

The Impact of Adaptation to Pregnancy on Breastfeeding Self-Efficacy

Abstract

Background: This is a cross-sectional study conducted to evaluate the impact of adaptation to pregnancy on breastfeeding self-efficacy perception of women who applied to the Gynecology and Obstetrics Outpatient Clinic of a public hospital between March 1, 2018 and May 30, 2018.

Methods: A total of 140 pregnant women were included in the study. Data were analyzed using Statistical Package for the Social Sciences 21 program. Shapiro-Wilk test was used for testing the normal distribution of the data, and the Levene test was used to test for homogeneity of variance. Student's t-test was used for comparing 2 independent means, 1-way analysis of variance was used for comparing >2 independent means, and Turkey posthoc test was used for pairwise comparisons. The Pearson correlation coefficient was calculated in the linear relationship between 2 continuous variables.

Results: There was a statistically significant difference between the educational groups, spouses, and coeducation levels of the women and the mean scores of the Pregnancy Breastfeeding Self-Efficacy Scale. There was a statistically significant difference in the mean total Prenatal Self-Assessment Scale score by training groups ($P = .004$). In the second half of the pregnancy period, compliance with total Prenatal Self-Assessment Scale scores was found to increase ($P = .019$). A positive and weak relationship was found between the Pregnancy Breastfeeding Self-Efficacy Scale score and the Prenatal Self-Assessment Scale score ($r = 0.202$, $P = .017$).

Conclusion: It has been found that the belief in breastfeeding self-efficacy increases significantly as women's compliance with pregnancy increases. In all polyclinics where pregnant women use actively, it is recommended that breastfeeding and breast milk training be widely conducted and that pregnant women are encouraged to use breast milk polyclinic and pregnancy school.

Keywords: Breastfeeding, breastfeeding self-efficacy, pregnancy, pregnancy adaptation

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Introduction

Pregnancy is a process in which women experience physiological, psychological, and social changes. There is a unique psychological adaptation in each of the 3 trimesters making up this process. Emotional changes experienced during pregnancy affect the woman's adaptation to pregnancy as well as the status of experiencing psychological problems. Conditions, such as complications in pregnancy, multiple pregnancies, infertility, role conflicts, moving home, and loss of work and social security, can complicate the process of adaptation to pregnancy and gaining a maternal role.¹⁻⁴

In addition, the woman's employment status and relationship with her family and spouse affect her ability to adapt to new difficulties or needs that may arise during pregnancy. Some studies emphasize that the support received from the social environment and family members plays a significant role in promoting health, preventing health problems, avoiding stress sources, and coping with stress and positively affects pregnancy experience and postpartum process.^{5,6} Social support structures include the size of the support network, types of support (e.g., emotional and instrumental), and people who provide the support. It has been reported that women mostly receive support from their spouses and mothers and that marriage or spouse relationship is an important source of support.⁷ In measuring social support, it is recommended to focus on people closest to the woman and other support systems, and it has been reported that the sincere support received from the spouse or any of the family members helps the woman to experience less stress and affects the growth of the fetus positively.⁷ According to another study, women living in nuclear families have higher levels of adaptation to pregnancy than women living in an

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extended family (a lack of enough support due to a weak relationship with the spouse).⁸

Women's adaptation to pregnancy also affects the process of gaining the role of motherhood. Maternal role acquisition is a process that begins during pregnancy, continues in the postpartum period, and is completed with the formation of maternal identity development.⁶ In a study, it has been emphasized that the level of a mother's satisfaction from marriage is important in the transition to the maternal role.⁷

In the postpartum period, the most important activity of a woman's maternal role is breastfeeding. Breastfeeding is universally the most suitable method for infant feeding in the first year after birth.⁹ According to the data of the 2018 Turkey Demographic and Health Surveys,¹⁰ 59% of babies aged <2 months receive only breast milk, the duration of exclusive breastfeeding is 1.8 months, and the median duration of breastfeeding is 16.7 months. It is also emphasized that 98% of children aged <5 months are breastfed for a while, that 95% of babies aged <2 months are breastfed, that 71% of children aged <5 months are breastfed within the first hour after birth, that 86% are breastfed within the first 24 hours, and that 42% of the infants are given prelacteal feeds (before breastfeeding) after birth. Ip et al.¹¹ found that although mothers breastfed their babies in the first 72 hours after birth, only 25% of them continued breastfeeding. However, the most important and suitable food source for the nutrition of the newborn is breast milk. Therefore, it is important to consider the issue of breastfeeding during pregnancy and to increase the self-efficacy of mothers. As a matter of fact, studies conducted on this subject indicate that the perception of breastfeeding self-efficacy affects breastfeeding success.¹²⁻¹⁴

It is necessary to determine the reasons and factors affecting the low level of breastfeeding and exclusive breastfeeding behavior in Turkey. In this respect, women should be handled with a holistic perspective as of the moment pregnancy is detected. In this context, it will be useful to determine the impacts of adaptation to pregnancy on the perception of breastfeeding self-efficacy. Therefore, this study was conducted to determine the impact of women's adaptation to pregnancy on their perception of breastfeeding self-efficacy.

Material and Methods

This cross-sectional study was conducted between March 1, 2018 and May 30, 2018 in the gynecology and obstetrics outpatient clinic of a public hospital. At the time of the study, no routine training on breast milk and breastfeeding was given in the outpatient clinic, and the breast milk outpatient clinic and pregnancy school were not active.

Study Population and Sample

The population of the study consisted of 9,647 women who gave birth in 2017 in the maternity ward of the hospital where the study was conducted (study population was taken as the total number of births in 2017 because it would be difficult to obtain complete and accurate information owing to repeated presentations of women with pregnancy). The study sample size was calculated as 128 women with pregnancy on the MedicRes software on the basis of a confidence interval of 99% and a p of 0.01 by considering that there would be a minimum correlation r of 0.30 between the mean scores of the Lederman Prenatal Self-Evaluation Questionnaire (PSEQ) and the Breastfeeding Self-Efficacy Scale-Short Form (BSES-SF). A total of 140 women with pregnancy who presented to the public hospital between the dates specified and met the inclusion criteria (those who and whose babies did not have any problems that would prevent breastfeeding, who spoke Turkish, and who did not have a communication impairment) were included in the sample.

Data Collection

The data were collected by the researchers using data collection tools through a face-to-face interview method. It took approximately 15 minutes to collect the data.

Data Collection Tools

Descriptive Information Form: This form was developed by the researchers in line with the literature.^{8,14} There are a total of 18 items on the form questioning sociodemographic, general health, obstetric, breastfeeding, and breast milk information of the women.

Breastfeeding Self-Efficacy Scale-Short Form: The short form of this scale was developed by Dennis¹⁵ in 2003 to evaluate mothers' feeling of self-efficacy in breastfeeding, and Cronbach's alpha value was found to be 0.94. The Turkish adaptation study of the scale was conducted in 2010 by Tokat and Okumuş,¹⁶ Cronbach's α value was reported as 0.86, and it was stated to be reliable. BSES-SF is a 5-point Likert-type scale, where 1 indicates "Not confident at all" and 5 indicates "always confident." The minimum and maximum scores obtained from the scale range between 14 and 70. The higher the score is, the higher the breastfeeding self-efficacy level is. In our study, Cronbach's alpha reliability coefficient of the scale was calculated as 0.87.

Prenatal Self-Evaluation Questionnaire: This scale was developed in 1979 by Lederman¹⁷ to evaluate the adaptation of women with pregnancy to maternity. Cronbach's alpha coefficient of the scale was found between 0.75 and 0.92. The Turkish adaptation study of the scale was conducted in 2006 by Beydağ and Mete,¹⁸ and the Cronbach's alpha coefficient was found to range between 0.72 and 0.85. This 79-item and 4-point Likert-type scale, which assesses adaptation of mothers to pregnancy, consists of 7 subscales, namely, acceptance of pregnancy, definition of motherhood role, the women's relationship with their own mothers, the women's relationship with their husbands, women's birth preparedness, women's fear of birth, and women's concerns for their well-being and those of their babies. Each subscale contains 10-15 items. Negative items are scored in reverse. Each item on the scale is evaluated using a 4-point rating system, and adaptation to pregnancy is evaluated on the basis of the results of these scores. Scores that can be obtained from the scale range between 79 and 316. Low scores show that adaptation to pregnancy is high. Cronbach's alpha coefficients of the scale for different trimesters were found to vary between 0.75 and 0.94 by Lederman. Cronbach's alpha reliability coefficients of the subscales of PSEQ in our study varied between 0.68 and 0.89.

Statistical Analysis

IBM Statistical Package for the Social Sciences (SPSS) 21 software package (IBM Corp.; Armonk, NY, USA) was utilized for data analysis. The normality of the data was tested with the Shapiro-Wilk test, and the homogeneity of variances was tested with Levene's test. Descriptive statistics were expressed as mean, standard deviation, and minimum and maximum values. For the comparison of mean BSES-SF, mean PSEQ, and mean PSEQ subscale scores for 2 independent groups, Student's t -test was used for independent means, and 1-way analysis of variance (ANOVA) was used for >2 independent groups. The Tukey test was employed to identify the group that caused the variance in the findings detected as a result of the 1-way ANOVA. Pearson correlation coefficient was used to determine the relationship between BSES, PSEQ, and PSEQ subscale scores. Cronbach's alpha coefficients were calculated for the reliability of the scales. Statistical significance level was taken as 0.05 in the analysis of the data.

Ethical Aspects

The written permission of the Mersin University Non-Invasive Clinical Research Ethics Committee and the hospital where the study was conducted, and the verbal consent of the participating pregnant women were obtained for the study.

Limitations of the Study

The results of the study can only be generalized to women with pregnancy in the hospital where the study was conducted.

Results

According to the findings, 55.7% of the women with pregnancy in the study were aged between 25 and 34 years, 52.9% were primary school graduates, 91.4% were not working, the husbands of 90.7% were employed, and 85.7% had health insurance. In addition, 74.3% of the women had >1 pregnancy experience, 85.7% were in their 28th-40th gestational week, 82.1% had a planned pregnancy, 75.7% did not have any problem during pregnancy, and 67.9% had not received information about breastfeeding and breast milk (Table 1).

The mean BSES score of the study participants was 51.79 ± 9.50 . There was no statistically significant difference between the overall BSES score of the women and their age, the number of pregnancies, gestational week, breastfeeding, and receiving information about breast milk ($P > .05$) (Table 2).

A statistically significant difference was found between the education levels of the women and their mean BSES scores ($P < .05$). The difference in education levels was observed between the literate-primary school and literate-high school groups. There was a statistically significant difference in terms of mean BSES scores according to the age groups of the husbands and the education level of the husbands ($P < .001$). This difference was observed between the group aged 35-44 years and the groups aged 18-24 and 25-34 years and between the literate and primary and high school groups (Table 2).

The mean PSEQ score of the study participants was 247.86 ± 34.18 . There was no statistical difference between the age groups of the women and their overall PSEQ scores ($P > .05$). The decrease in mean scores obtained from the acceptance of pregnancy, definition of motherhood role, and relationship with own mother subscales as the age of the women with pregnancy increased was statistically significant ($P < .05$). There was a statistically significant difference between the age groups of the women in terms of the mean scores obtained from the fear of birth subscale ($P < .05$). This difference was found between the group aged 18-24 years and the groups aged 25-34 ($P < .01$) and ≥ 35 ($P < .01$) years. There was a significant difference between the age groups of the women in terms of their mean scores from the birth preparedness subscale ($P < .05$). This difference was observed between the groups aged 18-24 and 25-34 years ($P < .05$) (Table 3).

There was a statistically significant difference between the women's mean total PSEQ scores according to their education level ($P < .05$). The difference according to education levels emerged between those who had an undergraduate level of education and those who had above the undergraduate level of education and between those who were literate and those who had primary school levels. In addition, a statistically significant difference was found between the level of education and the mean scores obtained from the acceptance of pregnancy, definition of motherhood role, birth preparedness, and relationship with husband subscales of the PSEQ ($P < .05$) (Table 3).

Table 1. Descriptive Characteristics

Descriptive characteristics	n	%
Age, years		
18-24	46	32.9
25-34	78	55.7
35-45	16	11.4
Education		
Literate	37	26.4
Primary education	74	52.9
High school	19	13.6
University+	10	7.1
Working status		
Yes	12	8.6
No	128	91.4
Working status of husband		
Yes	127	90.7
No	13	9.3
Health insurance		
Yes	120	85.7
No	20	14.3
Number of pregnancies		
Primigravida	36	25.7
Multigravida	104	74.3
Gestational age		
Second trimester	20	14.3
Third trimester	120	85.7
Wanted pregnancy		
Yes	115	82.1
No	25	17.9
Planned pregnancy		
Yes	77	55.0
No	63	45.0
Problems during pregnancy		
Yes	34	24.3
No	106	75.7
Receiving information about breastfeeding		
Yes	45	32.1
No	95	67.9

The examination of the mean total PSEQ scores in terms of the gestational week showed that women's adaptation increased in the second half of pregnancy ($P < .005$). A statistically significant increase was found between women's mean scores obtained from the birth pre-

Table 2. Katılımcıların EÖYÖ Puan Ortalamalarının Tanıtıcı Özelliklere Göre Dağılımı

Descriptive characteristic	BSES-SF Mean±SD	Min-max	P
Age, years			
18-24	49.5 ± 11.02	14-64	F:2.930 P: .057
25-34	52.32 ± 8.82	24-70	
35+	55.75 ± 9.49	37-64	
Education			
Literate ^a	47.65 ± 12.26	14-61	F:3.702 P: .013* a<b,c
Primary education ^b	53.04 ± 7.65	36-67	
High school ^c	55.00 ± 9.08	37-70	
University ^{+d}	51.70 ± 6.83	38-61	
Number of pregnancies			
Primigravida	50.08 ± 6.19	35-63	t:-1.583
Multigravida	52.37 ± 10.36	14-70	P: .117
Gestational age			
Second trimester	50.85 ± 13.95	14-70	t:-0.475
third trimester	51.94 ± 8.61	24-67	P: .636
Receiving information about breastfeeding			
Yes	50.82 ± 9.95	24-67	T:-0.825
No	52.24 ± 9.29	14-70	P: .411
Age of husband			
18-24 ^a	46.17 ± 5.22	35-50	F:6.843 p<.001 a,b<c
25-34 ^b	49.91 ± 10.24	14-64	
35-44 ^c	56.34 ± 7.32	37-70	
45+ ^d	56.00 ± 0.00	56-56	
Education of husband			
Literate ^a	45.00 ± 11.85	14-60	F:9.247 P < .001 a<b,c
Primary education ^b	54.70 ± 7.59	38-70	
High school ^c	53.57 ± 8.74	36-67	
University ^{+d}	49.38 ± 5.95	38-60	

*P < .05; ANOVA, analysis of variance; BSES-SF: Breastfeeding Self-Efficacy Scale-Short Form; F: 1-way ANOVA; max: maximum; Min: minimum; t: t-test in independent groups (Student's t).

paredness, fear of birth, and relationship with own mother subscales of the PSEQ in the second half of pregnancy ($P < .05$) (Table 3).

No statistically significant difference was found between primigravida and multigravida women in terms of their overall PSEQ scores ($P > .05$). The mean scores of women from the acceptance of pregnancy, definition of motherhood role, and relationship with own mother subscales were higher in primigravidas ($P < .05$). On the other hand, the mean scores obtained from the fear of birth subscale were higher in multigravidas than in primigravidas ($P < .05$) (Table 3).

There was no statistically significant difference between the age groups of the husbands and the overall PSEQ score ($P > .05$). A statistically significant difference was found between the mean scores obtained from the acceptance of the motherhood role, birth preparedness, fear of birth, and the relationship with husband subscales and the age groups of husbands ($P < .05$) (Table 3).

A statistically significant difference was found between women's mean overall PSEQ scores according to the education level of their husbands ($P < .05$). This difference was found to emerge between those who had a high school level of education and those who were literate and had primary school education levels. A statistically significant difference was found between the education level of the husbands and the women's mean scores of their concerns about their well-being and those of their babies, acceptance of pregnancy, birth preparedness, fear of birth, relationship with their own mother, and relationship with husband subscales ($P < .05$) (Table 3).

In the study, a positive, weak, and linear relationship was found between participants' BSES and PSEQ scores ($P < .05$). Accordingly, as women's adaptation to pregnancy increased, their sense of breastfeeding self-efficacy increased as well. In addition, their mean BSES scores were found to have a positive linear correlation with the mean scores obtained from the subscales of the PSEQ, with the correlation being weak with concerns for their well-being and those of their babies and being very weak with birth preparedness subscales (Table 4).

Discussion

In our study, which we conducted to determine the impact of women's adaptation to pregnancy on their perception of breastfeeding self-efficacy, it was found that as the level of women's education increased, the subscales of PSEQ, such as maternity role development, birth preparedness, acceptance of pregnancy, and adaptation to pregnancy, also increased (Table 3). Koç et al.¹⁹ found that the educational level of mothers positively affected their maternal role development, and in another study, it was found that women with pregnancy with high education levels had better adaptation to pregnancy and motherhood.⁸ It is envisaged that mothers with a high level of education may try to obtain more information about themselves and their babies and that having information can increase self-confidence and adaptation. In addition, it was determined in our study that as the age of women increased, the fear of childbirth also increased. It is thought that this was caused by increased awareness and risks with age.

Although pregnancy is a natural process, physiological and psychosocial changes in women make this process special. The adaptation of women to these changes presents its own characteristics in each trimester. Symptoms such as nausea, fatigue, and weakness in the first months of pregnancy may negatively impact the mother's adaptation process to this new situation. In addition, this period is a process in which mothers experience fear of not being ready for motherhood and birth. Acceptance of pregnancy and the perception of maternal role increase as birth approaches.²⁰ In our study, it was found that the adaptation of women to pregnancy who were in their 28th-40th gestational week increased and that their scores from the birth preparedness subscale were higher than those of women who were in their 13th-27th gestational week. In addition, their scores from the fear of birth subscale increased.

Having a high sense of self-efficacy makes it easier to reach goals and cope with tasks that require effort. In cases of failure, such people can work on their emotions much faster. According to self-efficacy and breastfeeding self-efficacy theories, the individual's previous experiences, psychological status, examples from the environment,

Descriptive characteristics	Concern for the well-being of self and baby	Acceptance of pregnancy	Identification of a motherhood role	Preparation for labor	Fear of helplessness and loss of control in labor	Relationship with her mother	Relationship with her husband	PSEQ total scale score
Age	Ort±S.S	Ort±S.S	Ort±S.S	Ort±S.S	Ort±S.S	Ort±S.S	Ort±S.S	Ort±S.S
18-24 ^a	26.65 ± 6.32	47.35 ± 6.79	52.20 ± 6.27	27.54 ± 5.64	26.09 ± 5.26	34.28 ± 6.44	35.17 ± 5.80	249.28 ± 31.36
25-34 ^b	25.81 ± 6.87	46.37 ± 9.35	50.59 ± 6.47	30.63 ± 5.73	29.23 ± 5.25	33.86 ± 6.80	33.32 ± 8.13	249.81 ± 35.79
35+ ^c	26.75 ± 6.95	40.25 ± 8.81	47.50 ± 7.79	29.19 ± 6.61	30.94 ± 5.70	29.50 ± 7.38	30.13 ± 7.97	234.25 ± 32.78
F	.0292	4.285	3.100	4.106	7.161	3.227	2.840	1.444
P	.747	.016*	.048*	.019*	.001**	.043*	.062	.239
Dual comparison		c<a.b	c<a	a<b	a<b.c	c<a		
Education								
Literate ^a	25.38 ± 6.14	44.22 ± 9.97	48.08 ± 8.28	31.03 ± 5.49	27.76 ± 5.62	32.32 ± 7.91	31.19 ± 8.49	239.97 ± 37.59
Primary education ^b	25.65 ± 6.7	45.24 ± 8.36	50.81 ± 6.1	28.11 ± 5.7	27.95 ± 4.89	32.91 ± 6.81	33.45 ± 7.38	244.11 ± 31.33
High school ^c	28.84 ± 6.95	50.11 ± 6.97	53.05 ± 3.88	29.79 ± 6.28	29.74 ± 6.11	36.32 ± 5.3	36.05 ± 6.2	263.89 ± 32.63
University ^d	28.20 ± 7.1	50.30 ± 6.41	56.00 ± 2.75	32.90 ± 6.45	31.50 ± 7.78	36.90 ± 2.42	38.50 ± 1.96	274.30 ± 24.61
F	1.675	3.039	5.249	3.457	1.777	2.514	3.549	4.689
P	.175	.031*	.002**	.018*	.154	.061	.016*	.004**
Dual comparison		a.b<c	a<c.d	b<a.d			a<d	a.b<d
Gestational age								
Second trimester	24.05 ± 6.86	44.20 ± 9.62	50.00 ± 5.69	24.15 ± 4.70	25.60 ± 5.42	30.20 ± 7.17	33.10 ± 7.20	231.3 ± 32.53
Third trimester	26.55 ± 6.59	46.29 ± 8.58	50.89 ± 6.82	30.33 ± 5.66	28.86 ± 5.44	34.05 ± 6.68	33.64 ± 7.60	250.62 ± 33.79
t	-1.561	-0.992	-0.553	-4.621	-2.483	-2.487	-0.297	-2.379
P	.121	.323	.581	<.001**	.014*	.020*	.767	.019*
Number of pregnancies								
Primigravida	25.81 ± 6.81	48.69 ± 5.84	52.89 ± 5.02	28.61 ± 6.03	26.00 ± 5.51	35.50 ± 4.93	34.31 ± 6.19	251.81 ± 26.29
Multigravida	26.33 ± 6.65	45.06 ± 9.37	50.03 ± 7.01	29.74 ± 5.90	29.22 ± 5.32	32.81 ± 7.30	33.31 ± 7.94	246.49 ± 36.52
t	-0.403	2.717	2.639	-0.984	-3.102	2.470	0.772	0.939
P	.687	.008**	.010*	.327	.002**	.015*	.442	.350
Age of husband								
18-24 ^a	25.05 ± 8.62	47.58 ± 7.46	55.92 ± 3.68	27.17 ± 6.03	25.25 ± 5.69	35.17 ± 6.03	34.33 ± 4.98	250.92 ± 31.01
25-34 ^b	25.54 ± 5.94	46.03 ± 8.57	50.39 ± 6.79	28.60 ± 5.93	27.36 ± 5.21	33.43 ± 6.55	34.23 ± 7.31	245.56 ± 34.24
35-44 ^c	27.32 ± 7.52	45.77 ± 9.69	50.59 ± 6.38	32.05 ± 5.23	31.14 ± 5.27	33.93 ± 7.50	33.23 ± 8.01	254.02 ± 34.68
45+ ^d	29.00 ± 2.00	43.00 ± 4.69	44.75 ± 7.09	24.75 ± 3.20	28.25 ± 2.87	25.25 ± 2.22	21.75 ± 1.26	216.75 ± 21.17
F	0.954	0.295	3.790	5.221	6.512	2.289	3.780	1.763
P	.416	.829	.012*	.002**	<.001	.081	.012*	.157
Dual comparison			b.d<a	a.b<c	a.b<c		d<a.b.c	
Education of husband								
Literate ^a	24.23 ± 6.12	45.23 ± 9.42	49.67 ± 7.02	30.87 ± 4.39	27.17 ± 5.02	32.93 ± 7.95	30.07 ± 8.27	240.17 ± 35.44
Primary education ^b	25.29 ± 6.87	44.06 ± 9.28	50.14 ± 7.14	28.00 ± 6.30	27.50 ± 5.49	32.02 ± 7.29	33.18 ± 7.62	240.18 ± 34.09
High school ^c	28.50 ± 5.68	50.25 ± 5.37	52.50 ± 3.75	30.00 ± 5.86	30.79 ± 5.69	36.46 ± 4.73	36.82 ± 4.84	265.32 ± 24.1
University ^d	29.56 ± 6.61	47.94 ± 7.33	52.38 ± 7.58	31.81 ± 5.95	30.19 ± 5.08	35.50 ± 3.48	36.00 ± 6.88	263.38 ± 33.31
F	3.992	3.864	1.425	2.928	3.555	3.472	4.911	5.673
P	.009**	.011*	.238	.036*	.016*	.018*	.003**	.001**
Dual comparison	a<d	b<c		b<d	b<c	b<c	a<c.d	a.b<c

The dual comparison was performed with the Tukey test; **P* < .05 and ***P* < .01. ANOVA: analysis of variance; PSEQ: Prenatal Self-Evaluation Questionnaire; t: t-test in independent groups (Student's t), F: 1-way ANOVA

Table 4. Comparison of the Participants' Mean Scores of BSES-SF and Their Mean Scores of PSEQ and its Subscales

		BSES-SF	Concern for the well-being of self and baby	Acceptance of pregnancy	Identification of a motherhood role	Preparation for labor	Fear of helplessness and loss of control in labor	Relationship with her mother	Relationship with her husband
Concern for the well-being of self and baby	r	.219							
	P	.009**							
Acceptance of pregnancy	r	.134	.308						
	P	.115	<.001						
Identification of a motherhood role	r	.036	.210	.714					
	P	.673	.013*	<.001					
Preparation for labor	r	.188	.411	.407	.367				
	P	.026*	<.001	<.001	<.001				
Fear of helplessness and loss of control in labor	r	.324	.612	.372	.298	.631			
	P	<.001	<.001	<.001	<.001	<.001			
Relationship with her mother	r	.044	.148	.594	.529	.355	.276		
	P	.605	.080	<.001	<.001	<.001	.001**		
Relationship with her husband	r	.109	.293	.580	.549	.264	.341	.508	
	P	.200	<.001	<.001	<.001	.002**	<.001	<.001	
PSEQ Total scale score	r	.202	.580	.832	.757	.661	.675	.703	.735
	P	.017*	<.001	<.001	<.001	<.001	<.001	<.001	<.001

* $P < .05$ and ** $P < .01$; r: Pearson correlation. BSES-SF: Breastfeeding Self-Efficacy Scale-Short Form; PSEQ: Prenatal Self-Evaluation Questionnaire.

and social support impact perception of self-efficacy.²¹ It has been reported that women with low breastfeeding self-efficacy are 3 times more likely to stop breastfeeding before 6 months than women with high breastfeeding self-efficacy.²¹ Studies have reported that mothers with high breastfeeding self-efficacy beliefs follow complete and longer breastfeeding.²²⁻²⁵ In addition, breastfeeding self-efficacy is a dynamic process; it can be increased, and it is among the top factors that can affect women's breastfeeding decisions.^{24,26} Prenatal breastfeeding self-efficacy scores of mothers predict exclusive breastfeeding after birth.²⁷ In our study, the mean BSES score of women with pregnancy was found to be 51.79 ± 9.50 (Table 2). No significant difference was found between age, gestational week, number of pregnancies, and getting information about breastfeeding and breast milk and breastfeeding self-efficacy ($P > .05$). Some studies have reported that characteristics, such as women's age, education level, gestational age, employment status, and the number of pregnancies, do not affect breastfeeding self-efficacy.^{25,28,29} In other studies conducted for similar purposes, it was found that as the number of pregnancies and the age of mothers increased, the mean scores obtained from breastfeeding self-efficacy increased as well.^{27,30} According to our findings, although there was no significant difference between them, it was observed that women had more confidence in themselves in terms of breastfeeding as their age and the number of pregnancies increased. This situation is thought to be related to experience. In addition, in our study, it was found that the breastfeeding self-efficacy perception of women who and whose husbands had a low level of education was found to be significantly lower ($P < .05$). In the study conducted by

Akkoyun and Arslan,³⁰ it was found that as the educational level of mothers increased, their breastfeeding self-efficacy increased as well, which supports our findings. Breastfeeding attitude and social support are potential determinants of breastfeeding self-efficacy.²⁸ In this context, practices implemented during pregnancy that will increase breastfeeding intentions, self-efficacy, and social support promote successful and long-term breastfeeding.³¹ However, current breastfeeding strategies of healthcare professionals often include social support, but attempts to change breastfeeding intention and self-efficacy are not addressed adequately.²⁶ Midwives and nurses have great potential to strengthen women's breastfeeding self-efficacy. It is thought that the continuation of evidence-based breastfeeding counseling starting from the pregnancy period to the postpartum period may increase the exclusive breastfeeding rates and women's sense of achievement. In a study, it was found that a training program based on breastfeeding self-efficacy theory increased breastfeeding success.¹⁶

Pregnancy is a challenging process in which physiological and psychological balance changes and the woman with pregnancy attempts to adapt to new roles.³² Many questions that cause anxiety in mothers and fathers arise during pregnancy. Although conflicting questions about the baby's health, mother's health, acceptance of pregnancy, or parenting cause fear and anxiety, they also prepare the ground for the birth and parenting process. The release of emotional energy facilitates the woman's adaptation to pregnancy and motherhood and strengthens the bond between her and the baby.³³ Increased adaptation of the woman to pregnancy and strengthening her self-confidence play an important role in mother-baby attachment. It is known that women

who have a higher adaptation to the gestational period are more confident in performing their maternal roles in the postpartum period.³⁴ In our study, it was found that breastfeeding self-efficacy increased significantly as the adaptation to pregnancy increased ($P<.05$) (Table 4). In addition, it was determined that breastfeeding self-efficacy of women with pregnancy was affected by birth preparedness, fear of birth, and concerns for the woman's well-being and that of her baby. The first stage of preparing for the maternal role is attachment and preparation for the baby during pregnancy.³² Breastfeeding support is important in the attachment. Evaluation of the negative feelings of the woman with pregnancy about the process she's experiencing and her sustainment should be done in antenatal follow-ups and especially in preparation training for birth.³³ For this reason, it is thought that to increase breastfeeding self-efficacy and adaptation to pregnancy, evidence-based training programs should be provided during pregnancy, childbirth, and postpartum periods and that women should be given support and that this support should continue in the postpartum period. Visger³⁵ found that social support (especially from the spouse and mother) and supportive midwifery care were the most important determinants in increasing the adaptation of women to pregnancy. The most important indicator of high-quality antenatal care is the adaptation of the woman to changes in pregnancy, which is ensured by the health professional.³³ In the study carried out by Baghdarivd,³⁶ it was determined that the training, which was different from the standard training, increased the scores for adaptation to pregnancy and maternal-fetal attachment. It is important that the services provided have a standard, but the services provided (training/consultancy) should be given by considering personal factors so that the training provided can be adopted and behavioral changes can be created.

In conclusion, it was found in our study that as the educational level of women increased, maternal role development, birth preparedness, acceptance of pregnancy, and adaptation to pregnancy increased as well and that as the age increased, the fear of birth increased, too. In addition, it was observed that the pregnant women in the last trimester exhibited higher adaptation to pregnancy and birth preparedness than those in the second trimester and that their scores from the fear of birth subscale increased. The difference between breastfeeding self-efficacy and age, gestational week, number of pregnancies, breastfeeding, and getting information about breast milk was found to be insignificant. It was observed that women had more confidence in themselves regarding breastfeeding as their age and the number of pregnancies increased, and it was found that breastfeeding self-efficacy increased significantly as the adaptation to pregnancy increased. Besides, it was determined that there was a positive correlation between the breastfeeding self-efficacy of women with pregnancy and their concerns for the well-being of themselves and of their baby, birth preparedness, and fear of birth.

In line with the results obtained from this study, we recommend that health professionals should provide breastfeeding and breast milk training in all polyclinics that are in close contact with pregnant women, that the training provided to health professionals should be reviewed and improved accordingly, that pregnancy schools and breast milk and breastfeeding polyclinics should be activated, and that pregnant women should be encouraged to use these services.

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Informed Consent: Researchers obtained informed verbal consent from pregnant women participating in the study.

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