	-0.084	0.276
Marriage age	0.043	0.580
Duration of marriage	-0.068	0.376
Pregnancy sequence	-0.047	0.623
Gestational week	-0.025	0.796
Number of pregnancies	-0.057	0.459
Number of living children	-0.022	0.771

PDS: Psychological Distress Scale.

DISCUSSION

This study, which investigated maternal ambivalence and related factors among women living in Şanlıurfa province, determined that women experienced a moderate level of maternal ambivalence (mean MAS score: 29.8±0.2). Similar results were obtained in international and national studies to determine maternal ambivalence in the literature. In these studies, the mean MAS score was reported as 26.48±6.71 in the study by Martín-Sánchez et al. (5), 27.81±5.07 in the study by Ünal et al. (13), and 23.04±6.96 in the study by Erbil et al. (22). Although the socio-demographic and cultural factors of the study population and the populations of these studies in the literature were different, similar results were obtained regarding maternal ambivalence, suggesting that the feeling of motherhood and maternal roles are universal and standard social dynamics are more effective.

The study found that spousal support during pregnancy, birth and postpartum periods was an essential factor in maternal ambivalence, and women who received support from their partners had lower maternal ambivalence. In the literature, it has been shown that women whom their partners support are mentally and physically healthier during pregnancy and the postpartum period (23,24). It has also been reported that women who receive partner support during pregnancy and delivery perceive the pregnancy

process as less stressful (25-27). In the study of Işık et al., it was stated that as perceived spousal support decreased, the level of postnatal trauma stress increased (28). Considering these findings, it is unsurprising that spousal support positively affected maternal ambivalence in our study.

In the study, it was found that socio-demographic and obstetric characteristics were not effective on maternal ambivalence. In Eastern culture, having a child is generally a status indicator for women (18). Therefore, motherhood is seen as an essential duty of women (29). Thus, cultural and social dynamics are more dominant than individual differences in fertility and motherhood. However, unlike our study, Ünal et al. (13) reported that socio-demographic (number of siblings, educational status, income status and spouse's educational status) and obstetric (number of pregnancies, number of children, age at marriage, perception of social support) characteristics of pregnant women were practical factors in maternal ambivalence. This difference may have resulted from the characteristics of the study population.

In the study, it was determined that there was a negative, albeit weak, relationship between women's maternal ambivalence and psychological distress. As mothers' psychological distress increases, their maternal ambivalence decreases. However, psychological distress is expected to increase maternal ambivalence. Although there is no study in the literature examining the relationship between maternal ambivalence and psychological distress, in a study examining the factors associated with pregnancy ambivalence, it was reported that the perceived stress levels and depressive symptoms of women experiencing ambivalence were higher (30). This situation, which was found to be different from the literature in the study findings, may have resulted from the fact that women could not clearly distinguish the symptoms related to maternal ambivalence and psychological distress or that they did not give clear answers to the questions related to maternal ambivalence for different reasons. Indeed, in the Button et al. study (31), it was emphasised that women did not always understand the symptoms of psychological distress or could not express how they felt even if they detected that something was wrong and that women were afraid of being seen as 'bad mothers' by society and stigmatised for not being able to cope with this situation and that this could lead to 'silencing themselves'.

Limitations of the study: Women may not have fully expressed their thoughts about motherhood ambivalence or psychological distress due to fear of being stigmatised as ‘bad mothers’. Since there was no measurement tool or question to measure stigmatisation in the study, this may be a limitation of the study.

CONCLUSION

As a result of this study, it was determined that women in Şanlıurfa had a moderate level of maternal ambivalence and that spousal support and psychological distress were the factors affecting maternal ambivalence. In line with these results, it is recommended to increase psychological support and awareness-raising activities for women, to organize communication and parenting training to strengthen the supportive roles of spouses, to enhance psychological support mechanisms in health services and to develop social policies that support the parenting process.

DESCRIPTIONS

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