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A Development Study of the Perceived Partner Support Scale in Maternity Period

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ABSTRACT

Objective: This study aimed to develop and test the psychometric properties of the Perceived Partner Support Scale in the Maternity Period, based on the perceptions of women.

Methods: Data from 368 mothers with babies aged 0-12 months volunteers in Türkiye were gathered online for this methodological study. Following literature review and focus group discussions, 57 items were generated. Based on these items, the Perceived Partner Support Scale in the Maternity Period (PPSSMP) was developed and psychometrically tested.

Results: Exploratory factor analysis resulted in three dimensions: (1) emotional support, (2) support in baby care, and (3) support in daily life practices. The total explained variance was 60.64%. The coefficient alpha for the entire scale was 0.837, while for the first, second, and third subscales, it was 0.788, 0.460, and 0.838, respectively.

Conclusion: Psychometric tests have shown that the Perceived Partner Support Scale in the Maternity Period is a valid and reliable measurement tool.

Keywords: Maternal role, postpartum period, psychometrics, social support

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Introduction

While the birth of a child is a joyful experience, it is also a complex life event that can be accompanied by stress (Clout & Brown, 2016; Nahaee et al., 2024). Changes that occur from the beginning of pregnancy, along with limitations in social and professional life, can contribute to the mother's stress. Additionally, during the postpartum period, managing the baby's nutrition, sleep, and changes in the mother's health status presents significant psychological challenges. This transition to motherhood is considered a major life event, often leading to confusion, concerns, and a loss of self-confidence (Athan & Reel, 2015; Lopez-Gonzalez & Mikes, 2026). Although it is an individual experience, the transition to motherhood is a particularly sensitive period for many women (Don et al., 2014). During this time, mothers often perceive their partners as their primary support system (Rowe et al., 2013; Sampson et al., 2015).

Partner support plays a critical role in helping mothers adapt to and manage new postpartum stressors, as well as in fostering the relationship between the mother and baby. It is well-established that partner support enhances perceived parenting skills and self-confidence in mothers (Copeland & Harbaugh, 2019). Moreover, a supportive father has been shown to positively impact the mother's mental health during the postpartum period (Copeland & Harbaugh, 2019; Kızılırmak et al., 2021). According to the World Health Organization (WHO), approximately one in five women experience a mental health condition during pregnancy or within the first year after childbirth. WHO reports that perinatal anxiety and depression affect approximately one in ten women in high-income countries and one in five women in low- and middle-income countries (WHO, 2022). Therefore, one of the primary goals of interventions aimed at postpartum mental health problems is to identify the components of partner relationships and develop tailored interventions (Pilkington, 2016). Relationship-related life events may play a role in the onset of depression during pregnancy and the postpartum period (Wright et al., 2015). Healthcare professionals should assess the quality of partner support and, when necessary, provide care and consultation to families within the framework of postpartum care to guide the situation toward a positive outcome (Mermer et al., 2010).

Studies examining postpartum partner support often utilize scales that assess general partner adaptation or social support, rather than focusing specifically on the postpartum period (Tambag et al., 2018). A review of the literature shows that there are few studies that measure partner support exclusively during the maternity period. One example is "The Partner Support Scale Perceived by Women in the Early Postpartum Period," which was developed for use during the first six weeks after birth (Şahin et al., 2014). Another is "The Postpartum Partner Support Scale," developed for mothers in the 8-week postpartum period (Dennis et al., 2017). The formation, acceptance, and development of the maternal role begin during pregnancy and continue to evolve within 4 to 6 months after birth (Leahy-Warren, 2005; Esmaelzadeh et al., 2017; Huang et al., 2022). However, these scales often address only a limited timeframe of the postpartum period, which may not allow for generalization in terms of content. This highlights the need for a more comprehensive and easily applicable measurement tool.

In response to this need, the "Perceived Partner Support Scale in the Maternity Period" was developed to cover a broader timeframe and provide a more detailed assessment of mothers' perceptions of partner support. This study aimed to evaluate the validity and reliability of the scale, with the goal of addressing postpartum partner support more comprehensively.

Therefore, there is a need for an assessment tool that covers not only the first 8 weeks but also extends beyond that period, capturing the transitional phase of motherhood. A specific scale would be beneficial in determining the partner support status during this transitional period, helping to guide interventions. In line with this approach, the aim of the research is to develop a scale to determine the perceived spousal support of mothers. Furthermore, it is aimed that the developed scale will guide healthcare professionals in planning the services they will offer to mothers and their spouses who need spousal support, and contribute to the literature.

Methods

Type of the Study

This study is a methodological research conducted to develop a scale instrument to evaluate the support that fathers provide to their partners during the transitional period to motherhood.

Data were collected through social media platforms between January and March 15, 2020. Due to the restrictions imposed by the COVID-19 pandemic, face-to-face data collection was not feasible. Therefore, data were collected online, and the survey link was disseminated through widely used social media platforms, including Facebook, WhatsApp, and Instagram, to enhance accessibility and recruit mothers from different regions of Türkiye.

Participants

A total of 392 mothers with infants aged 0–12 months who consented to participate completed the survey. Following data screening, 24 questionnaires were excluded because of incomplete or invalid responses, resulting in a final analytical sample of 368 mothers. The inclusion criteria were being 18 years old or above, having given live birth in the last 12 months, the baby being alive, and being literate in Turkish. There are different suggestions on sample size in scale development studies. It is also recommended that the sample size must be five or ten times the number of the items (Esmaelzadeh et al., 2017). In this study, the sampling size consisted of 368 mothers. Since the number of the items in the instrument was 49, the sample met the size requirements

Measures

The form developed in this study was carried out in three stages. This study, items 57 of the scale was created in the first stage, while in the second stage this item outline was presented to expert assessment, and in the third stage were data collected and analyses.

Preparation of the scale items: A comprehensive literature scan regarding the relationship between partner support and its effects was conducted. In the literature search, the terms “spousal support in the transition to motherhood” “spousal support during puerperium,”, “postpartum partner support” “postpartum mother's needs” “validity,” “reliability” and “scale” were used. Scales developed for transition to motherhood and partner support roles were examined. Also, focus group discussion was carried out with mothers in the postpartum period (having babies aged 0 to 12 months). In total, there were 30-40 minute interviews with 7 different groups and 28 mothers. In the process of developing the scale, an item pool of 57 items was created by the researchers in line with the literature and focus group discussion.

Expert assessment: As a result of the reviews and recommendations of 10 academicians who are experts in the field of drafting scales, the items with the same meanings and those thought not to serve the purpose of the scale were removed from the draft scale. Finally, the draft scale was decided with 49 items. The items composed for the scale form were expressed in such away that mothers could understand. Likert type scoring was used to express the consistency levels of the participants’ views regarding the items.This scoring included such options as “Absolutely Disagree, Disagree, Indecisive, Agree, Absolutely Agree”. Data collected and analyses: The data collection tool was comprised of three parts. The first section consists of an descriptive information form containing the sociodemographic and obstetric characteristics of the participants. In the second part, the prepared scale form “Perceived Partner Support Scale in Maternity Period” (PPSSMP) was distributed. In the third part, a scale that had similar characteristics “The Partner Support Scale Perceived by Women in Early Postpartum Period” (PSSPWEPP) were used to be evaluated simultaneously for criterion-related validity.

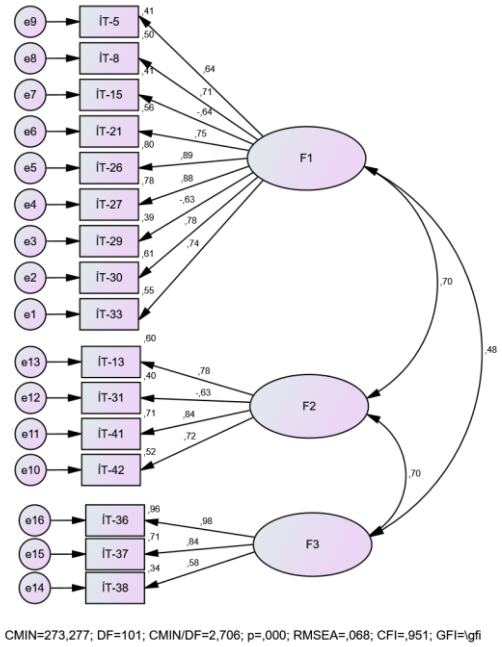


Figure 1. *Flow diagram of the development process of the Perceived Partner Support Scale in Maternity Period*

PPSSMP: Prepared scale form was 5-Likert type format and 49 items. The scale was graded from 1 = “Absolutely Disagree” to 5 = “Absolutely Agree”. The scale score was obtained through addition. A high score reflected that the partner support that the mothers perceived in their

transitional period to motherhood was high. The details on the analyses of the validity and reliability of the scale have been presented in the results section.

PSSPWEPP: It was developed by Şahin et al. (2014). There are 16 items in this scale. Developed in 5-Likert type format, the objective of this scale is to determine the partner support perceived by women in the early postpartum period. The highest score to be obtained from the scale is 80, while the lowest is 16. The cronbach's alpha value of the scale was determined to be 0.87 by Şahin et al. (2014) The higher the score obtained from the scale is, the more sufficiently the partner support is reflected to be perceived in the early postpartum period. The scale has emotional, physical, and social support subscales. The cronbach's alpha value of this scale was found to be 0.78 in this study.

Data Collection

Research data were collected online between January and March 15, 2020. The survey was distributed using Google Forms via motherhood and parenting-related social media networks, such as Facebook, WhatsApp, and Instagram. The survey link was shared five times at different times on social media networks such as Facebook, WhatsApp and Instagram. The target groups was completed by the participants voluntarily and anonymously.The first page of the form included an informed consent statement explaining the aim and scope of the study, the principle of voluntary participation, and confidentiality procedures. Participants who provided consent then completed the questionnaire items. No personal identifiers (name, phone, or email) were collected to ensure anonymity.

To ensure data quality and prevent multiple entries from the same individual, we implemented certain controls. Each participant was allowed to submit the survey only once by activating the option in Google Forms to limit responses to one submission per user. This option was linked to participants' email addresses or Google accounts, preventing them from submitting more than one entry. Additionally, incomplete and duplicate forms were excluded from the analysis. We did not use IP address tracking due to privacy concerns; however, we relied on Google Forms' built-in features to limit multiple submissions.

Statistical Analysis

After the data were obtained, they were evaluated with SPSS 22 and Amos 24 computer software programs. To determine the participants' information, the frequency distribution was evaluated with percentage analysis. While coming up with the items, the Lawshe method was used in determining the content validity to evaluate the expert opinion. The construct validity of the scale was evaluated with exploratory factor analysis (EFA) and confirmatory factor analysis (CFA) respectively. Cronbach's alpha was used for the internal consistency and the correlation values were analyzed to assess the consistency among the items.

Ethics

The study was carried out in accordance with the Declaration of Helsinki and a research ethics committee approval was obtained from a state Balıkesir university (Date: September 25, 2019, No: 2019/118). Before participating in the research, the participants first approved the statement "I agree to participate in the research" on the online questionnaire. After the approval of their participation in the study, the mothers then were asked to fill in the data collection tools. It was explained to the participants that they could quit the study without giving any reason.

Results

Among the mother women comprising the study group in the research, the mean age was 29.55±4.20, the mean number of pregnancies was 1.54±1.66, the mean number of miscarriages was 0.21±0.52, the mean number of children alive was 1.32±0.77, and the mean age of their babies in months was 8.02±7.19, 97.6% of the mothers were found to have given singleton birth in their latest pregnancy, and 94.3% were detected to have had planned birth. As for their educational background, 4.3% were primary school graduates, 12.8% were high school graduates, and 82.9% had a bachelor's degree or above; among the fathers, 7.1% were primary school graduates, 23.4% were high school graduates, and 69.6% had a bachelor's degree or above. Also, the majority of the mothers and fathers (54.6% and 97.3% respectively) were found to work in income-generating jobs, 84.0% were found to have a moderate income status, 83.7% were found to have been married for 1 to 5 years, and 93.2% were determined to have a nuclear family (Table1).

Validity

Linguistic And Content Validity

In the linguistic and content validity stage, each item is tested to determine whether it is a sufficient or suitable statement to measure behavior in terms of content and

quality.

Table1.
Sociodemographic Characteristics of Participants

Characteristics	Variables	n	%
Number of Babies Born in Last Pregnancy	Singleton birth	359	97.6
	Multiple birth	9	3.4
Planned Pregnancy	Yes	347	94.3
	No	21	5.7
Educational Level of Mothers	Primary education	16	4.3
	High School	47	12.8
	University degree or high	305	82.9
Educational Level of Fathers	Primary education	26	7.1
	High School	86	23.4
	University degree or high	256	69.6
Employment Status of Mothers	Yes	200	54.6
	No	167	45.4
Employment Status of Fathers	Yes	358	97.3
	No	10	2.7
Income Status	Low income level	18	4.8
	Moderate Income Level	309	84.0
	High income level	10	11.1
Duration of marriage	1-5 years	308	83.7
	5 Years and More	60	16.3
Family Type	Nuclear Family	343	93.2
	Extended Family	25	6.8
X±±SD (Min-Max)			
Mean Age of Mothers		29.55±4.20	
Mean Number of Pregnancies		1.54±1.66	
Mean Number of Miscarriages		0.21±0.52	
Mean Number of Children Alive		1.32±0.77	
Mean Age of Babies (months)		8.02±7.19	
Mean Age of Mothers		29.55±4.20	

One of the logical methods used to test the linguistic and content validity is to consult to expert opinion (Büyüköztürk et al., 2010). Expert opinion was taken to evaluate the scale for linguistic and content validity. Expert group; obstetrics nurse two professors and two associate professors; It consists of one midwife professor and five midwife assistant professors. In this respect, to obtain an expert opinion, the 57-item outline scale form previously created was developed with three options, namely "Important, not to be discarded", "Somewhat important, could be discarded", and "Unimportant, to be discarded", and with space under each item so that the experts could write their thoughts. It was also created with three options for language validity, namely "Clear", "Somewhat clear", and "Unclear". Expert opinion was also received to assess the suitability of the scale for the Turkish culture and language. The expert group comprised of two professor doctors, two associate professors, and six faculty members. The quality and number (between 5 and 40) of the experts play a crucial role in calculations made to determine the content validity (Lawshe, 1975). The number of experts included in this study was considered sufficient based on the recommended criteria. These individuals were informed of the study process and asked to evaluate the 57 items in terms of the suitability of their content, their ability to reflect the field desired to be measured, and their language validity. Based on the Lawshe method (1975), the obtained data was converted to quantitative data by calculating CVO and CVI with regard to the experts' opinion to determine the content and language validity of the items to be included in the scale (Ayre & Scally, 2014). According to Lawshe (1975), based on the significance level of α=0.05 for each positively valued item, the minimum CVR in 10 experts' opinions should be 0.62 (Ayre & Scally, 2014; Lawshe, 1975). The linguistic and content validity of the study was found to be 0.85 and 0.89 respectively. The obtained CVI value being bigger than the CVR value (CVI>CVR) reflects that the content validity of the items included in the scale is statistically significant (Ayre & Scally, 2014). After linguistic and content validity had been established, the draft scale was pilot-tested with 22 mothers who had characteristics similar to those of the target population to assess its face validity, clarity, comprehensibility, and feasibility.

Participants reported that all items were clear and understandable, and no modifications to the wording or content of the scale were required. The final 49-item draft scale was then administered in the main study.

Table 2.
Factor Load Values of the Perceived Partner Support Scale in Maternity Period

	Items	Factors		
Emotional Support	Item 5: My partner listens to my concerns over our marriage life after we have become parents.	.693		
	Item 8: My partner cares about me.	.772		
	Item 9: My partner talks about his concerns about me	.605		
	Item 14: My partner is not interested in me as before	-.628		
	Item 15: I cannot talk about myself to my partner.	-.695		
	Items 17: My partner displays accusing behavior toward me.	-.614		
	Item 21: My partner talks to me when I feel bad.	.751		
	Item 26: My partner provides emotional support that I need.	.784		
	Item 27: My partner spares time for me.	.766		
	Item 29: I have had difficulties in talking about our problems with my partner.	-.680		
	Item 30: My partner behaves with common sense in solving the problems that we face.	.741		
	Item 33: My partner is more sympathetic to me than ever during the postpartum period.	.639		
Support in Baby Care	Item 13: My partner enables me to spare some time for myself to rest.		.687	
	Item 31: My partner thinks that he is not responsible for baby care.		-.628	
	Item 41: My partner makes it possible for me to have some sleep if I am sleep-deprived.		.651	
	Item 42: We make the decisions about our baby together.		.662	
	Item 48: My partner changes our baby's diaper.		.743	
Support in Daily Life Practices	Item 36: My partner helps with chores around the house.			.837
	Item 37: My partner helps in the kitchen (cooking, washing the dishes etc.)			.832
	Item 38: My partner helps with caring our other children/other individuals in the house			.698
	Eigenvalue	8.82	2.18	1.11
	Variance explained by the factor (Total variance 60.64%)	44.13	10.92	5.58
	Cronbach's alpha (Total :0.837)	0.788	0.460	0.838

Exploratory Factor Analysis

To see whether factor analysis could be conducted for the items in PPSSMP, the KMO value and Bartlett's test were used. The Kaiser-Meyer-Olkin (KMO) value of PPSSMP was found to be 0.942. The KMO value being within the normal range reflects the factor analysis results applied to the data to be used. As a result of Bartlett's test of sphericity, it was found that there was a significantly high correlation among the variables and the data were suitable for factor analysis application (x2: 11901.576, SD: 1176, $p < .000$). According to Tabachnick and Fidell (2013), an item's factor load on a factor should be 0.32 minimum. It could be deduced that an item with a factor load between 0.30 and 0.60 measures the construct moderately, while an item with a factor load above 0.60 (positive or negative) measures the construct at a high level (Stevens, 2002) Besides, the difference between the factor loads applied by a variable on more than one factor should be 0.1 minimum (Tabachnick & Fidell, 2013). The undesired items were excluded gradually from the scale, and after

each exclusion, the factor analysis process was repeated by checking how the factor loads changed (Kline, 1994). In this respect, during the factor analysis process, 12 items (3, 6, 11, 12, 16, 18, 19, 22, 28, 39, 43, 49) in the first analysis, 7 items (1, 2, 4, 7, 25, 44, 47) in the second analysis, 3 items (32, 45, 46) in the third analysis, 2 items (23, 40) in the fourth analysis, and 5 items (10, 20, 24, 34, 35) in the fifth analysis were discarded, all of whom had factor loads close to each other or below 0.30. After these items rotation was used as a factorization technique, as a result of which the scale was determined to have three subscales. Based on EFA results, three factors were detected. There were 12 items in the first factor, 5 items in the second factor, and 3 items in the third factor. In PPSSMP, the eigenvalue of and the variance explained by the first factor was found to be 8.82 and 44.13% respectively, the eigenvalue of and the variance explained by the second factor was found to be 2.12 and 10.92% respectively, and the eigenvalue of and the variance explained by the third factor was found to be 1.11 and 5.58% respectively. The total variance explained was 60.64% (Table 2). It is safe to state that the distribution of the items in the 20-item scale was balanced.

Confirmatory Factor Analysis

Generally used in scale development and validity analyses, CFA tries to confirm the predicted theoretical construct of a scale. The confirmation of a scale by CFA demonstrates that scale to be valid. In this respect, CFA was conducted to confirm the construct created as a result of EFA and comprising 20 items and 3 factors. The AMOS 24.0 package software was used for CFA.

The CFA results of the first-level factorial design of the scale, made of 3 subscales and 16 items (9-item emotional support, 4-item support in baby care, and 3-item support in daily life practices), have been shown in figure 2.

Concurrent Validity

To test the criterion-related validity of PPSSMP, the correlation between the total obtained points from PSSPWEPP, developed in Turkey, and the total obtained points from PPSSMP was analyzed. The correlation between the points from two simultaneously applied scales was evaluated with the Pearson product-moment correlation analysis, and a highly positive and significant correlation was observed between two scale score distributions (0.170**, p<.001).

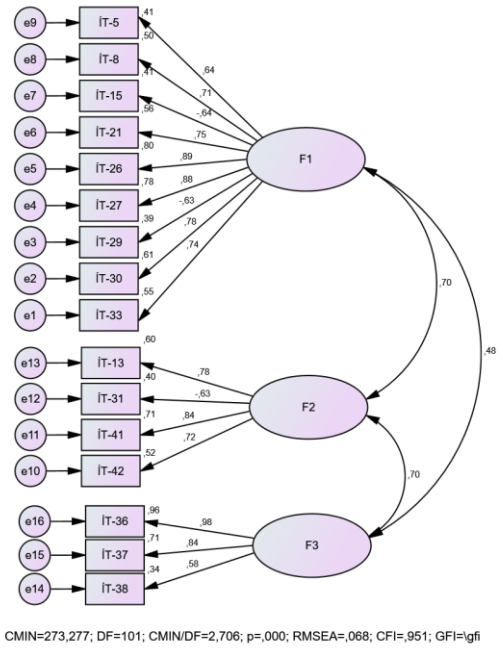


Figure 2: *First-level measurement model of the Perceived Spouse Support Scale during*

Reliability

The items that would represent the factors were determined after EFA. After determining the related items, these factors should be expressed with specific names. The items under a factor are named based on such aspects as theoretical background, mutual characteristics of the items, and the significance expressed by the items with a high load factor (Şencan, 2005). Therefore, with consideration given to the mutual characteristics of the items representing the factors, the 1st, 2nd, and 3rd factors were named "emotional support", "support in baby care", and "support in daily life practices" respectively. The internal consistency coefficient was analyzed for the reliability of PPSSMP. To that end, its Cronbach's alpha coefficient was first measured.

Cronbach's alpha for the instrument was .837 for the total scale. Cronbach's alpha for Factor 1 was .788 and Factor 2 was 0.460 and Factor 3 was 0.838 (Table 2).

Within the scope of CFA, as can be seen in Table 3, the x2/DF (chi-square/degree of freedom) value was found as 2.706. This shows that the model has a good consistency. The RMSEA value of the model was calculated to be 0.068. An RMSEA value lower than .08 indicates acceptable goodness of fit (Brown, 2006). Based on this, the model can be said to have fine goodness of fit value. The values obtained upon

analyzing the goodness of fit in the created model are as follows; CMIN=509.654; DF=167; CMIN/DF=3.052; *p*=.000; RMSEA=0.75; CFI=0.919. The modification indices were analyzed based on the obtained values and, as a result, items 9, 14, 17, and 48 were discarded as they had a lower factor load than 0.50. The model fit indices obtained upon reanalyzing the model after creating the relevant construct were found to be within the desired threshold. The results of the completed model analysis have been presented in Table 2 as follows; CMIN=273.277; DF=101; CMIN/DF=2.706; *p*=.000; RMSEA=0.68; CFI=0.951. The good fit level of the x2/DF, RMSEA, NFI, and CFI values of the scale can be seen in these results.

Table 3.
First Level Confirmatory Factor Analysis Fit İndex

Measurement (Fit Indices)	Goog Fit	Acceptable Fit	Model
General Model Fit $\chi^{2/SD}$	≤3	$3\leq\chi^{2/SD}\leq5$	2.706
Comparative Fit Index (CFI) (RMSEA)	0.950≤CFI≤1.00 0≤RMSEA≤0.050	0.900≤CFI≤0950 0.050≤RMSEA≤0.80	.951 .068
Root Mean Square Residual (RMR)	0≤RMR≤0.050	0.050≤RMR≤0.80	0.50
Incremental Fit Index (IFI)	0.950≤IFI≤1.00	0.900≤IFI≤0950	0.950
Tucker – Lewis Index (TL)	0.950≤IFI≤1.00	0.900≤IFI≤0950	0.950

Upon analyzing the standard regression coefficient of the PPSSMP items and its subscales, the values were found to be between 0.63-0.89, 0.62-0.84, and 0.58-0.97 for “emotional support”, “support in baby care”, and “support in daily life practices” subscales respectively (Table 4).

Table 4.
Standard Regression Coefficients of the Perceived Partner Support Scale in Maternity Period

Measurement Model		β1	β2	SE	CR	*p*
IT-33	F1	0.741	1			
IT-30	F1	0.778	0.957	0.063	15.175	<.001
IT-29	F1	0.767	0.812	0.065	14.715	<.001
IT-27	F1	0.886	1.156	0.066	17.508	<.001
IT-26	F1	0.896	1.16	0.065	17.718	<.001
IT-21	F1	0.750	0.823	0.056	14.575	<.001
IT-15	F1	0.630	-0.91	0.075	-12.066	<.001
IT-5	F1	0.631	0.605	0.05	12.086	.001
IT-8	F1	0.708	0.57	0.042	13.674	.001
IT-42	F2	0.724	1			
IT-41	F2	0.843	0.999	0.067	14.979	.001
IT-31	F2	0.627	-0.741	0.066	-1.305	.001
IT-13	F2	0.777	0.981	0.07	13.956	.001
IT-38	F3	0.582	1			
IT-37	F3	0.841	1.596	0.131	12.203	.001
IT-36	F3	0.979	1.85	0.148	12.495	.001

Discussion

Partner support has been identified as a key protective factor against emotional state issues during and after pregnancy (Pilkington et al., 2016). During the postpartum period, partner support that is especially characterized by practical help, approval, empathy, and encouragement is crucial in laying the ground for a positive state of mind and protecting against mental health threats (Uludağ & Öztürk, 2020). Therefore, the objective of this study has been determined to develop a

valid and reliable, specific scale to assess the support of fathers who play the most significant role for mothers to adapt to their new lifestyle after giving birth.

Exploratory factor analysis identified a three-factor structure comprising 20 items. Following confirmatory factor analysis and the removal of four items, the final scale consisted of 16 items distributed across three subscales: Emotional Support (9 items), Support in Baby Care (4 items), and Support in Daily Life Practices (3 items). This three-factor structure reflects the multidimensional nature of perceived partner support during the maternity period by encompassing emotional, infant care–related, and daily life support. Similarly, the partner support scale developed by Dennis et al. (2017) comprises a single-factor structure, whereas the scale developed by Şahin et al. (2014) has a three-factor structure consisting of Emotional Support, Social Support, and Physical Support. Although both PPSSMP and the scale developed by Şahin et al. (2014) yielded three-factor structures, the dimensions identified in the present study differ conceptually by specifically addressing partner support during the maternity period, particularly in relation to baby care and daily life practices.

Regarding the total reliability level of the scale, the Cronbach's alpha coefficient for the scale itself was found to be 0.837, while it was calculated to be 0.788, 0.460, and 0.838 for the first, second, and third subscales respectively. A Cronbach's alpha coefficient of 0.60 – 0.80 reflects good reliability, while a coefficient of 0.80 – 1.00 reflects great reliability (Kula Kartal & Mor Dirlik, 2016). Regarding the internal consistency coefficients of PPSSMP, the partner relations subscale was found to have great reliability, the 5-item support in partner responsibility subscale was found to be reliable, and the support in daily life practices subscale was found to have great reliability. The total internal consistency value of PPSSMP was highly above the alpha>0.70 criterion desired in newly developed scale tools (Nunnally & Bernstein, 1994). The Cronbach's alpha coefficient of the scale with three subscales developed by Şahin et al. (2014) is 0.87, while that of the scale with one subscale developed by Dennis et al. (2017) is 0.96.

The total PPSSMP score was found to have a positive and highly significant correlation with PSSPWEPP. This finding constitutes proof of the validity of the scale. In the study carried out by Dennis et al. (2017) in which they developed "the Postpartum Partner Support Scale", it is stated that a general partner/spouse support and global social support form was used for criterion related validity and a positive correlation was observed. The fact that the study was carried out only with married women is assessed as a limitation. Although online recruitment through social media enhanced the feasibility of data collection and increased geographical reach, it may have introduced self-selection bias and limited the representativeness of the sample. Women who are more digitally engaged, have higher educational attainment, or are more interested in parenting-related topics may have been more likely to participate. Therefore, the psychometric properties of the PPSSMP should be further examined in more heterogeneous populations using clinic-based or probability sampling approaches to strengthen its generalizability.

Conclusion and Recommendations

The PPSSMP is a psychometrically sound instrument that can be used to comprehensively assess the perceived support provided by fathers during women's transition to motherhood. Beyond measuring the level and dimensions of partner support, the scale enables the early identification of mothers experiencing insufficient support, thereby facilitating timely psychosocial assessment and intervention. The instrument has potential applications across a wide range of clinical and community settings, including postpartum wards, primary healthcare centers, family health services, maternal and child health clinics, home-visiting programs, and routine postpartum follow-up services. Healthcare professionals, particularly midwives, nurses, and family physicians, may use the PPSSMP to identify women at increased risk of inadequate partner support, tailor family-centered interventions, strengthen paternal involvement, and monitor changes in partner support throughout the postpartum period. Furthermore, the scale may contribute to maternal mental health promotion by supporting the early recognition of women who may be vulnerable to postpartum depression, anxiety, impaired maternal adaptation, or difficulties in mother–infant bonding associated with insufficient partner support. It may also serve as an outcome measure for evaluating the effectiveness of educational, psychosocial, or couple-based interventions designed to improve paternal support during the transition to parenthood. Despite these strengths, the findings should be interpreted in light of several limitations. The psychometric properties were evaluated

using data collected from a specific population and cultural context, which may limit the generalizability of the results. Future studies should examine the scale's performance in diverse populations, different healthcare settings, and longitudinal designs to further establish its responsiveness, predictive validity, and cross-cultural applicability. Overall, the PPSSMP represents a valid and reliable assessment tool that can support evidence-based postpartum care by facilitating the identification of support needs, guiding individualized interventions, and improving maternal well-being through strengthened partner involvement. By providing a standardized assessment of paternal support during the transition to motherhood, the PPSSMP has the potential to enhance family-centered postpartum care, inform evidence-based clinical decision-making, and contribute to the development of policies aimed at promoting paternal engagement and maternal well-being.

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