

## ORIGINAL ARTICLE

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## The impact of perceived social support on maternal–infant bonding in the postpartum period

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### Abstract

The study aimed to assess whether mothers' perceptions of social support influence the quality of maternal–infant bonding after childbirth. A descriptive and correlational design was employed. The study was conducted between June and December 2024 with mothers of infants aged 1–4 months who attended the obstetrics, gynecology, and pediatrics outpatient clinics of Erzincan Binali Yıldırım University (EBYU) Mengücek Gazi Training and Research Hospital. The sample size was calculated as 471 using Epi Info with a 5% margin of error and 97% confidence level; the study was completed with 505 mothers. Data were collected through face-to-face interviews using the Descriptive Information Form, the Multidimensional Scale of Perceived Social Support (MSPSS), and the Maternal Attachment Inventory (MAI). The participants' mean age was  $30.04 \pm 5.67$  years, and 60.4% were between 26 and 34 years old. Nearly half had completed high school (49.5%), most lived in nuclear families (88.3%), the majority were housewives (81.8%), and most perceived their income level as moderate (81.6%). A positive and statistically significant correlation was found between total MSPSS and MAI scores ( $r=0.289$ ,  $p<0.001$ ). At the subscale level, the strongest correlation was observed between “significant other” support and bonding ( $r=0.311$ ,  $p<0.001$ ), followed by family ( $r=0.242$ ,  $p<0.001$ ) and friends ( $r=0.187$ ,  $p<0.001$ ). However, regression analyses including each subscale and the total MSPSS score independently revealed no significant predictive power for maternal bonding ( $t=0.777-1.101$ , all  $p>0.05$ ). Perceived social support has a positive relationship with maternal–infant bonding in the postpartum phase. However, in univariate models, its explanatory power is limited. These findings underscore the importance of strengthening partner and family support and integrating systematic social support screening into postpartum care practices.

**Keywords:** Maternal–infant bonding, postpartum period, perinatal care, social support

### Introduction

The postpartum period represents a critical stage for both maternal physical recovery and psychosocial adjustment, serving as a determinant phase for maternal and infant health. During this period, maternal–infant bonding is recognized as a fundamental process. It supports the infant's healthy development, contributes to the formation of secure attachment styles, and helps the mother adapt successfully to her parenting role [1-3]. Maternal bonding is defined as the intensity and persistence of the mother's emotional relationship with her infant, and the quality of this bond established in the early stage has lasting effects on both immediate and long-

term aspects of child development [1-4].

The literature identifies a wide range of factors influencing maternal bonding, including maternal self-efficacy, birth experiences, psychological status, social support, partner support, breastfeeding practices, and cultural norms [5-7]. Among these, social support emerges as one of the most frequently emphasized protective factors. High levels of perceived social support reduce depressive symptoms in the postpartum period, enhance maternal coping capacity, and facilitate adaptation to the parenting role [7-12]. Social support not only fulfills emotional needs but also provides informational and practical assistance that can directly strengthen

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bonding. Furthermore, it supports the mother–infant relationship indirectly by enhancing marital satisfaction, reducing feelings of loneliness, increasing prenatal breastfeeding self-efficacy, and promoting maternal self-efficacy [5,8,9,13-15].

The World Health Organization (WHO) identifies the promotion of maternal mental health and parent–infant relationships as a strategic priority within Sustainable Development Goal 3 (Good Health and Well-Being) [16]. Nevertheless, bonding difficulties and insufficient social support remain prevalent worldwide. In particular, in low- and middle-income countries, cultural norms and health system limitations often restrict the availability of support for mothers in the postpartum period [8,17-19]. Within the Turkish context, family and partner support are culturally highly valued and represent strong determinants of perceived social support. In traditional extended family structures, active involvement of relatives in postpartum care is common, whereas the shift toward nuclear families and modern living conditions has reshaped the functionality of these support mechanisms [10,12,20-22].

Despite the well-established role of social support, national evidence on its relationship with maternal–infant bonding remains limited. In particular, few studies examine support subdimensions (family, friends, significant other) or include broad and representative samples. Therefore, the purpose of this research was to thoroughly evaluate the relationship between perceived social support and maternal bonding in the postpartum phase and to identify the predictive contribution of its subdimensions. The findings are expected to provide a scientific foundation for integrating social support screening into postpartum care services and for developing evidence-based interventions that strengthen partner participation.

### Research Questions

1. Is there a statistically significant relationship between mothers' perceived social support (total and subdimensions) and their levels of maternal bonding?
2. Do perceived levels of social support (family, friends, significant other) significantly predict maternal bonding?

## Material and Methods

### Study Design

This study was conducted using a quantitative research approach with a descriptive and correlational design. The study was carried out in accordance with the STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) checklist [23].

### Population and Sample

The study population consisted of all mothers with infants aged 1–4 months who attended the Obstetrics and Gynecology Outpatient Clinic and the Pediatrics Outpatient Clinic of EBYU Mengücek Gazi Training and Research Hospital. Data were collected between June and December 2024.

The sample size was calculated using Epi Info software (version 7.3). Since no precise prevalence estimates were available from

similar studies in Türkiye, the expected maximum proportion was conservatively set at 50% to ensure the largest possible sample size. With a 5% margin of error and a 97% confidence interval, the minimum required sample was calculated as 471 mothers. The study was completed with 505 participants, exceeding the minimum requirement and thereby increasing the reliability and generalizability of the findings.

### Sampling Method

Mothers who met the inclusion and exclusion criteria were recruited using criterion sampling, a purposive sampling- criterion sampling method. The study sample consisted of individuals who satisfied the inclusion criteria and agreed to participate by giving informed consent.

**Inclusion Criteria:** During the study period, mothers were eligible for participation if they had a healthy infant aged 1–4 months, were 19 years of age or older, were literate in Turkish, and voluntarily agreed to participate by providing written informed consent.

**Exclusion Criteria:** Mothers were excluded if their infant had congenital anomalies, chronic illness, or severe health conditions requiring intensive care; if they themselves had serious physical or psychiatric health problems; if they had vision, hearing, or language impairments preventing effective communication; or if they failed to complete the questionnaires or withdrew before data collection was finalized.

The participant recruitment process was conducted according to the predetermined inclusion and exclusion criteria. Initially, 733 individuals were evaluated as potentially eligible candidates; however, a total of 228 were excluded due to having a psychiatric disorder (n=8), having an infant younger than one month or older than four months (n=150), declining participation (n=15), having an infant with a serious health problem (n=35), or being younger than 19 years of age (n=20). Consequently, 505 participants were confirmed to meet the eligibility criteria, completed follow-up, and were included in the final analyses.

### Data Collection Instruments

Data were collected using three instruments:

- **Descriptive Information Form:** Developed by the researchers, this form included 43 items addressing maternal sociodemographic and obstetric characteristics such as age, education level, income status, duration of marriage, obstetric history, health status, postpartum care support, quality of relationship with spouse, and support in child care [14,20,21,24].
- **Multidimensional Scale of Perceived Social Support (MSPSS):** Originally developed by Zimet et al. (1988), this 12-item, 7-point Likert-type scale measures perceived levels of social support [25]. The Turkish version was first validated by Eker & Akar (1995) and later revised by Eker et al. (2001), which was used in this study [26,27]. The MSPSS consists of three subscales representing sources of social support: family (items 3, 4, 8, 11), friends (items 6, 7, 9, 12), and significant

other (items 1, 2, 5, 10). The subscale scores were derived from the sum of the items included in each domain, resulting in an overall score interval between 12 and 84. A higher score corresponds to stronger perceived support. In the reliability study of the Turkish version, Cronbach's alpha coefficients were found to be 0.85 for Family, 0.88 for Friends, 0.92 for Significant Other, and 0.88 for the total scale. For this research, Cronbach's  $\alpha$  coefficients were calculated as 0.925 for Family, 0.903 for Friends, 0.899 for Significant Other, and 0.939 for the total scale. Participants were instructed to answer the "Significant Other" items with reference to support perceived from their spouse/partner.

- **Maternal Attachment Inventory (MAI):** Mary E. Muller (1994) designed a 26-item scale to measure affectionate maternal bonding. The instrument uses a 4-point Likert response format ("always" to "never"), producing scores between 26 and 104, where higher values denote greater bonding [28]. The Turkish adaptation was validated by Kavlak & Şirin (2009) [2]. In the original study, Cronbach's  $\alpha$  was reported as 0.85; in the present study, the reliability coefficient was 0.915.

### Data Collection Procedure

Data collection was carried out through face-to-face interviews with eligible mothers who visited the outpatient clinics of EBYU Mengücek Gazi Training and Research Hospital. Mothers who satisfied the inclusion criteria received verbal information about the study and provided written informed consent. Each interview session took approximately 20–30 minutes.

### Dependent and Independent Variables

Independent variables were defined as perceived social support—measured by the MSPSS total and subscales (Family, Friends, and Significant Other)—and maternal sociodemographic attributes such as age, educational attainment, household income, duration of marriage, parity, delivery type, postpartum support, quality of relationship with spouse, and childcare assistance. These variables were analyzed in terms of their associations with and potential effects on maternal bonding.

### Statistical Analysis

The dataset was processed using IBM SPSS Statistics software (version 22). Descriptive analyses were carried out in the preliminary phase, covering frequencies, percentages, means, and standard deviations. Normality was assessed using the Shapiro–Wilk test and by examining skewness and kurtosis values within the  $\pm 2$  range. Values within this interval were accepted as indicative of normal distribution according to recommended criteria [28]. For normally distributed variables, independent samples t-tests, one-way ANOVA, and Pearson correlation analyses were conducted. For non-normally distributed variables, Mann–Whitney U tests, Kruskal–Wallis tests, and Spearman correlation analyses were applied. Post-hoc tests, including LSD, Tukey HSD, Dunnett C, and Mann–Whitney U, were used to determine group differences where applicable [29]. Internal consistency of the scales

was assessed using Cronbach's alpha coefficients. Statistical significance was set at  $p < 0.05$ . All analyses were evaluated based on a significance criterion of  $p < 0.05$ .

### Ethical Considerations

Ethical approval was obtained from the Erzincan Binali Yıldırım University Ethics Committee for Human Research (Decision No: 350327 Date: 01 March 2024), and institutional permission was granted by EBYU Mengücek Gazi Training and Research Hospital (Ref. No: 246092254). The research was carried out in line with the ethical standards of the Declaration of Helsinki. Before data collection, participants were provided with both verbal and written information regarding the aim of the study, voluntary participation, and assurances of confidentiality and privacy. Written informed consent was then obtained from all participants.

### Results

A total of 505 mothers were included in the study. The mean age of the mothers was  $30.04 \pm 5.67$  years, with the majority (60.4%) between 26 and 34 years. Most participants were married (99.0%), housewives (81.8%), and living in nuclear families (88.3%). Nearly half had completed high school (49.5%), and most perceived their income level as moderate (81.6%). The mean number of births was  $1.98 \pm 1.00$ , and the mean duration of marriage was  $7.40 \pm 5.58$  years. The average birth weight of infants was  $3259.93 \pm 500.11$  g, and the mean number of living children was  $1.93 \pm 0.92$ . The participants' sociodemographic and obstetric features are summarized in Table 1.

Regarding the main study variables, the mean total MSPSS score was  $65.03 \pm 18.50$ , indicating a generally high level of perceived social support. Among MSPSS subscales, the Family subscale had the highest mean score ( $23.68 \pm 6.53$ ), while the Friends subscale had the lowest ( $20.30 \pm 7.23$ ). The mean MAI score was  $99.30 \pm 6.89$ , reflecting high maternal attachment levels in the sample (Table 2).

Correlation analysis revealed a positive and moderate significant association between the total MSPSS score and maternal attachment ( $r = 0.289$ ,  $p < 0.001$ , 95% CI: 0.207–0.366). Subscale-level analysis showed that the strongest correlation was between maternal attachment and perceived support from a significant other ( $r = 0.311$ ,  $p < 0.001$ ), followed by family support ( $r = 0.242$ ,  $p < 0.001$ ) and friends' support ( $r = 0.187$ ,  $p < 0.001$ ). The explained variance ( $r^2$ ) was 9.7%, 5.9%, and 3.5% for these domains, respectively. These findings suggest that increased perceived social support across all dimensions enhances maternal attachment, with support from a significant other exerting the strongest influence (Table 3).

However, regression analyses revealed that neither the MSPSS total score nor its subscales significantly predicted maternal attachment ( $t = 0.777$ – $1.101$ ; all  $p > 0.05$ ). Although correlations indicated meaningful associations, these variables alone did not statistically explain variations in maternal attachment. This suggests that maternal bonding may be influenced by additional psychological, social, or contextual factors not captured within the scope of MSPSS scores (Table 4).

**Table 1.** Distribution of mothers' sociodemographic and obstetric characteristics

| Characteristics                        | n                           | %                |
|----------------------------------------|-----------------------------|------------------|
| Age (years)                            | 19-25                       | 115              |
|                                        | 26-34                       | 305              |
|                                        | 35-42                       | 85               |
| Educational status                     | Primary school graduate     | 77               |
|                                        | Secondary school graduate   | 84               |
|                                        | High school graduate        | 250              |
|                                        | University graduate         | 94               |
| Marital status                         | Married                     | 500              |
|                                        | Single                      | 5                |
| Occupation                             | Housewife                   | 413              |
|                                        | Worker                      | 22               |
|                                        | Civil servant               | 70               |
| Place of residence                     | Village                     | 33               |
|                                        | District                    | 333              |
|                                        | City                        | 139              |
| Perceived income level                 | Low                         | 31               |
|                                        | Moderate                    | 412              |
|                                        | High                        | 62               |
| Health insurance                       | Yes                         | 488              |
|                                        | No                          | 17               |
| Family type                            | Extended family             | 59               |
|                                        | Nuclear family              | 446              |
| Planned pregnancy                      | Yes                         | 876              |
|                                        | No                          | 156              |
|                                        | Unplanned but later desired | 105              |
| Variables                              | Mean $\pm$ SD               | Median (Min–Max) |
| Age (years)                            | 30.04 $\pm$ 5.67            | 30 (19-42)       |
| Duration of marriage (years)           | 7.40 $\pm$ 5.58             | 6 (1-25)         |
| Number of births                       | 1.98 $\pm$ 1.00             | 2 (1-6)          |
| Number of living children              | 1.93 $\pm$ 0.92             | 2 (1-6)          |
| Week of first perceived fetal movement | 17.21 $\pm$ 4.01            | 17 (6-32)        |
| Week of first ultrasound visualization | 2.49 $\pm$ 1.56             | 2 (1-9)          |
| Birth weight of the baby (g)           | 3259.93 $\pm$ 500.11        | 3200 (3150-4500) |

**Table 2.** Distribution of mothers' MSPSS subscale and total scores and MAI scores

| Scale and subscale | n   | Min.  | Max.   | Mean  | SD.   |
|--------------------|-----|-------|--------|-------|-------|
| Family             | 505 | 4.00  | 28.00  | 23.68 | 6.53  |
| Friends            | 505 | 4.00  | 28.00  | 20.30 | 7.23  |
| Significant other  | 505 | 4.00  | 28.00  | 21.05 | 7.40  |
| MSPSS              | 505 | 15.00 | 84.00  | 65.03 | 18.50 |
| MAI                | 505 | 68.00 | 104.00 | 99.30 | 6.89  |

Min.: Minimum, Max.: Maximum, SD.: Standard deviation, MSPSS: Multidimensional Scale of Perceived Social Support, MAI: Maternal Attachment Inventory

**Table 3.** Correlations between MSPSS subscales and total scores and maternal attachment

| Subscales         | Statistics | MAI     |
|-------------------|------------|---------|
| Family            | r          | 0.242   |
|                   | p          | p<0.001 |
|                   | n          | 505     |
| Friends           | r          | 0.187   |
|                   | p          | p<0.001 |
|                   | n          | 505     |
| Significant other | r          | 0.311   |
|                   | p          | p<0.001 |
|                   | n          | 505     |
| MSPSS             | r          | 0.289   |
|                   | p          | p<0.001 |
|                   | n          | 505     |

Correlation coefficients were calculated using Pearson’s correlation analysis. r=correlation coefficient; p=significance level; n=sample size. Effect size (r²): total scale=8.4%; significant other=9.7%; family=5.9%; friends=3.5%, MSPSS: Multidimensional Scale of Perceived Social Support, MAI: Maternal Attachment Inventory

**Table 4.** Regression analysis of MSPSS subscale and total scores on MAI total score

| Predictor         | B<br>(Unstandardized Beta) | SE<br>(Standard Error) | β<br>(Standardized Beta) | t       | p       | 95% CI<br>(Lower–Upper) |         |
|-------------------|----------------------------|------------------------|--------------------------|---------|---------|-------------------------|---------|
| Constant          | 98.075                     | 1.153                  |                          | 85.030  | p<0.001 | 95.809                  | 100.341 |
| Family            | 0.052                      | 0.047                  | 0.049                    | 1.101   | 0.272   | -0.041                  | 0.144   |
| Constant          | 98.630                     | 0.914                  |                          | 107.877 | p<0.001 | 96.834                  | 100.426 |
| Friends           | 0.033                      | 0.042                  | 0.035                    | 0.777   | 0.438   | -0.050                  | 0.116   |
| Constant          | 98.616                     | 0.925                  |                          | 106.607 | p<0.001 | 96.799                  | 100.434 |
| Significant other | 0.032                      | 0.041                  | 0.035                    | 0.782   | 0.434   | -0.049                  | 0.114   |
| Constant          | 98.215                     | 1.121                  |                          | 87.626  | p<0.001 | 96.013                  | 100.417 |
| MSPSS             | 0.017                      | 0.017                  | 0.045                    | 1.005   | 0.315   | -0.016                  | 0.049   |

B = unstandardized regression coefficient; SE = standard error; β = standardized regression coefficient; CI = confidence interval. MSPSS: Multidimensional Scale of Perceived Social Support, Separate simple linear regression analyses were conducted for each MSPSS subscale and total score predicting MAI total score.

Discussion

This study demonstrated a positive but weak association between perceived social support and maternal–infant attachment in the postpartum period, with the strongest correlation emerging for support from a “significant other” (partner/spouse). This pattern aligns with broader evidence that partner/relationship-related support is often the most salient support domain for early bonding outcomes, compared with support from friends or more distal networks [5,6]. However, neither the subscales of social support nor the overall score significantly predicted maternal attachment in simple regression models. This pattern suggests that while social support is related to attachment, it is not a strong determinant in itself; rather, its effects appear to operate primarily through indirect pathways [3]. Notably, similar

interpretive frameworks have been used in community samples in which social support co-varies with postpartum psychosocial risk but does not always emerge as a standalone driver once broader maternal wellbeing indicators are considered [9]. Consistent with national and international literature, perceived social support has been shown to strengthen maternal–infant attachment both directly and indirectly through mediating factors such as depression, anxiety, perceived stress, marital satisfaction, and parental self-efficacy [5-7,9,10,30]. For example, McNamara et al.’s systematic review emphasized that maternal wellbeing and interpersonal relationship factors (including partner-related support) are repeatedly linked to maternal–fetal attachment and early postpartum bonding, suggesting that “support–bonding” associations frequently operate alongside mental health and

relationship quality pathways rather than in isolation [5]. Oxytocin-related affiliative processes and caregiver–infant synchrony have been implicated in early caregiving and bonding [31]. In parallel, social support is associated with higher maternal self-efficacy and lower postnatal depressive symptoms [32] and may buffer maternal distress while facilitating adaptation to the maternal role in the postpartum period [33]. These pathways may help explain the relatively higher correlation observed for partner support in the present study. In addition, mechanistic/indirect pathway evidence is supported by mediation modeling: Wang et al. reported that perceived social support influenced postpartum stress both directly and indirectly via marital satisfaction and maternal postnatal attachment; the combined indirect effect accounted for 58.2% of the total effect, underscoring the plausibility of “support → relationship/attachment processes → psychosocial outcomes chains” [7]. Turkish evidence similarly indicates that perceived support is tightly coupled with postpartum psychological burden: women with better support reported lower traumatic stress and lower depressive symptoms in the postpartum period [10], which is clinically relevant because these mental health states are repeatedly implicated in bonding/attachment quality [5,9].

The modest effect sizes obtained (e.g.,  $r^2 \approx 9.7\%$  for “significant other”) further indicate that social support alone is not a robust predictor of maternal–infant attachment, with much of its influence likely mediated through other variables [13]. Additionally, the cross-sectional design, the relative homogeneity of the sample, and a potential ceiling effect in MAI scores may have constrained predictive power. Accordingly, future research should prioritize multivariate approaches (e.g., mediation/moderation analyses, SEM) and longitudinal designs to capture the complexity of these relationships. This recommendation is consistent with recent model-based work: La Rosa et al. ( $n=1,495$ ) identified postpartum depression, poor sleep, emergency cesarean section, low social support, and low partner support as significant predictors of worse mother–child bonding, with depressive symptoms showing the strongest negative association—illustrating how support typically exerts its impact within a broader psychosocial model rather than as a single dominant predictor [6].

Notably, contradictory findings in the literature appear to reflect contextual differences. In societies where extended family structures predominate, support is often derived from relatives, whereas in nuclear families, partner support tends to be more salient [7,13,20,22]. Such differences underscore that the effect of social support on attachment is conditioned by cultural norms and family dynamics. While several studies have reported that high levels of social support exert a protective effect on attachment [8–10,13], in extended family contexts, overly intrusive or critical support may paradoxically undermine attachment [12,21,22,32]. In this context, it is also important to acknowledge that “more perceived support” is not uniformly

equivalent to “less distress”: Özkan et al. reported a weak but significant positive association between perceived social support and postpartum-specific anxiety ( $r=0.236$ ), which may reflect reverse causality (anxious mothers mobilizing or perceiving more support), measurement timing, or qualitative differences in the functionality of support [30].

Türkiye’s cultural context, in which family and partner support are highly valued, provides a meaningful background for the significant associations observed in the “significant other” and “family” subdimensions in this study [12,20–22]. However, the quality of support is decisive: while practical assistance and emotional validation strengthen bonding, excessive interference or criticism may have detrimental effects [8,10,11,24,32]. Therefore, future studies and clinical screening may benefit from distinguishing supportive behaviors that are autonomy-supportive versus controlling/critical, particularly in extended-family settings.

Friend support, although particularly relevant in urbanized nuclear family settings, generally demonstrates weaker associations compared to partner and family support [20–22]. This finding suggests that the quality and source of support, rather than its sheer quantity, are critical for mother–infant bonding [8,10,11,32]. This interpretation is compatible with model-based findings where partner-related variables and maternal mental health indicators explain more variance in bonding outcomes than broader “general support” indices alone [6].

From a clinical perspective, it is essential to screen and strengthen social support during postpartum care. Interventions that prioritize partner involvement through antenatal and postnatal educational programs, midwifery-based holistic practices (e.g., skin-to-skin contact, rooming-in care, breastfeeding counseling), and psychosocial support for at-risk groups should be emphasized [5,7,8,16,20,33]. It is clear that interventions must focus not only on the amount of support but also on its quality and functionality. Given the evidence that relationship satisfaction and attachment-related processes may channel the effects of support (and that mental health burden co-occurs with support perceptions), integrated postpartum approaches that include partner-focused components, mental health screening, and relationship/attachment support may be more impactful than “support enhancement” alone [6,7,10].

## Conclusion

In summary, the findings indicate that perceived social support—especially support from family members and partners—is positively related to mother–infant bonding during the postpartum period. Yet, social support alone shows limited explanatory power, with most effects emerging through indirect mechanisms. For clinical practice and health policy, culturally tailored programs that enhance partner involvement and emphasize the qualitative components of support should be prioritized.

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**Ethical Approval**

*Approved by the Erzincan Binali Yıldırım University Ethics Committee for Human Research (No: 350327; Date: 01 March 2024).*

**Patient Consent**

*Written informed consent was obtained from all participants.*

**Conflict of Interest**

*The authors declare no conflict of interest.*

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