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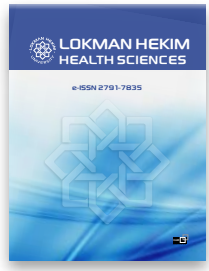

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ORIGINAL ARTICLE

Childhood Experiences, Emotional Intelligence, and the Maternal Role in Postpartum Women: A Cross-Sectional Study

Hafize Dağ Tüzmen[1], Huriye Altınkaynak[2], Arzu Çiftçi[2]

[1]Department of Midwifery, KTO Karatay University Faculty of Health Sciences, Konya, Türkiye
[2]KTO Karatay University, Graduate School, Midwifery Program, Konya, Türkiye

Abstract

Introduction: The purpose of this study is to investigate the associations between childhood experiences, emotional intelligence levels, and maternal roles in postpartum women.

Methods: This study employed a cross-sectional design. The study population consisted of women aged 18–49 years living in Konya province who were within 2 months to 2 years postpartum. Data were collected using the Individual Identification Form, the Early Life Experiences Scale, Trait Emotional Intelligence Questionnaire–Short Form, and the Barkin Index of Maternal Function. The data obtained from the research were analyzed in the Statistical Package for the Social Sciences 25.0 program. Necessary permits were obtained before the work began. The STROBE checklist was taken into account in writing the study report.

Results: The study included 294 female participants. The mean scores of the participants were 33.20 for childhood experiences, 82.17 for emotional intelligence and 74.86 for maternal functioning, respectively. Regression analysis showed that the variables explained 12.5% of the variance.

Discussion and Conclusion: Research findings indicate a negative relationship between adverse childhood experiences and maternal functioning, and a positive relationship between emotional intelligence level and maternal functioning. These results suggest that considering women's early-life experiences and emotional intelligence levels may be clinically important in assessing and supporting maternal functioning during the post-natal period.

Keywords: Childhood experiences; Emotional intelligence; Maternal role

Motherhood is a period during which a baby is understood, and their needs are met. This includes the physiological and psychological changes that begin with pregnancy.[1] The role of motherhood has been defined as one of the most fundamental roles that women assume throughout their lives.[2] Becoming a mother is associated with physical, social and psychological changes that can affect a woman's mental health, personal life, and family dynamics.[3] Other variables found to be important in performing the mother role include the mother's own parenting experiences, her relationship with her husband, previous experiences with children, and the events and policies in the mother's environment.[2]

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Correspondence: Hafize Dağ Tüzmen. KTO Karatay Üniversitesi Sağlık Bilimleri Fakültesi, Ebelik Anabilim Dalı, Konya, Türkiye
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It is stated that women adapt to the role of motherhood in the postpartum period. During this period, mothers should continue their daily activities while trying to learn the role of motherhood and adapting to new situations in order to meet their baby's wants and needs.[4] The way mothers perceive and interact with their babies during this period shapes the basic structure of the mother–baby relationship in the future.[5] The first years of childhood have a significant impact on the child's life. During this period, positive interactions that children have with their mothers form the basis of children's multifaceted development.[6] Parents' emotion regulation skills have been shown to affect children's developmental processes in various ways.[7] Many studies have examined the effects of childhood traumas on individuals' emotion regulation skills.[8,9] In these studies, it has been observed that individuals who have experienced childhood trauma have difficulties in emotion regulation processes.[10] In this direction, the child's first experiences of the environment are often formed through the family. As the child gets older, social interactions in a wider area replace the family.[11] Children with negative physical and psychological development are usually reported to come from problematic families.[12] On the other hand, individuals with balanced and healthy growth come from families who are able to communicate more effectively and know the necessary approaches to raising children. Parents whose needs are not adequately met during childhood often exhibit indifferent parenting behaviors.[13] It was found that the neglectful parenting behaviors of parents who were exposed to neglect in their childhood were approximately 2 ½ times higher than those of non-neglected parents, whereas physically abusive parenting behaviors were 2 times higher.[7] When the literature is examined, although there are many studies addressing the role of motherhood, studies that jointly consider childhood experiences and emotional intelligence within the context of the maternal role are limited. Examining these factors together may contribute to a more comprehensive understanding of maternal role development during the postpartum period.

Purpose

This study aimed to investigate the associations among childhood experiences, emotional intelligence levels, and the maternal role of women in the postpartum period.

Materials and Methods

Study Place and Design

The study was carried out using a cross-sectional research design and was conducted online with mothers residing in Konya, Türkiye. The STROBE checklist was taken into account in the reporting of the study.

Population and Sample of Research

The population of the study consisted of women aged 18–49 years living in Konya province who were within 2 months to 2 years postpartum. The G*Power 3.1 package program was used to calculate the sample size. In the study conducted by Cankaya and Akın (2023), the sample size was determined as 294 people with an effect size of 0.19, 95% power and 5% margin of error based on the Barkin index of maternal function (BIMF) score.[14] Participants were recruited using a snowball sampling approach. Initially, mothers who voluntarily agreed to participate in the study were reached through online platforms, and subsequently, additional participants were included through referrals. Thus, the number of mothers included in the study increased gradually. Women aged 18–49 years, having at least one child, giving birth within at least 2 months, and volunteering to participate in the study were included. Individuals who were unable to read, write, speak and understand Turkish were excluded.

Data Collection

Data were collected through an online questionnaire developed by the researchers using the Google Forms platform. Participants were recruited via the snowball sampling method, and the survey link was distributed through e-mail and social media channels. Before participation, women were informed about the purpose of the study, the voluntary nature of participation, the confidentiality of the data, and the use of the information solely for scientific purposes. Informed consent was obtained electronically at the beginning of the survey. The questionnaire required approximately 5–10 min to complete, and no identifying personal information was requested. All responses were stored in a secure digital environment accessible only to the research team to ensure data privacy and confidentiality.

Data Collection Tools

Data were collected online using a structured questionnaire between January 30, 2025 and February 20, 2025.

Individual Identification Form

This form was created by the researchers as a result of a literature review.[15]

Early Life Experiences Scale (ELES)

The ELES, originally developed by Gilbert et al.,[16] was adapted into Turkish by Akın et al.,[17] who also conducted

its validity and reliability analyses. The scale comprises 15 items across three subdimensions: Devaluing (items 6, 7, and 9), Subjugating (items 1, 2, 3, 5, 10, and 12), and Threatening Memories (items 4, 8, 11, 13, 14, and 15). Items are rated on a 5-point Likert scale, with items 6, 7, and 9 reverse-coded. Total scores range between 15 and 75, with higher scores indicating greater levels of negative early life experiences. In the original adaptation study, the Cronbach's alpha was reported as 0.85, whereas in the current study, it was found to be 0.90.

Trait Emotional Intelligence Questionnaire-Short form (TEIQue-SF)

The TEIQue-SF was developed by Petrides based on the conceptualization of emotional intelligence as a personality trait.[18] According to Deniz et al.,[19] the Turkish adaptation and psychometric evaluation of the scale were conducted. Adapted from the long form, the TEIQue-SF consists of 30 items rated on a 7-point Likert-type scale (1=strongly disagree and 7=strongly agree) and is designed to assess individuals' perceptions of their emotional competence. The scale includes four subscales: Subjective well-being, self-control, emotionality, and sociability. These dimensions have been shown to have significant negative correlations with neuroticism and positive correlations with personality traits such as extraversion, openness to experience, agreeableness, and conscientiousness.[19] Higher scores reflect greater emotional intelligence, and in the present study, the internal consistency coefficient for the total scale was 0.70.

BIMF

The BIMF, developed by Barkin (2009), is designed to assess the functional status of mothers in the postpartum period.[20] The scale initially demonstrated strong internal consistency (Cronbach's α=0.87). The Turkish adaptation and psychometric evaluation were conducted by Aydın and Kukulu (2018) with a sample of 235 mothers aged 18–40 years. In their study, the overall internal consistency was reported as 0.95. Subscale reliability coefficients were as follows: Self-Care (0.66), maternal psychology (0.71), infant care (0.62), social support (0.69), and adaptation to motherhood (0.50). The scale comprises 16 items rated on a 7-point Likert-type scale (0=completely disagree and 6=completely agree), yielding total scores between 0 and 96.[21] In this study, Cronbach's alpha coefficient was found to be 0.96. Subscale reliability coefficients were as follows: Self-care (0.81), maternal psychology (0.79), infant care (0.96), social support (0.86), and adaptation to motherhood (0.85).

Statistical Evaluation of the Data

The data were analyzed using IBM Statistical Package for the Social Sciences Statistics for Windows, Version 25.0 (IBM Corp., Armonk, NY, USA). Descriptive statistics were presented as mean±standard deviation for continuous variables and frequency (n) and percentage (%) for categorical variables. The normality of continuous variables was assessed using skewness and kurtosis values. Homogeneity of variances was evaluated using Levene's test. When the assumptions of normal distribution and homogeneity of variances were met, parametric tests were applied. Independent samples t-tests were used for comparisons between two groups, and one-way analysis of variance (ANOVA) was used for comparisons among three or more groups. When ANOVA results were statistically significant, Tukey's HSD post hoc test was performed to determine pairwise group differences. To determine the predictive effects of early life experiences and emotional intelligence on maternal functioning, multiple linear regression analysis was conducted. Multicollinearity was evaluated using tolerance and variance inflation factor values. Statistical significance was set at $p<0.05$.

Ethical Dimension of the Research

Ethics committee permission dated January 30, 2025 and numbered 2025/037 was obtained from the KTO Karatay University Drug and Non-Medical Device Research Ethics Committee to conduct the research. The individuals participating in the study were informed about the purpose of the study, and their verbal and written permissions were obtained. Permission was obtained from the authors of the scale via e-mail. The research was carried out in line with the principles set out in the Declaration of Helsinki.

Results

The study was conducted with 294 female participants. Most participants were aged 27–35 years (58.5%; n=172), whereas 28.9% (n=85) were aged 18–26, and 12.6% (n=37) were aged 35 and above. The majority were university graduates (66.7%; n=196), and 60.5% (n=178) were unemployed. Regarding income status, 69.0% (n=203) reported an average income level, 24.8% (n=73) a good level, and 6.1% (n=18) a poor level. Most participants lived in the city center (68.0%, n=200) and had a nuclear family structure (91.8%, n=270). The proportion of non-smokers was 84.7% (n=249). Most spouses were aged 27–35 years (65.3%; n=192) and were university graduates (57.5%; n=169). The majority of participants married after

Table 1. Comparison of the descriptive characteristics of the participants and the mean scores of the BIMF, ELES, and TEIQue-SF (n=294)

Variables	n	%	$\bar{X}$±SD BIMF	$\bar{X}$±SD ELES	$\bar{X}$±SD TEIQue-SF
Age					
18–26[a]	85	28.9	77.20±11.02	34.69±13.80	82.28±14.15
27–35[b]	172	58.5	73.50±11.12	32.47±12.87	82.15±13.06
35 and above[ab]	37	12.6	75.83±9.97	33.21±11.27	82.02±14.86
F/p			F=3.410/**p=0.03**	F=0.836/p=0.43	F=0.005/p=0.99
Education status					
Primary-secondary school	33	11.2	77.54±9.57	33.78±13.55	80.87±14.76
High school	65	22.1	75.09±12.40	34.09±12.43	81.29±16.09
University	196	66.7	74.33±10.78	32.81±13.07	82.68±12.45
F/p			F=1.211/p=0.29	F=0.273/p=0.76	F=0.424/p=0.65
Employment status					
Yes	116	39.5	74.18±11.22	34.42±13.35	81.52±12.69
No	178	60.5	75.30±10.93	34.41±12.66	82.59±14.13
t/p			0.855/p=0.39	t=1.299/p=0.19	t=0.66/p=0.51
Income status					
Good[a]	73	24.8	75.94±11.78	30.61±10.96	85.75±13.59
Middle[a]	203	69.0	74.96±10.56	33.14±12.84	81.66±12.98
Bad[b]	18	6.1	69.33±12.27	44.44±16.21	73.38±15.72
F/p			F=2.643/p=0.073	F=8.661/**p=0.000**	F=6.705/**p=0.001**
Place of residence					
Province center	200	68.0	75.18±10.69	33.27±13.12	81.62±13.03
District center	94	32.0	74.18±11.78	33.07±12.66	83.35±14.65
t/p			t=0.72/p=0.46	t=0.120/p=0.90	t=1.020/p=0.30
Family type					
Nuclear family	270	91.8	74.74±11.08	33.51±12.93	82.00±13.51
Extended family	23	7.8	76.47±10.85	29.00±12.66	83.30±14.12
t/p			t=0.721/p=0.47	t=1.608/p=0.10	t=0.441/p=0.65
Smoking					
Yes	45	15.3	70.62±10.83	36.26±14.43	81.33±13.27
No	249	84.7	75.63±10.93	32.65±12.62	82.32±13.64
t/p			t=2.832/**p=0.005**	t=1.727/p=0.08	t=0.451/p=0.65
Age of spouse					
18–26[a]	36	12.2	80.52±8.77	32.38±12.46	81.69±13.57
27–35[b]	192	65.3	73.93±10.92	32.97±12.91	82.09±13.52
35 and above[b]	66	22.4	74.46±11.71	34.31±13.46	82.65±13.90
F/p			F=5.621/**p=0.004**	F=0.343/p=0.71	F=0.066/p=0.93
Spouse's education status					
Primary-secondary school	51	17.3	77.25±11.42	33.35±12.90	80.52±15.40
High school	74	25.2	73.86±10.28	34.45±13.41	81.27±14.37
University	169	57.5	74.57±11.21	32.61±12.80	83.06±12.60
F/p			F=1.559/p=0.21	F=0.523/p=0.59	F=0.902/p=0.40

Table 1 (cont.). Comparison of the descriptive characteristics of the participants and the mean scores of the BIMF, ELES, and TEIQue-SF (n=294)

Variables	n	%	$\bar{X}$±SD BIMF	$\bar{X}$±SD ELES	$\bar{X}$±SD TEIQue-SF
Form of marriage					
By meeting and negotiating	236	80.3	74.32±11.19	33.46±13.44	82.02±13.61
Arranged marriage	58	19.7	77.06±10.23	32.15±10.78	82.75±13.50
t/p			t=1.702/p=0.09	t=0.690/p=0.49	t=0.366/p=0.45
Duration of marriage					
0–5 year	170	57.8	74.36±10.96	33.68±13.74	82.78±12.71
5 years and above	124	42.2	75.54±11.16	32.55±11.81	81.33±14.67
t/p			t=0.907/p=0.36	t=0.753/p=0.45	t=0.909/p=0.36
Assessing Physical appearance					
Good[a]	147	50.0	77.54±10.68	31.35±11.76	83.14±13.35
Middle[b]	121	41.2	72.93±10.71	34.29±13.70	80.41±13.52
Bada[b]	26	8.8	68.69±10.60	38.61±14.19	79.26±13.89
F/p			F=10.924/**p=0.000**	F=4.291/**p=0.015**	F=3.198/p=0.042

a,b,c: Means with different superscripts differ significantly according to the Tukey HSD test (p<0.05). n: number, %: Percentage, $\bar{X}$: Mean; SD: Standard deviation; BIMF: Barkin index of maternal function; ELES: Early life experiences scale; TEIQue-SF: Trait emotional intelligence questionnaire–Short Form; t= Independent samples t-test; F: One-way analysis of variance test; P: Significance value.

meeting/dating (80.3%; n=236), and 57.8% (n=170) had been married for 0–5 years. Half of the participants rated their physical appearance as good (50.0%; n=147), 41.2% (n=121) as average, and 8.8% (n=26) as poor. A comparison of Descriptive Characteristics of the Participants and the Mean Scores of BIMF, ELES, and TEIQue-SF (N: 294) is given in Table 1. A significant difference was found in the BIMF scores across age groups (F[2, 292]=3.410, p=0.03), and participants aged 18–26 years scored significantly higher than participants aged 27–35 years. However, no significant difference was observed in the scores of BIMF and TEIQue-SF according to age groups (F=0.836, p=0.43 for BIMF; F=0.005, p=0.99 for TEIQue-SF). There were no significant differences between the scores of BIMF, ELES, and TEIQue-SF according to educational levels (F=1.211, p=0.29 for BIMF; F=0.273, p=0.76 for ELES; F=0.424, p=0.65 for TEIQue-SF).

There was no significant difference between working and non-working participants in the scores of BIMF, ELES, and TEIQue-SF (t=0.855, p=0.39 for BIMF; t=1.299, p=0.19 for ELES; t=0.66, p=0.51 for TEIQue-SF). According to perceived income status, no significant difference was found in maternal functioning scores (p>0.05). However, significant differences were observed in childhood trauma and emotion regulation difficulty scores. Participants who evaluated their income as poor had significantly higher childhood trauma and emotion regulation difficulty scores compared to those reporting good or moderate income levels (p<0.05). No significant differences were found between the good and moderate income groups (p>0.05). No significant difference was found between the participants living in urban and rural areas in terms of BIMF, ELES and TEIQue-SF scores (t=0.72, p=0.46 for BIMF; t=0.120, p=0.90 for ELES; t=1.020, p=0.30 for TEIQue-SF).

There was no significant difference between participants from nuclear and extended families in terms of BIMF, ELES and TEIQue-SF scores (t=0.721, p=0.47 for BIMF; t=1.608, p=0.10 for ELES; t=0.441, p=0.65 for TEIQue-SF). Smokers had significantly lower BIMF scores than non-smokers (t=2.832, p=0.005), but no significant difference was found for ELES and TEIQue-SF scores (t=1.727, p=0.08 for ELES; t=0.451, p=0.65 for TEIQue-SF). A significant difference was found in BIMF scores according to spouse age (F[2, 292]=5.621, p=0.004). Post hoc analysis showed that participants whose spouses were aged 18–26 had higher BIMF scores. No significant difference was found in the ELES and TEIQue-SF scores according to the age of the partner (F=0.343, p=0.71 for ELES; F=12.066, p=0.93 for TEIQue-SF).

No significant difference was found in the scores of BIMF, ELES, and TEIQue-SF according to the educational level of the spouses (F=1.559, p=0.21 for BIMF; F=0.523, p=0.59 for ELES; F=0.902, p=0.40 for TEIQue-SF. There was no significant difference in the scores of BIMF, ELES, and TEIQue-SF according to the type of marriage (t=1.702,

Table 2. Comparison of the Obstetric Characteristics of the Participants with the Mean Scores of BIMF, ELES, and TEIQue-SF (n=294)

Variables	n	%	$\bar{X}$±SD BIMF	$\bar{X}$±SD ELES	$\bar{X}$±SD TEIQue-SF
Baby's month					
0–6 month	133	45.2	76.06±11.23	32.81±13.12	80.82±13.73
7–12 month	80	27.2	73.77±11.68	32.63±12.75	84.33±12.62
13–18 month	52	17.7	73.34±10.19	35.67±13.31	82.48±14.35
19–24 month	29	9.9	75.06±9.63	32.17±12.17	81.82±13.82
F/p			F= 1.117/ p=0.34	F= 0.506/p=0.50	F= 1.131/p=0.337
Relationship status with spouse					
Good[a]	240	81.6	76.35±10.67	31.86±12.17	82.65±13.68
Middle[b]	47	16.0	68.06±10.37	38.78±15.16	79.31±13.13
Bada[b]	7	2.4	69.42±10.32	41.71±11.33	84.71±11.48
F/p			F=12.906/**p<0.001**	F=7.407/**p<0.001**	F=1.318/p=0.26
Number of pregnancy					
0–2	225	76.5	74.73±11.00	33.29±12.95	81.44±13.39
3 and above	69	23.5	75.27±11.24	32.91±13.06	84.53±13.97
t/p			t=0.353/p=0.72	t=0.215/p=0.83	t=1.658/p=0.98
Last form of pregnancy					
Planned	230	78.2	75.11±10.80	33.44±13.36	81.68±13.39
Unplanned	64	21.8	73.96±11.91	32.34±11.43	83.93±14.13
t/p			t=0.732/p=0.46	t=0.602/p=0.54	t=1.176/p=0.24
Last mode of delivery					
Vaginal	113	38.4	76.22±11.28	33.77±12.60	82.53±12.47
Cesarean section	181	61.6	74.01±10.84	32.85±13.19	81.95±14.24
t/p			t=1.670/p=0.09	t=0.59/p=0.55	t=0.356/p=0.72
History of abortion/curettage					
Yes	71	24.1	74.08±10.63	32.90±13.02	82.90±12.67
No	223	75.9	75.11±11.18	33.30±12.96	81.94±13.86
t/p			t=0.682/p=0.49	t=0.228/p=0.82	t=0.518/p=0.60
Intervention in childbirth					
Yes	220	74.8	74.03±11.18	33.80±13.45	81.88±13.58
No	74	25.2	77.33±10.30	34.44±11.25	83.00±13.57
t/p			**t=2.242/p=0.02**	t=1.345/p=0.17	t=0.625/p=0.53
The baby's diet					
Breast milk	161	54.8	75.33±11.25	33.34±12.90	83.32±13.03
Formula food	27	9.2	75.62±11.17	34.77±13.48	79.18±14.38
Breast milk+supplementary food	57	19.4	73.49±10.70	32.31±12.96	80.49±14.50
Breast milk+formula	38	12.9	74.71±10.94	35.52±12.99	82.68±13.29
Formula+supplementary food	11	3.7	73.72±11.04	34.36±13.39	79.54±15.50
t/p			F=0.354/p=0.84	F=0.510/p=0.72	F=0.433/p=0.43
Social support status					
Yes	217	73.8	77.37±9.77	31.39±11.73	83.59±12.96
No	17	26.2	67.77±11.39	38.31±14.82	76.15±14.50
t/p			t=7.078/**p=0.000**	t=4.132/**p=0.000**	t=3.067/**p=0.002**

Table 2 (cont.). Comparison of the Obstetric Characteristics of the Participants with the Mean Scores of BIMF, ELES, and TEIQue-SF (n=294)

Variables	n	%	$\bar{X}$±SD BIMF	$\bar{X}$±SD ELES	$\bar{X}$±SD TEIQue-SF
Mother's health problem					
Yes	34	11.6	75.50±10.89	34.61±16.04	88.85±14.05
No	260	88.4	74.78±11.08	33.02±12.52	81.30±13.28
t/p			t=0.356/p=0.72	t=0.67/p=0.52	**t=3.096/p=0.002**
Baby's sleep problem					
Yes	111	37.8	71.62±11.74	34.43±13.49	79.63±13.97
No	183	62.2	76.83±10.13	32.46±12.59	83.71±13.12
t/p			**t=4.020/p=0.000**	t=1.264/p=0.209	t=2.525/p=0.012
Mother's sleep problem					
Yes	124	42.2	71.42±10.68	34.52±12.74	80.12±13.80
No	170	57.8	77.37±10.65	32.24±13.06	83.67±13.23
t/p			**t=1.718/p=0.000**	t=1.491/p=0.137	t=2.230/p=0.027

a,b,c: Means with different superscripts differ significantly according to the Tukey HSD test (p<0.05). n: Number; %: Percentage, $\bar{X}$: Mean; SD: Standard deviation; BIMF: Barkin index of maternal function; ELES: Early life experiences scale; TEIQue-SF: Trait emotional intelligence questionnaire–short form, t= Independent samples t-test; F: One-way analysis of variance test; P: Significance value.

p=0.09 for BIMF; t=0.690, p=0.49 for ELES; t=0.366, p=0.45 for TEIQue-SF). No significant difference was found in BIMF, ELES, and TEIQue-SF scores according to duration of marriage (t=0.907, p=0.36 for BIMF; t=0.753, p=0.45 for CDI; t=0.909, p=0.36 for TEIQue-SF). Significant differences were found in all three variables (BIMF, ELES, and TEIQue-SF) according to physical appearance assessment. Participants who rated their physical appearance as "good" had significantly higher BIMF (F=10.924, p<0.001), ELES (F=4.291, p=0.015), and TEIQue-SF (F=3.198, p=0.042) scores than those who rated their physical appearance as "average" or "poor" (Table 1).

Comparison of obstetric characteristics of the participants and the mean scores of BIMF, ELES, and TEIQue-SF (N: 294) is given in Table 2. When the mean scores were examined according to the baby's month variable, no significant difference was found between the groups in terms of BIMF, ELES, and TEIQue-SF (p>0.05). Significant differences were observed in maternal functioning and childhood trauma scores according to relationship quality with the spouse. Women who evaluated their relationship as good had significantly higher maternal functioning scores compared to those reporting a moderate relationship ($\bar{X}$=8.29, p<0.001).

In addition, participants reporting good spousal relationships had significantly lower childhood trauma scores compared to those reporting moderate relationships ($\bar{X}$=–6.92, p=0.002). No significant differences were found in emotion regulation difficulty scores (p>0.05).

No significant differences were found in BIMF, ELES and TEIQue-SF scores in the comparison made according to the number of pregnancies (p>0.05). Similarly, no significant differences were observed in scale scores according to whether the last pregnancy was planned or unplanned or according to the type of birth (p>0.05). There was no significant difference between the BIMF, ELES and TEIQue-SF scores of mothers with and without a history of abortion/curettage (p>0.05). However, there was a significant difference in BIMF scores according to whether there was intervention at birth (p=0.02). The BIMF score of mothers who did not receive intervention ($\bar{X}$=77.33, SD=10.30) was higher than that of mothers who received intervention. The effect of social support status on the BIMF, ELES, and TEIQue-SF scores was found to be significant (p<0.01).

The BIMF score of mothers who received social support ($\bar{X}$=77.37, SD=9.77) was higher. A significant difference was found in TEIQue-SF scores between mothers with and without health problems, and the scores of mothers with health problems were higher (p=0.002). Significant differences were found in the BIMF and TEIQue-SF scores according to the baby's sleep problems and the mother's sleep problems (p<0.05). BIMF scores were higher in mothers without sleep problems ($\bar{X}$=77.37, SD=10.65) (Table 2).

Multiple Linear Regression Analysis of the Effect of ELES, TEIQue-SF on BIMF is shown in Table 3. When Table 3 is examined, the model is statistically significant, F(2, 291)=20.717, p<0.001, and the independent variables

Table 3. Multiple linear regression analysis regarding the effect of ELES, TEIQue-SF on BIMF (n=294)

Predictor	B	SE	B	t	p	95% CI for B	Tolerance	VIF
Constant	67.892	4.220		16.087	<0.001	(59.586, 76.199)		
ELES	0.207	0.046	-0.249	-4.472	<0.001	(-0.299, -0.116)	0.973	1.207
TEIQue-SF	0.170	0.044	0.213	3.838	<0.001	(0.083, 0.257)	0.973	1.207

Dependent variable=BIMF; R^2=0.125; Adjustment R^2=0.119; F(2, 291)=20.717; p<0.001. SE: Standard errors; CI: Confidence interval; VIF: Variance inflation factor.

explain 12.5% of the total variance (R^2=0.125, adjusted R^2=0.119). ELES (B=-0.207, SE=0.046, ß-0.249, t=-4.472, p<0.001) has a negative and significant effect on BIMF. This result shows that an increase in ELES level leads to a decrease in the BIMF score. TEIQue-SF (B=0.170, SE=0.044, β=0.213, t=3.838, p<0.001) has a positive and significant effect on BIMF. This shows that an increase in TEIQue-SF is associated with an increase in the BIMF score (Table 3).

Discussion

This study examined the effects of postpartum women's childhood experiences and emotional intelligence levels on their role as mothers and discussed the possible contributions of these two important variables to motherhood.

Although the postpartum period offers an important opportunity for the mother's personal development, negative experiences during childhood can have a negative impact on parenting skills during this period. [22] The transition to motherhood involves adapting to physical changes, forming a maternal identity, and bonding with the baby. This process is particularly challenging for women who experienced emotional neglect in childhood. [23] In this context, it is clear that adaptation to motherhood is not only a biological process but also deeply connected to psychological and emotional history.

Our findings indicate that negative childhood experiences were significantly and negatively associated with maternal functioning (p<0.001). In addition, there is a positive and statistically significant relationship between emotional intelligence levels and maternal functioning (p<0.001). These findings suggest that individuals' past negative experiences may be associated with both their personal mental health and their parenting roles in later life. In particular, maternal functioning is closely related to an individual's emotional history and emotional competence levels. It is thought that this finding may be related to the long-term impact of adverse childhood experiences on emotion regulation and stress-coping capacities. Women who were exposed to emotional neglect or insecurity in early life may have greater difficulty adapting to the emotional demands of motherhood.

Our findings indicate that negative childhood experiences are negatively associated with maternal functioning, whereas higher emotional intelligence levels are positively associated with maternal functioning. Similar to our findings, Akintunde et al.[24] found that negative childhood experiences among 1st-time mothers were associated with dissatisfaction with motherhood. This finding supports the results of our current study and highlights the impact of negative childhood experiences on shaping the motherhood experience. In a study conducted by Mammadov and Şentürk Erenel,[22] it was found that mothers with high emotional intelligence performed their maternal roles more successfully. Priyam and Nath[9] conducted a cross-sectional observational study in East India and found that negative childhood experiences were significantly negatively associated with emotional management and relationship management (p<0.05). These studies demonstrate that emotional intelligence is critical not only for individual adaptation but also for the healthy maintenance of complex social roles such as motherhood.[8,23] In addition, it is understood that the development of emotional intelligence is strongly influenced by the experiences an individual encounters during childhood. Similarly, the studies by Racine et al.[23] and Racine et al.,[8] also support these findings, showing that negative childhood experiences have lasting effects on an individual's emotional functioning and parenting competence. Thus, it is understood that an individual's past experiences are reflected not only in their inner world but also in the relationships they establish with their children. Consistent with the existing evidence in the literature, the findings of our study emphasize the importance of childhood experiences and the positive role of emotional intelligence in the development of maternal functioning. In this regard, our study shows that the fundamental building blocks shaping maternal functioning are closely related to an individual's past experiences and the impact of these experiences on emotional processes. In contrast, it can be said that mothers with high emotional intelligence levels can respond to the difficulties they encounter in the post-natal period more calmly and harmoniously, thereby enabling them to fulfill their maternal roles more effectively. Various studies have shown that individuals exposed to

adversity during childhood experience difficulties in various emotional processing and exhibit higher levels of reactivity, expressive suppression, and rumination.[23,25] At the same time, it has been found that higher levels of perceived maternal acceptance-rejection in adolescents are associated with lower levels of emotional intelligence.[5] These data suggest that emotional neglect or rejection experienced in childhood may be associated with difficulties in emotion regulation and with parenting patterns observed in later life. These findings reveal that emotional intelligence in motherhood is not merely a personal competency but also a fundamental component that directly influences the child's developmental process. According to previous studies, negative childhood experiences can lead to mental health problems and maladaptive parenting behaviors in adulthood.[26,27] This situation reveals that the negativity experienced by individuals during childhood does not remain in the past, but can also be reflected in their future parenting performance. Research based on Belsky's parenting model and personal development theory also supports this finding, suggesting that negative childhood experiences do not directly affect maternal functioning but rather indirectly through mediating variables such as psychological distress, lack of self-compassion, and social support. Within this framework, the findings of our study also show that maternal functioning is shaped not only by individual historical experiences but also by how these experiences are processed at the psychological and social levels. The relationship between maternal childhood difficulties and parenting stress, when evaluated together with the positive correlation between attachment styles and maternal functioning,[28] suggests that emotional deprivation experienced in childhood may increase stress levels during parenting and that this situation may negatively affect mother-child interaction. A systematic review showed that maternal adversity has serious negative effects on early childhood interactions.[29] Similarly, a meta-analysis revealed that these experiences have moderate negative effects on maternal mental health.[8]

In addition to all these results, the explanatory power of the regression model is relatively low (R^2=0.125). This indicates that the perception of the maternal role may be related not only to the variables examined but also to numerous biopsychosocial factors. Therefore, although the model is statistically significant, its explanatory power is limited from a clinical and practical perspective.

In this context, our study supports the existing literature, indicating that negative childhood experiences are associated with maternal functioning and may be linked to this relationship through various psychological and social pathways. This finding underscores the importance of holistic intervention approaches that consider not only individuals' past experiences but also focus on strengthening emotional skills and enhancing psychological resilience to support maternal functioning. In this regard, it is suggested that such supportive interventions should not be limited to the postpartum period, but may be more effective when initiated during pregnancy.

Limitations

This study has several limitations that should be considered when interpreting the findings. First, the cross-sectional design precludes any causal inferences regarding the relationships between childhood experiences, emotional intelligence, and maternal functioning. The observed associations reflect correlations at a single point in time and do not establish directionality. Second, the study employed a snowball sampling method, which is a non-probability sampling technique. Although the sample size was determined through power analysis, this recruitment strategy may limit the representativeness of the sample and reduce the generalizability of the findings to the broader population of postpartum women. Third, data were collected through self-report measures administered online. Self-reported data are subject to recall bias and social desirability bias, particularly when assessing early life experiences and maternal role perceptions. In addition, online data collection may have excluded women without internet access, potentially introducing selection bias.

Finally, the regression model explained a modest proportion of the variance in maternal functioning (R^2=0.125), indicating that other unmeasured biological, psychological, and social factors may also contribute to maternal role functioning. Future studies incorporating longitudinal designs and additional contextual variables may provide a more comprehensive understanding of these relationships.

Conclusion

It was found that negative childhood experiences decreased maternal functioning, whereas high levels of emotional intelligence increased it. In this direction, it is recommended that intervention programs offered by midwives and nurses, specially developed for the postpartum period, be designed in experimental-type studies with a focus on mothers' ability to process childhood traumas and increase their emotional intelligence levels. It is suggested that such programs may contribute to improvements in mothers' emotional well-being and their relationships with their children.

Ethics Committee Approval: The KTO Karatay University Drug and Non-Medical Device Research Ethics Committee granted approval for this study (date: 30.01.2025, number: 2025/037).

Informed Consent: The individuals participating in the study were informed that they could withdraw from the study at any time, and informed consent was obtained from the individuals.

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