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The Examination of Psychological Well-Being in Pregnant Women in Terms of Demographic and Pregnancy-Related Features and Self-Compassion

Fadime Kaya[1], İdil Yaren Akdoğan[2]

[1]Division of Psychiatric Nursing, Department of Nursing, Kafkas University Faculty of Health Sciences, Kars, Turkey
[2]Department of Nursing, Kafkas University Faculty of Health Sciences, Kars, Turkey

Abstract

Aim: The aim of this research is to determine the effects of self-compassion is associated with psychological well-being.

Methods: This research was carried out in a cross-sectional design. Research sampling consisted of 337 pregnant women in gynecology and obstetrics service, non-stress test unit, and maternity wards of a state hospital. Research data were collected via Pregnancy Information Form, Psychological Well-Being Scale, and Self-Compassion Scale-Short Form. In data analysis frequency, mean and standard deviation, Kruskal–Wallis H test, Mann–Whitney *U* test, and Spearman's rho correlation analysis were performed.

Results: Mean age of pregnant women was found to be 26.97 ± 5.36 years. The total Psychological Well-Being Scale mean score of pregnant women was 45.21 ± 7.08 and the total Self-Compassion Scale-Short Form mean score was 37.14 ± 6.70. A statistically significant difference ($P < .05$) was measured between pregnant women's education level, employment status, the place of residence, income level, family type, the number of children, satisfaction with the relationship with partner, and the total score obtained from psychological well-being. It was also identified that a statistically significant relationship in positive direction ($P < .05$) prevailed between the Psychological Well-Being Scale and Self-Compassion Scale-Short Form scores of pregnant women.

Conclusion: In this research, major effects of demographic, pregnancy-related features, and self-compassion on the psychological well-being of pregnant women have been documented.

Keywords: ***Pregnancy, psychological well-being, self-compassion, woman***

Introduction

Mental health is defined as the state of well-being in which every individual can realize his/her own potential, can manage usual stress of daily life, work productively and efficiently, and offer a contribution to society at large.[1] Well-being is a multi-faceted structure necessitating to consider living and functioning at optimal level. In 1 study on the well-being concept, it was stated that the concept was formed on the basis of 2 points of view: the first viewpoint is *hedonic approach* focusing on happiness and pleasure-seeking while avoiding pain and the second viewpoint is *eudemonism approach* defining the well-being of an individual dedicated to grasping and self-realization with respect to full-functionality level.[2,3] Ryff[4] reports that psychological well-being integrates these dimensions: self-acceptance, positive interpersonal relationships, autonomy, environmental command, life purpose, and self-development. These dimensions allow individuals to play an active and contributive role in their own life cycle.[5]

Allan et al[6] conceptualized the well-being notion (perinatal well-being) during the pregnancy period. Perinatal well-being is a multi-dimensional and multi-faceted construct. That being said, well-being in this period involves "the time interval between pre and post laboring, in terms of physical, psychological, social, spiritual, economic, and environmental aspects, a subjective cognitive and/or affective self-evaluation of one's personal life."[6,7] Well-being concept is particularly critical for pregnant women. Throughout the pregnancy period, in order to acknowledge the arrival of a new human being, it is a must

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Corresponding author: Fadime Kaya
E-mail: fadimee36@hotmail.com

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to establish and improve the physical and emotional bond between the mother and the baby.[8] The period of pregnancy and childbirth is a struggle physiological and psychological challenge in which various biological changes emerge in tandem with hard and intense sentimental transfers.[6] Perinatal period is a transition stage, and perinatal well-being of mothers is vital not only for their own goodness but also for the welfare of newborn and family.[8] Psychological well-being of pregnant women affect their emotional state and this state, in turn, plays a vital role in fetal development, birth-giving, and successful adaptation of new mother into the post-partum period.[9] Based on this definition, the pregnancy period could be acknowledged as a transition stage in a woman's life and may be associated with a woman's emotional and psychological state. An impaired mental health during the pregnancy period affects a woman's life-long health condition as well as the well-being of her children and her family. During the pregnancy period, mothers and fathers cultivate expectations and aspirations for their prospective child but both the mother and father also feel stressful (in the first child at most) against all mysteries related to pregnancy. Parents are too anxious about specific aspects (baby's health, pregnancy period, birth-giving, finances, relationship with the partner, etc.) of pregnancy period and these worries collectively can affect their psychological well-being.[9,10]

In recent years, there has been a rise in the number of researches related to the benefits of self-compassion on psychological health. Since the publication of first paper on the topic by Neff[11], more than 1600 papers and dissertations on self-compassion have been documented. Self-compassion, in its simplest definition, is channeling one's tenderness to inner-self.[12] Neff[11] described self-compassion in a way to entail 3 main aspects: "self-kindness, common humanity, and mindfulness." These dimensions unite to form a logical frame of self-compassion and interact reciprocally. Self-compassion plays a vital role not only in unexpected life experiences, often painful, but also in personal problems, mistakes, and failures too. There is an increasing number of evidence on the predictive role self-compassion plays in psychological well-being during different stages of human life.[13-17]

In the direction of the results findings above, it is detected that psychological well-being during the pregnancy period is closely linked with women's mental health and welfare of their children and family. Recognizing the value of self-compassion for mental health, it would be vital to demonstrate its contribution, with other crucial factors, to psychological well-being during the pregnancy period, known to be a transition stage in women's life. Hence, in this research, it was aimed to determine the effects of self-compassion and demographic and pregnancy-related features on the psychological well-being of pregnant women. In line with this objective, the following questions have been sought for answers:

- Among pregnant women, what is the level of psychological well-being?
- Among pregnant women, what is the level of self-compassion?
- Do demographic and pregnancy-related features play a role in the psychological well-being of pregnant women?
- Does self-compassion play a role in the psychological well-being of pregnant women?

Material and Method

This research was carried out in a cross-sectional design.

Research Population and Sampling

This research was conducted between September 1, and December 30, 2019, in a state hospital in Kars city. The number of childbirths in Kars city was 5661. Sampling was not assigned from population; instead, random sampling method was administered and pregnant women having applied to the hospital in the 4-month period and meeting the inclusion criteria of the research were included in the research. The sampling of this research constituted 337 volunteering pregnant women who were above age 18 and treated in the gynecology and obstetrics services, non-stress test (NST) units, and maternity services of the hospital. In order to measure the adequacy of sampling size, power analysis was conducted via G*Power program and result was computed as 95.5%.

Data Collection Tools

Data collection tools are Pregnancy Information Form, Psychological Well-Being Scale (PWBS), and Self-Compassion Scale-Short form (SCS-SF). Research data were gathered via face-to-face data collection method.

Pregnancy Information Form

Pregnancy Information Form was designed by researchers themselves. The form contained a total of 15 questions; 8 questions on the demographic features of participants (age, income level, education level, employment status, family type, the number of children, and the place of residence), 5 questions assessing the features on current/previous pregnancy (the total number of pregnancy, pregnancy weeks, if any risks are involved in the current pregnancy, if any risks are involved in the previous pregnancy, and the presence of any previous miscarriage/abortion), 2 questions analyzing the presence of a previous psychiatric disease and treatment story, and 1 question examining satisfaction with the relationship with the partner. In measuring satisfaction with the relationship with the partner, participants were asked to respond to the question "how do you evaluate your relationship with your partner?" by choosing one of the options: "strongly unsatisfied, somehow satisfied, strongly satisfied, and quite satisfied."

Psychological Well-Being Scale

Psychological Well-Being Scale developed by Diener and his colleagues (2009) consists of 8 items that define a range of vital components of human functions from the positive relationship, and the feeling of competency to leading a meaningful and purposeful life.[18] Items in PWBS are answered in between 1 and 7 points as: strongly disagree (1) to strongly agree (7). All items are stated in the positive form. Scores range from 8 to 56. Higher scores indicate that the person possesses multiple psychological sources and power. Although this scale fails to provide distinctive measures on all aspects of psychological well-being, it manages to offer a generic perspective on various positive functions in varied domains which we deem important.[19] Cronbach's alpha coefficient of the scale of Turkish language validity and reliability analysis conducted by Telef[20] was 0.80. In the current research, Cronbach's alpha coefficient is measured as 0.75.

Self-Compassion Scale-Short Form

Self-Compassion Scale-Short Form was developed by Raes et al[21] in 2011. This scale is formed with items retrieved from Self-Compassion Scale with 26 items.[11] In order to prepare the short form, 2 items were

integrated into the scale for every subcomponent of self-compassion. Of all these, subcomponents positive factors are self-kindness, common humanity, and mindfulness, while negative ones are self-judgment, isolation, and overidentification. Thus, a 12-item SCS-SF having both positive and negative components could be formed. It was suggested that this short form of the scale could be particularly useful in researches where the total score is computed. Turkish language validity and reliability analysis of the scale was conducted by Yildirim and Sari.[22] At the end of exploratory factor analysis, the scale explained 29.88% of the total variance of negative items and 14.99% of the total variance of positive items. Thus, 2 factors in combination explain 44.87% of the total variance. At the end of the reliability analysis, Cronbach's alpha coefficient was computed as 0.80. At the end of statistical analysis, Cronbach's alpha coefficient of the first subfactor in SCS-SF was computed as 0.73 and Cronbach's alpha coefficient of the second subfactor was computed as 0.71. Cronbach's alpha coefficient of the total scale was computed as 0.75.[22] In the current study, Cronbach's alpha coefficient was 0.69 for the first subfactor, 0.63 for the second subfactor, and 0.70 for the total scale.

Research Variables

Dependent and independent variables of the research are as listed below:

Dependent variable: the total score of the PWBS.

Independent variables: the total score of the SCS-SF, and demographic and pregnancy-related features of participants.

Data Analysis

Data collected from this study were analyzed via Statistical Package for the Social Sciences 20.0 program (IBM SPSS Corp.; Armonk, NY, USA). For constant variables, mean and standard deviation and for categorical variables, frequency, and percent values were computed. Data set was identified not to exhibit normal distribution between ±3 kurtosis and skewness value.[23] For difference statistics, the total score of PWBS was taken. Two-category variables and PWBS difference was analyzed via Mann–Whitney *U* test, the difference between variables with more than 2 categories and PWBS was analyzed via Kruskal–Wallis H test. The relationship between the total score of the PWBS and the total score of Self-Compassion Scale was tested via Spearmen's rho correlation analysis. Statistical significance value was accepted as $P < .05$.

Ethical Concerns

Ethical approval was requested on March 29, 2019 (81829502.903/42) from Ethics Committee of Kafkas University Faculty of Health Sciences as well as an institutional license from Provincial Directorate of Health was granted for the health establishment where the research took place. A utilization permit was acquired for the implemented scales in the research. The aim of the research was communicated to all research participants, both verbally and in written, prior to acquiring their informed consent.

Results

Demographic and pregnancy-related features of pregnant women are as exhibited in Table 1. It was seen that of all participants. 32.9% were middle school graduates, 83.8% were not employed, 44.8% resided in a village, 65.3% lived in a nuclear type of family, 53.1% gained an income level equal to expenses, 76.2% felt quite satisfied with their partner relationship, 97.0% had no previous history of psychiatric disease, and 97.9% had no history of psychiatric treatment. Of all pregnant women, 72.1% reported that it was not their first pregnancy, 68.5% were in their third trimester, 79.8% had no risks involved in their current pregnancy, 81.8% experienced no adversity in their previous pregnancy, and 70.6% had no history of miscarriage or abortion (Table 1).

Table 2 demonstrates total mean scores of pregnant women in Psychological Well-Being Scale and Self-compassion Scale-Short Form. It was identified that among pregnant women Psychological Well-Being Scale total mean score was 45.21 ± 7.08 and Self-compassion Scale-Short Form total mean score was 37.14 ± 6.70 (Table 2).

Table 3 depicts a comparison of total scores between demographic and pregnancy-related features and Psychological Well-Being Scale of pregnant women. Accordingly there is a statistically significant difference or relationship ($P < .05$) between pregnant women's education level, employment status, place of residence, income level, family type, number of children, satisfaction with the relationship with partner and their total score from Psychological Well-Being Scale. On the other hand it was identified that not a statistically significant difference prevailed ($P > .05$) between participants' age, previous psychiatric disease or treatment story, state of first pregnancy, pregnancy week, presence of a risky/negative situation in current and previous pregnancy, previous miscarriage/abortion story and total score received from Psychological Well-Being Scale.

Table 4 displays the correlation between Psychological Well-Being Scale and Self-compassion Scale-Short Form. In that case, there is a weak and positive-direction statistically significant relationship between Psychological Well-Being Scale and Self-Compassion Scale--Short Form ($P < .05$).

Discussion

In this research conducted to determine if or not self-compassion, and demographic and pregnancy-related features played a role in the psychological well-being of mothers, it was identified that total PWBS mean scores of pregnant women were 45.21 ± 7.08. In Radhakrishnan's[24] study, it was reported that the psychological wellness status was normal among 97.8% of pregnant women, while 2.24% of women reported to undergo a problem. Maaly Ebrahim et al[25] stated in a research on increasing the psychological well-being of pregnant women that prior to the intervention, the psychological well-being mean score was 31.46 ± 0.45. Scores of the PWBS employed in this research varied between 8 and 56. As known, in parallel with the increase in total score, there is a corresponding rise in psychological well-being score.[20] In that sense, it can be argued that among pregnant women, psychological well-being is at a high level.

As stated in the first research question of this study, the correlation between certain sociodemographic features of pregnant women and their psychological well-being score was examined. Accordingly, it was detected that compared to pregnant women with lower education level (middle school, elementary school, and illiterate) psychological well-being scores were statistically higher among pregnant women with higher-education level (high school graduate or university graduate). It was determined that during the pregnancy period, the psychological well-being status of women with higher education level was much greater than women with lower education level.[26] Increased

Table 1. Distribution of Demographic and Pregnancy-Related Features of Pregnant Women

Variables	$\bar{x} \pm SD$	Min-Max
Age	26.97 ± 5.36	18-43
Number of children	1.97 ± 1.15	1-8
	n	%
Education level		
Illiterate	17	5
Elementary School	59	17.5
Middle school	111	32.9
High school	83	24.6
University and similar higher education institutes	67	19.9
Employment status		
Yes, I am employed	54	16.2
No, I am not employed.	280	83.8
Place of residence		
City	124	37
District	61	18.2
Village	150	44.8
Family type		
Nuclear family	220	65.3
Extended family	115	34.1
Single-parent family	2	0.6
Income level		
Income < expenses	131	38.9
Income=expenses	179	53.1
Income > expenses	27	8
Satisfaction with the relationship with partner		
Strongly unsatisfied	3	0.9
Somehow satisfied	14	4.2
Strongly satisfied	63	18.8
Quite satisfied	256	76.2
Previous history of psychiatric disease		
Yes	10	3
No	327	97
Previous history of psychiatric treatment		
Yes	7	2.1
No	330	97.9
Is this the first pregnancy?		
Yes	94	27.9
No	243	72.1
Pregnancy week		
1-13	33	9.9
14-26	72	21.5
27-41	230	68.5
If any risks are involved in the current pregnancy		
Yes	68	20.2
No	268	79.8
If any risks are involved in the previous pregnancy		
Yes	61	18.2
No	274	81.8
Previous history of miscarriage/ abortion		
Yes	99	29.4
No	238	70.6

$\bar{x}$, mean; SD, standard deviation; min, minimum; max, maximum.

levels in education and health were also recognized as increased levels in psychological well-being[27]and it was reported that there was a correlation between low education level and anxiety.[28] Existing literature also verified that low education level may constitute a risk factor for psychological well-being during the pregnancy period. Obtained results from current research are also in parallel with relevant literature. It can thus reasonably be argued that in line with higher education level there might be elevated awareness among pregnant women with respect to both their physical and mental health needs.

Table 2. Psychological Well-Being and Self-Compassion Mean Scores of Pregnant Women

Scales	$\bar{x} \pm SD$	Median	Min-Max
Psychological Well-being Scale	45.21 ± 7.08	46.00	8-56
Self-Compassion Scale-Short Form	37.14 ± 6.70	37.00	14-55

$\bar{x}$, mean; SD, standard deviation; min, minimum; max, maximum.

Another independent variable of this study is related to employment status of pregnant women and according to this variable, among employed pregnant women, psychological well-being score is higher than unemployed pregnant women (Table 2).[29] There are literature[24,30] studies evidencing that employment status leads to a difference in psychological well-being but other researchers also suggest that there does not exist any relationship between employment status and psychological well-being during pregnancy.[26] In the current

Table 3. Psychological Well-Being Score of Pregnant Women with Respect to Demographic and Pregnancy-Related Features

	Psychological Well-Being Scale				
Variables	n	Median	KWX^2/Z	*P*	Intergroup Comparison
Education level					
Illiterate[1]	17	42	21.487	**.000***	4 > 1
Literate/elementary school[2]	59	46			5 > 1.2.3
Middle school[3]	111	46			
High school[4]	83	46			
University/Master's[5]	67	47			
Employment status					
Yes, I am employed[1]	54	49	−5.114	**.000***	1 > 2
No, I am not employed[2]	280	46			
Place of residence					
City[1]	124	47	16.264	**.000***	1 > 3
District[2]	61	46			
Village[3]	150	45			
Income level					
Income < expenses[1]	131	45	30.237	**.000***	2 > 1
Income=expenses[2]	179	47			3 > 1.2
Income > expenses[3]	27	53			
Family type					
Nuclear family[1]	220	47	14.790	**.001***	1 > 2
Extended family[2]	115	45			
Single-parent family[3]	2	36.50			
Satisfaction with the relationship with partner					
Strongly unsatisfied[1]	3	39	25.678	**.000***	4 > 2.3
Somehow satisfied[2]	14	41			
Strongly satisfied[3]	63	44			
Quite satisfied[4]	256	47			
Previous history of psychiatric disease					
Yes	10	43.50	−1.553	.120	
No	327	46			
Previous history of psychiatric treatment					
Yes	7	44	−0.916	.360	
No	330	46			
Is this the first pregnancy?					
Yes	94	47	−1.874	.061	
No	243	46			
Pregnancy week					
1-13	33	46	1.139	.566	

(*Continued*)

Table 3. Psychological Well-Being Score of Pregnant Women with Respect to Demographic and Pregnancy-Related Features (*Continued*)

	Psychological Well-Being Scale				
Variables	n	Median	*KWX²/Z*	*P*	Intergroup Comparison
14-26	72	47			
27-41	230	46			
If any risks are involved in current pregnancy					
Yes	68	46	−1.128	.260	
No	268	46.50			
If any risks are involved in previous pregnancy					
Yes	61	46	−0.032	.975	
No	274	46			
Previous history of miscarriage/abortion					
Yes	99	46	−0.439	.661	
No	238	46			
		$\bar{x}$ ±Sd	*r*	*P*	
Age	337	26.97±5.36	0.023	.666	
Number of children	234	1.970±1.15	-0.209	**.001***	

KWX², Kruskal–Wallis H test; *Z*, Mann–Whitney U test; $\bar{x}$, mean; SD, standard deviation; *r*, Spearman's Rho correlation coefficient. **P* < .05.

study, it was determined that the psychological well-being score was higher among pregnant women residing in the city than women living in villages. That result could be attributed to the fact that in rural areas transportation means to healthcare services are limited. Particularly among deprived and vulnerable communities residing in distant and remote locations with limited access to healthcare services, it is an acknowledged fact that maternal mortality rates are much higher.[31] It is suggested that since in the present study pregnant women residing in city center have easier means to accessing healthcare services, their psychological well-being might have been elevated. It was also identified here that compared to women with lower income level, psychological well-being of pregnant women whose income levels were equal or greater was significantly higher. In a research, it was detected that during transition to motherhood, social support and subjective well-being were much lower among pregnant women with poor finances and having recently given birth.[32] In the thematic analysis of the same study, economic problems and negative self-judgment were detected as the risk factors against one's well-being. Considering that a new member is about to join the family with already-low finances, it is likely that pregnancy period could have been perceived as a risk factor. It became apparent in this study that women with nuclear family structure obtained higher psychological well-being scores than women with an extended family structure. At the same time in contrast to higher numbers of children, there was lower level of psychological well-being score of pregnant women. Unlike this research we conducted, there are some studies indicating that there exists no correlation between the family type, the number of children,[26] and well-being during the pregnancy period. The results we collected are also conflicting with present literature stating that among adults, widows and divorcees undergo greater difficulties than those still married. Results of our research unveil that pregnant women having nuclear family and fewer numbers of children can acquire greater advantages in terms of psychological well-being. This is a finding similar to the results of this study highlighting that finances and women's employment status play a role in their psychological well-being.

Table 4. Correlation Between Psychological Well-Being Scale and Self-Compassion Scale-Short Form

Scales	$\bar{x}$ ± SD	*R*	*P*
Psychological Well-Being Scale	45.21 ± 7.08	-	-
Self-Compassion Scale-Short Form	37.14 ± 6.70	0.364**	.000

$\bar{x}$, mean; SD, standard deviation; *r*, Spearman's Rho correlation coefficient. ***P* < .001.

In this research, as the level of satisfaction with the relationship with partner increased, so did women's psychological well-being score. Ilska and Przybyła-Basista[9] identified partner support as the most powerful predictor of psychological well-being in 5 domains (environmental command, life purpose, personal development, inter-personal positive relationships, and self-acceptance). In their research, Li et al[33] listed social support components with the greatest effect on perinatal depression such as "support of partner," "support of close friends," and "support of colleagues." They suggested that among Chinese pregnant women, family support could be a protective shield against perinatal depression. The Turkey research by Bilgen and Tekin[34] likewise evidenced that marital harmony played a role in alleviating the depression during the last trimester of pregnancy.[34] In another study, the correlation was identified between weak family support and anxiety during pregnancy.[28] The results of this study are

similar to the results of previous research, which emphasized that social support from the spouse is particularly effective in ensuring the health and well-being of pregnant women.

In the second research question, it was detected that as pregnant women's self-compassion scores increased, there was also a statistically significant increase in their psychological well-being scores. Similarly, current literature also documents the correlation between positive psychological outcomes such as self-compassion, psychological well-being, happiness, and awareness.[35,36] In its simplest definition, self-compassion is affection directed to inner self. It means replicating the compassion, inquisition, and support shown to a dear friend for self-healing. When facing tough challenges in life or personal mistakes, self-compassion means acknowledging that mistakes are normal parts of human life and instead of judging oneself, it requires being kind to him/herself.[12] During pregnancy when these women avoid self-judgment but instead act compassionately, they may no longer feel alone and live their life with full-awareness of their emotions and it is suggested that this acceptance might well have been reflected on their psychological well-being.

Limitations

Current research has certain limitations. Firstly, because of the design pattern of the research, there exists no causality relationship with obtained outcomes. The second limitation is that sampling of the research could only be generalized within the context of Kars city. The third and last limitation of this research is that women having received psychiatric treatment or psychiatric disease story were likewise included in the research.

Conclusion

In the present research, it became apparent that among pregnant women, self-compassion correlates with psychological well-being, and as self-compassion score climbs higher, the psychological well-being score also escalates. Furthermore, it was identified that psychological well-being scores are higher among pregnant women with higher education level, having a job, living in city, having sufficient or higher income level, living with a nuclear family, having fewer numbers of children, and maintaining a satisfied relationship with partner. In order to generalize the results of this study, it can be reiterated in a larger sampling model across different regions among normal and high-risk pregnant women. In addition, it is suggested to draw a comparative research to analyze psychological well-being during pregnancy and after giving birth. With this research, it was aimed to underline certain aspects that can affect psychological well-being of women during their transition stage to motherhood. It is suggested to utilize these insights in developing intervention programs that can protect and improve maternal mental health.

Ethics Committee Approval: Ethics committee approval was received for this study from the Ethics Committee of Kafkas University Faculty of Health Sciences. (29.03.2019-81829502.903/42).

Informed Consent: Written informed consent was obtained from the patients who volunteered to participate in the study.

Peer-review: Externally peer-reviewed.

Author Contributions: Concept – F.K.; Design – F.K.; Supervision – F.K.; Resources – İ.Y.A.; Materials – F.K., İ.Y.A.; Data Collection and/or Processing – F.K., İ.Y.A.; Analysis and/or Interpretation – F.K.; Literature Search – F.K., İ.Y.A.; Writing Manuscript – F.K.; Critical Review – F.K., İ.Y.A.

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