

*Research Article*

## Factors Associated with Baby Blues Syndrome among Postpartum Mothers at a Maternal and Child Hospital in Indonesia

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**Abstract:** The postpartum period is a critical transitional phase that involves substantial physical recovery and psychological adaptation for mothers following childbirth. During this period, many women experience emotional disturbances, one of the most common being baby blues syndrome. Baby blues syndrome is characterized by mood swings, tearfulness, anxiety, irritability, and emotional instability that typically occur within the first week after delivery. Although often considered a mild and self-limiting condition, unresolved baby blues may progress into postpartum depression, leading to adverse consequences for maternal well-being, infant development, and family functioning. This study aimed to analyze factors associated with baby blues syndrome among postpartum mothers at a maternal and child hospital in Makassar, Indonesia. A quantitative analytical study with a cross-sectional design was conducted involving 50 postpartum mothers selected through purposive sampling. Data were collected using the Edinburgh Postnatal Depression Scale (EPDS) and structured questionnaires assessing occupational status, husband support, and family support. Data analysis was performed using Fisher's Exact test with a significance level of 0.05. The findings revealed that 82% of respondents experienced baby blues syndrome. Statistically significant associations were identified between occupational status ( $p = 0.000$ ), husband support ( $p = 0.000$ ), and family support ( $p = 0.000$ ) with the occurrence of baby blues syndrome. In conclusion, occupational and psychosocial factors play a crucial role in the development of baby blues syndrome. Strengthening family-centered support and implementing early psychological screening during the postpartum period are recommended to prevent more severe maternal mental health problems.

**Keywords:** Baby Blues Syndrome; Family Support; Husband Support; Occupational Status; Postpartum Mothers.

### 1. Introduction

The postpartum period represents a major life transition for women, marked by complex physiological changes and psychological adjustments following childbirth. During this period, mothers are required to adapt to new roles, responsibilities, and expectations related to infant care, while simultaneously recovering from the physical demands of pregnancy and delivery. These rapid changes place postpartum women at increased risk of psychological disturbances, particularly mood disorders (Tsokkou et al., 2024; World Health Organization [WHO], 2018).

One of the most frequently reported psychological conditions during the early postpartum period is baby blues syndrome. Baby blues syndrome is a mild affective disorder characterized by emotional lability, tearfulness, anxiety, irritability, sleep disturbances, and difficulty concentrating, typically emerging between the third and fifth day after delivery (Chechko et al., 2024; Tosto et al., 2023). Although the condition is often transient and

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resolves spontaneously within two weeks, its high prevalence warrants clinical attention due to the potential progression to postpartum depression if left unmanaged (Iyengar & Hunt, 2024).

Globally, the prevalence of baby blues syndrome varies considerably, ranging from 0.5% to more than 60%, depending on sociocultural context, assessment tools, and population characteristics (WHO, 2018). In Asian countries, reported prevalence rates are substantially higher, reaching up to 85% in some settings (Sri et al., 2024). In Indonesia, national health data indicate that approximately 50–70% of postpartum mothers experience symptoms consistent with baby blues syndrome, highlighting the magnitude of this mental health issue within maternal care services (Risksedas, 2022).

Previous studies have demonstrated that the development of baby blues syndrome is multifactorial, involving an interaction between biological, psychological, and social determinants. Biological factors include hormonal fluctuations following childbirth, particularly the abrupt decline in estrogen and progesterone levels, which are known to influence mood regulation (Hariyanti, 2020). Psychological factors such as maternal readiness, parity, and coping capacity also contribute to emotional vulnerability during the postpartum period (Pratiwi Kasmara et al., 2023). In addition, social determinants—including occupational status, socioeconomic conditions, and social support—play a pivotal role in shaping maternal psychological adaptation (Utami & Nurfitra, 2022).

Social support, particularly from husbands and family members, has been consistently identified as a protective factor against postpartum psychological disorders. Adequate husband support in the form of emotional reassurance, practical assistance, and shared responsibility in infant care has been shown to reduce maternal stress and enhance emotional stability (Komariah, 2024; Kurniawati et al., 2022). Similarly, family support provides additional emotional and instrumental resources that help mothers cope with postpartum challenges, thereby reducing the risk of baby blues syndrome (Eristono et al., 2023).

Occupational status may also influence maternal mental health during the postpartum period. Mothers who are unemployed or primarily engaged in domestic roles may experience social isolation, limited access to health information, and increased self-blame, which can heighten vulnerability to emotional disturbances (Merlina et al., 2022). Conversely, working mothers may face role conflict and fatigue related to balancing employment and childcare responsibilities, which can also contribute to psychological stress (Afrina & Rukiah, 2024).

Despite the growing body of literature on postpartum mental health, evidence regarding the relative contribution of occupational status, husband support, and family support to baby blues syndrome in Indonesian hospital settings remains limited. Most existing studies focus on community-based samples or broader postpartum depression outcomes. Therefore, this study aimed to analyze factors associated with baby blues syndrome among postpartum mothers at a maternal and child hospital in Makassar, Indonesia. The findings are expected to provide empirical evidence to support early detection and family-centered nursing interventions for postpartum mental health care.

## 2. Literature Review

Baby blues syndrome is recognized as a transient mood disturbance occurring during the early postpartum period and is considered the mildest form of postpartum affective disorders. Despite its self-limiting nature, baby blues syndrome is clinically significant due to its high prevalence and its potential progression to postpartum depression when early symptoms are ignored (Iyengar & Hunt, 2024). Understanding factors associated with baby blues syndrome is therefore essential for preventive maternal mental health care.

Biological factors have long been implicated in the development of postpartum mood disturbances. Following childbirth, women experience a rapid decline in estrogen and progesterone levels, which are hormones closely associated with mood regulation and emotional stability. These abrupt hormonal changes may trigger emotional lability and depressive symptoms in susceptible individuals (Hariyanti, 2020; Tsokkou et al., 2024). However, biological explanations alone are insufficient to fully account for the occurrence of baby blues syndrome, as not all postpartum women experience emotional disturbances despite similar hormonal changes.

Psychosocial factors play a central role in maternal emotional adaptation during the postpartum period. Parity, maternal readiness, and psychological coping capacity influence how women respond to the demands of caring for a newborn (Pratiwi Kasmara et al., 2023).

First-time mothers, in particular, may experience heightened anxiety and uncertainty related to infant care, increasing vulnerability to baby blues syndrome (Dwi Febriati, 2023).

Occupational status has been identified as an important social determinant of postpartum mental health. Mothers who are not formally employed or are solely engaged in domestic roles may experience reduced social interaction, limited access to health-related information, and increased self-blame when facing difficulties in infant care (Merlina et al., 2022). Conversely, working mothers may encounter role conflict, fatigue, and psychological stress associated with balancing professional responsibilities and maternal duties, which can also contribute to emotional distress during the postpartum period (Afrina & Rukiah, 2024).

Social support is consistently reported as one of the strongest protective factors against postpartum psychological disorders. Husband support, encompassing emotional, informational, and instrumental assistance, has been shown to significantly reduce maternal stress and improve emotional well-being after childbirth (Komariah, 2024; Kurniawati et al., 2022). Adequate spousal involvement in infant care and household responsibilities fosters a sense of shared responsibility and emotional security for postpartum mothers.

In addition to spousal support, family support plays a crucial role in maternal psychological adjustment. Extended family members can provide practical assistance, emotional reassurance, and guidance in newborn care, particularly in collectivist cultures such as Indonesia, where family involvement in postpartum care is common (Eristono et al., 2023). Lack of family support has been associated with increased emotional burden and a higher risk of developing baby blues syndrome.

Although numerous studies have examined postpartum mental health, findings regarding the relative contribution of occupational status, husband support, and family support to baby blues syndrome remain inconsistent across different sociocultural contexts. Furthermore, hospital-based studies focusing specifically on baby blues syndrome in Indonesian maternal health settings are still limited. Therefore, further investigation is needed to clarify the role of these psychosocial factors in the development of baby blues syndrome among postpartum mothers.

### 3. Materials and Method

This study employed a quantitative analytical design with a cross-sectional approach to examine factors associated with baby blues syndrome among postpartum mothers. The study was conducted in the postpartum ward of a maternal and child hospital in Makassar, Indonesia, from January 13 to January 18, 2025. The study population comprised postpartum mothers who met the inclusion criteria, and a total of 50 respondents were recruited using purposive sampling. Eligible participants were mothers on the third day postpartum who were able to read and write and had delivered either vaginally or by cesarean section. Mothers with severe physical complications, decreased consciousness, or who were unable to complete the questionnaire were excluded from the study.

Data were collected using the Edinburgh Postnatal Depression Scale (EPDS) to assess the presence of baby blues syndrome, with a score of  $\geq 10$  indicating baby blues. Additional structured questionnaires were used to assess occupational status, husband support, and family support. All instruments demonstrated satisfactory reliability, with Cronbach's alpha values exceeding 0.80. Data analysis was performed using descriptive statistics and Fisher's Exact test to examine associations between independent variables and baby blues syndrome, with statistical significance set at  $p < 0.05$ . Ethical approval was obtained prior to data collection, and all participants provided informed consent.

### 4. Results and Discussion

In this section, the author needs to explain the hardware and software used, dataset sources, initial data analysis, results, and results analysis/discussion. Presenting the results with pictures, graphs and tables is highly recommended. Formulas or evaluation measuring tools also need to be included here. There must be discussion/analysis, and you can't just rewrite the results in sentence form, but you need to provide an explanation of their relationship to the initial hypothesis. In addition, this section needs to discuss and elaborate on important findings.

## Figures and Tables

Tabel. 1. Characteristics of Respondents.

| Variabel                | Frekuensi<br>n=50 | Presentase<br>(%) |
|-------------------------|-------------------|-------------------|
| <b>Age</b>              |                   |                   |
| 19–25 years             | 31                | 62                |
| 26–30 years             | 15                | 30                |
| 31–36 years             | 2                 | 4                 |
| 37–41 years             | 2                 | 4                 |
| <b>Mode of Delivery</b> |                   |                   |
| Vaginal delivery        | 41                | 82                |
| Cesarean section        | 9                 | 18                |
| <b>Parity</b>           |                   |                   |
| First pregnancy         | 25                | 50                |
| Second pregnancy        | 22                | 44                |
| Third pregnancy         | 1                 | 2                 |
| Fourth pregnancy        | 1                 | 2                 |
| Sixth pregnancy         | 1                 | 2                 |
| <b>Occupation</b>       |                   |                   |
| Housewife               | 31                | 62                |
| Self-employed           | 10                | 20                |
| Teacher/Lecturer        | 3                 | 6                 |
| Student                 | 1                 | 2                 |
| Farmer                  | 3                 | 6                 |
| Nurse                   | 1                 | 2                 |
| Civil servant           | 1                 | 2                 |

A total of 50 postpartum mothers participated in this study. The majority of respondents were aged 19–25 years (62%), followed by those aged 26–30 years (30%). Most respondents experienced vaginal delivery (82%), while 18% delivered by cesarean section. Half of the respondents were primiparous (50%). Regarding occupational status, most respondents were housewives (62%), followed by self-employed mothers (20%), teachers/lecturers (6%), farmers (6%), and other occupations (6%).

Table 2. Association between Occupational Status and Baby Blues Syndrome.

| Occupational Status | Syndrome Baby Blues |    |               |    | Total |     | P value |
|---------------------|---------------------|----|---------------|----|-------|-----|---------|
|                     | Baby Blues          |    | No Baby Blues |    | n     | %   |         |
|                     | n                   | %  | n             | %  |       |     |         |
| Employed            | 3                   | 6  | 6             | 12 | 9     | 18  | 0,000   |
| Unemployed          | 38                  | 76 | 3             | 6  | 41    | 82  |         |
| Total               | 41                  | 82 | 9             | 18 | 50    | 100 |         |

Statistical analysis using Fisher's Exact test revealed a significant association between occupational status and baby blues syndrome ( $p = 0.000$ ). Mothers who were not formally employed showed a higher proportion of baby blues syndrome compared to those who were employed.

Table 3. Association between Husband Support and Baby Blues Syndrome.

| Husband Support           |       | Syndrome Baby Blues |    |               |    | Total |     | P value |
|---------------------------|-------|---------------------|----|---------------|----|-------|-----|---------|
|                           |       | Baby Blues          |    | No Baby Blues |    | n     | %   |         |
|                           |       | n                   | %  | n             | %  |       |     |         |
| With Husband Support      |       | 35                  | 70 | 0             | 0  | 35    | 70  | 0,000   |
| Twithouth Husband Support |       | 6                   | 12 | 9             | 18 | 15    | 30  |         |
|                           | Total | 41                  | 82 | 9             | 18 | 50    | 100 |         |

A significant association was identified between husband support and baby blues syndrome ( $p = 0.000$ ). Postpartum mothers who reported inadequate husband support were more likely to experience baby blues syndrome compared to those who received adequate support.

**Tabel 4.** Association between Family Support and Baby Blues Syndrome.

| Family Support         |        | Syndrome Baby Blues |    |               |    | Total |     | Nilai p |
|------------------------|--------|---------------------|----|---------------|----|-------|-----|---------|
|                        |        | Baby Blues          |    | No Baby Blues |    |       |     |         |
|                        |        | n                   | %  | n             | %  | n     | %   |         |
| With Family Support    |        | 35                  | 70 | 0             | 0  | 35    | 70  | 0,000   |
| Without Family Support | Family | 6                   | 12 | 9             | 18 | 15    | 30  |         |
|                        | Total  | 41                  | 82 | 9             | 18 | 50    | 100 |         |

Family support was also significantly associated with baby blues syndrome ( $p = 0.000$ ). Mothers who lacked sufficient family support demonstrated a higher prevalence of baby blues syndrome than those who received adequate family support.

## Discussion

This study revealed a high prevalence of baby blues syndrome among postpartum mothers, with more than four-fifths of respondents experiencing emotional disturbances in the early postpartum period. This finding indicates that baby blues syndrome remains a significant maternal mental health issue, particularly within hospital-based postpartum care settings. The prevalence observed in this study is consistent with reports from several Asian countries, where sociocultural expectations, limited psychosocial support, and rapid role transitions contribute to heightened emotional vulnerability among postpartum mothers (Sri et al., 2024; Riskesdas, 2022).

The association between occupational status and baby blues syndrome highlights the complex role of maternal employment in postpartum psychological adaptation. Mothers who were not formally employed demonstrated a higher prevalence of baby blues syndrome. This finding suggests that unemployment or exclusive engagement in domestic roles may increase emotional vulnerability due to social isolation, reduced access to health information, and increased self-focus on perceived parenting inadequacies (Merlina et al., 2022). In the absence of structured external activities, postpartum mothers may spend prolonged periods reflecting on physical discomfort, infant care challenges, and perceived personal shortcomings, which may intensify negative emotional responses.

Conversely, employment may serve as a protective factor by providing social interaction, cognitive engagement, and access to broader support networks. However, this protective effect is not absolute. Working mothers may also experience role conflict, fatigue, and stress related to balancing occupational responsibilities and maternal duties, which can exacerbate emotional strain during the postpartum period (Afrina & Rukiah, 2024). These findings indicate that occupational status influences baby blues syndrome through multiple pathways, underscoring the need for individualized psychosocial assessment rather than assuming employment status alone as a risk or protective factor.

Husband support emerged as one of the strongest determinants of baby blues syndrome in this study. Mothers who reported inadequate husband support were significantly more likely to experience baby blues syndrome. This finding reinforces existing evidence that emotional, informational, and instrumental support from husbands plays a crucial role in buffering postpartum stress (Komariah, 2024; Kurniawati et al., 2022). Active husband involvement in infant care, household tasks, and emotional reassurance can reduce maternal burden and foster a sense of shared responsibility, thereby promoting emotional stability during the postpartum period.

From a nursing and maternal health perspective, husband support is particularly important in facilitating maternal adaptation to new roles. The presence of a supportive partner enhances maternal confidence, reduces anxiety related to infant care, and improves coping capacity when facing postpartum physical discomfort and sleep deprivation. In contrast, lack of spousal support may lead to feelings of neglect, loneliness, and helplessness, which are key emotional triggers of baby blues syndrome.

Family support beyond the husband was also significantly associated with baby blues syndrome. In collectivist societies such as Indonesia, extended family members often play an integral role in postpartum care by providing practical assistance, guidance, and emotional reassurance. The absence of adequate family support may increase maternal workload and emotional strain, particularly among first-time mothers who lack prior experience in infant care (Eristono et al., 2023). This finding emphasizes the importance of considering broader family dynamics when addressing postpartum mental health.

The findings of this study support the biopsychosocial model of postpartum mental health, which posits that emotional disturbances following childbirth result from interactions between biological changes, psychological readiness, and social context. Although hormonal fluctuations are inevitable after delivery, the presence of strong social support systems appears to mitigate their psychological impact. Therefore, psychosocial factors should be prioritized in postpartum mental health screening and intervention programs.

From a clinical nursing perspective, these results have important implications for postpartum care. Nurses play a critical role in early identification of baby blues syndrome and in facilitating family-

centered interventions. Routine psychological screening using validated tools such as the EPDS, combined with counseling and education for husbands and family members, may help prevent the progression of baby blues syndrome into more severe postpartum mental health disorders. Future research should employ longitudinal designs to explore causal relationships and evaluate the effectiveness of targeted psychosocial interventions in reducing postpartum emotional distress.

The novelty of this study lies in its focused examination of psychosocial determinants—occupational status, husband support, and family support—in relation to baby blues syndrome within a hospital-based postpartum population in Indonesia. Unlike previous studies that predominantly emphasize biological or general demographic factors, this study highlights the central role of social and familial support systems in shaping maternal emotional outcomes during the early postpartum period. Furthermore, by situating the analysis within a maternal and child hospital setting, this study provides context-specific evidence that is directly applicable to clinical nursing practice. The findings contribute new insights for family-centered postpartum care by emphasizing the integration of psychosocial screening and partner involvement as essential components of maternal mental health interventions.

## 5. Conclusion

This study concludes that baby blues syndrome is highly prevalent among postpartum mothers in a maternal and child hospital setting in Indonesia. Occupational status, husband support, and family support were found to be significantly associated with the occurrence of baby blues syndrome.

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