Baby Blues: Husband's Support in Form of Communication

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Abstract

Baby blues is the mildest form of postpartum mood disorder, and it is a common condition in newborn mothers. Up to 50-80 percent of newborn mother experience baby blues. While it has the mildest effect, such factors as psychiatric history, environmental stressors, cultural context, breastfeeding, and parity may cause baby blues to progress to a more severe depression. The treatment required by mothers who are affected by baby blues is only reassurance. One of its forms is support system from those within the mother's immediate environment. The form of support that is discussed in this study is communication with husband. This study aims to discover whether communicating with one's partner, or husband in this context, is effective in decreasing mood disorder for newborn mothers experiencing baby blues. This study was conducted by interviewing 18 female participants who admitted that they experienced baby blues and were willing to participate in the study. The result of the interview showed that only eight of the eighteen participants stated that communication with their husbands was effective in decreasing their mood disorder during baby blues.

Keywords: postpartum, postpartum depression, baby blues, mood disorder, communication.

Introduction

Pregnancy is something that most women really look forward to. The final result of pregnancy is, of course, to deliver the baby into the world. As a highly anticipated process, pregnancy and childbirth should be a very encouraging experience. Being a mother, as a result of pregnancy and childbirth process, should be a happy moment for a woman. However, after becoming a newborn mother, happiness is not the only feeling experienced by women. Instead, most newborn mothers tend to suffer from anxiety and depression. An evidence report commissioned by Agency for Healthcare Research and Quality (AHRQ) found that

the estimated point prevalence ranged from 6.5 to 19.2 percent with regards to newborn mothers experiencing major and minor depression (Gaynes et al., 2005).

News related to postpartum depression can easily be found on the internet. For instance, in March, 2019, in Purwakarta, West Java, there was surprising news of a mother, named Wartini, who buried her five months old baby alive. It was suspected that Wartini was experiencing postpartum depression. Similarly, Aniek Qori'ah Sriwijaya killed her three children (nine months, three and six years old). Aniek was pronounced to have a psychiatric disorder which made her hate herself, and she transferred her hate to her three children because she was afraid of failing to raise them properly. In Indonesia, Hidayat (2007) mentioned that the percentage of mothers who experience baby blues syndrome is about 50-70 percent (as cited in Munawaroh, 2008).

Postpartum depression not only occurs in Indonesia, but is observed across the globe every year, impacting many women and children (Liu et al, 2016). Some research indicated that this devastating mood disorder is a universal and transcultural experiences (Beck et al, 2006). Regarding to Benneth (2007) that being a mom, especially a new one, is exceptionally difficult work on many levels: physically, psychologically and emotionally. Mothers often experience immense biological, emotional, financial, and social pressure during this time. Some women are at an increased risk of developing mental health problems, particularly depression and anxiety.

There is nothing definite known as cause of postpartum blues syndrome (Alvarado-Esquivel et al, 2006) but some factors, such as hormonal changes, socio-culture factor, economic condition, and relationship conflict, were discovered to be related with it. In their study found that lack of support and social understanding played important roles in postnatal depression in newborn mothers (Khan et al, 2009).

Regarding to O'hara (1995), there are three degrees of mood disorder during postpartum period, which can be distinguished based on severity: (1) postpartum blues, (2) postpartum depression, and (3) postpartum psychosis. Postpartum blues, commonly known as baby blues, is the most common disturbance, and it is relatively mild (Hapgood, Elkind, and Wright, 1988). Baby blues generally begins on the first to third day after parturition and is distinguished by sudden mood swings, unexplained weeping, irritability and impatience, lack of sleep, crying spells, anxiety, loneliness, and a feeling of vulnerability (Burt, 2006).

Adapted from Nonacs and Cohen (1998), in their study, Robertson et al (2003) drawing differentiated postpartum affective disorder as shown in Table 1 below.

Table 1. Postpartum Affective Disorder: Summary of Onset, Duration and Treatment

Disorder	Prevalence	Onset	Duration	Treatment
Blues	30-75%	Day 3 or 4	Hours to days	No treatment required other than reassurance
Postpartum Depression	10-15%	Within 12 months	Weeks – months	Treatment usually required
Puerperal Psychosis	0.1-0.2%	Within 2 weeks	Weeks – months	Hospitalisation usually required

Baby blues by definition has a limited duration, is mild and needs no treatment other than reassurance, and its symptoms emerge within days (Kennerly and Gath, 1989; Pitt, 1973). Dalfen (2009, p.48) grouped postpartum symptoms based on two criteria (see Table. 2):

Table 2. Postpartum Symptoms

Symptoms That Are Not Serious	Serious Symptoms
Several days of baby blues	Feeling very down or really anxious for more than two weeks
Occasional worries that come and go	Relentless anxiety that never goes away
Negative feelings and thoughts that come and go	Negative feelings that outweigh the positive feelings
You can take care of yourself and your baby	You are unable to cope with your life or your baby
Some escape fantasies	Thought about harming yourself or your baby
Poor sleep due to caring for your baby	Not able to sleep when the baby sleeps at night, or needing to stay in bed all the time
Fatigue	Extreme exhaustion or agitation
Normal appetite with normal fluctuation, i.e., your appetite may increase if you are nursing	Compulsive overeating or ongoing loss of appetite
Some forgetfulness	Severe inability to concentrate and focus

Moments of sadness	Intense feelings of sadness that do not go away
Worries that come and go	Relentless worrying
Needing a break from your responsibilities and from your baby	Avoiding your baby
Wanting to limit visitors and activity	Withdrawing from the world and becoming isolated
Occasional irritability and anger	Feelings of intense anger and irritability

Aside its effects on women, postpartum depression also affects a woman's partner. Engqvist and Nilsson (2011) asserted that "The men revealed a major disruption in their lives. They expressed fear, confusion and anger; they were also extremely concerned about their partners, and felt unable to help in overcoming the disorder." While postpartum blues may disappear without any medical treatment, its symptoms of mood disorder might disrupt the comfort of the mother when she's caring for her baby. Therefore, a sufficient support system is needed for the mother to, at least, reduce the effects of this unwanted mood disorder. Postpartum blues itself is not related to psychiatric history, environmental stressors, cultural context, breastfeeding, and parity (Hapgood et al, 1988), but these factors could cause postpartum blues to develop into a major depression (Miller, 2002).

In their study, Misri et al. (2000) found that partner support has a considerable effect on women with postpartum depression. Moreover, many studies showed that increased support levels are associated with lower postpartum depression scores (Quelopana et al, 2011; Edwards et al., 2012; Brown et al., 2011; Fowles et al., 2012; Corrigan et al, 2015; Ghaedrahmati et al., 2017; Ria et al, 2018).

According to paper by Andri (2018) mentioned that the family's role, especially the role of the husband, is very important. The form of partner support that is discussed in this study is communication. Keyton (2005) defines communication as a process of sending information and common understanding between one person and another. One function of communication is expressing emotions. Therefore, we tried to find out whether partner support, or husband's support in this context, in the form of communication is effective in decreasing mood disorder for newborn mothers experiencing baby blues.

Material and Method

The methodology used in this study was personal interview. We assumed that by using this method, all the participant can easily explain the form of support

they got when they experienced baby blues, and which form of support they think was most effective in reducing their mood disturbance during baby blues period.
The participants selected in this study were our female friends who claimed to have experienced baby blues. Participants were chosen based on the following criteria:

1. Women who have experienced baby blues;
2. Women who are willing to share their baby blues experience. This criterion was chosen because in the process of searching for participants, it was observed that there were several women who were known to have experienced baby blues but were apparently unwilling to share their experiences;
3. Women who are willing to participate in the study. This criterion was chosen since there were several women who were willing to share their experiences but did not want their names to be included as participants.

Based on these criteria, we selected 18 women as participants for this study. All the participants were working moms who have experienced baby blues. Participants were asked the same seven questions. Two questions are closed questions, and five questions are open questions. The seven questions are as follows:

1. Have you ever experienced baby blues?
2. For how long did you experience baby blues?
3. When experiencing baby blues, have you ever shared your feelings?
4. If yes, to whom did you share it with?
5. Do you think that you received support (in any form) from your husband while experiencing baby blues?
6. Do you think you received support (in any form) from your environment (other than husband)?
7. According to your experience, what is the most effective way to reduce the effects of baby blues?

The answers to questions five and six were transcribed into “yes” or “no” answer with the intention of equating the participants’ perceptions of whether they received support during baby blues period, while the answers to question seven was simplified with participants’ approval.

Result

The results of the interview are described in Table 3 below.

Tabel 3. **Interview Result**

No	Partici-pant	Question No						
		1	2	3	4	5	6	7
1	TMT	Yes	Less than a week after delivery	Yes	Friends	Yes	Yes	Chatting with husband
2	ASD	Yes	Two months after delivery	No	-	Yes	Yes	Husbands' and families' presence
3	NFA	Yes	Three months after delivery	Yes	Husband	Yes	Yes	Communicating with husband
4	NSB	Yes	Two weeks after delivery	Yes	Husband	Yes	Yes	Communicating with husband
5	KPA	Yes	A month after delivery	Yes	Husband	Yes	Yes	Having someone to talk to
6	IP	Yes	A weeks after delivery	Yes	Husband	Yes	Yes	Distracting those sad feelings
7	M	Yes	A month after delivery	Yes	Husband	No	No	Resolve without any treatment
8	F	Yes	A week after delivery	Yes	Parents	Yes	No	Distracting the feeling
9	SW	Yes	Two weeks after delivery	Yes	Husband	Yes	Yes	Communicating with husband
10	PA	Yes	Two weeks after delivery	No	-	Yes	Yes	Resolve without any treatment
11	Ic	Yes	A week after delivery	Yes	Friends	Yes	Yes	Resolve without any treatment
12	D	Yes	Ten days after delivery	Yes	Husband	Yes	No	Recalling that children are a mandate from God
13	A	Yes	Five days after delivery	Yes	Husband	Yes	No	Resolve without any treatment
14	DTY	Yes	Two weeks after delivery	Yes	Husband	Yes	Yes	Resolve without any treatment
15	R	Yes	Three months after delivery	Yes	Husband	Yes	No	Interact with coworkers

16	Is	Yes	Two weeks after delivery	Yes	Sister	No	Yes	Having communication with husband and relatives
17	NNO	Yes	A month after delivery	Yes	Homecare service	No	Yes	Accompanied by her husband
18	APH	Yes	Two days after delivery	Yes	Husband	Yes	Yes	Having conversation with husband

Based on the interviews, the durations of participants' baby blues experience varied from two days to three months. Despite that the durations of some participants are longer than the durations reported in many previous studies, the symptoms (such as occasional worries that come and go, the participants' inability to take care of themselves and their baby, negative feelings and thoughts that come and go) still showed that what they were experiencing was baby blues. Participant R observed that she no longer experienced the symptoms after she returned to work. The duration of maternity leave enjoyed by a working woman in Indonesia is three months as regulated in the Law No.13 Year 2003 about Employment article 82.

The interviews also showed that 16 of the 18 participants chose to share their feelings during baby blues period. This result is consistent with Thompson and Walker's (1989) finding that women tend to share their anxiety. The two participants who did not share their condition, PA and ASD, didn't feel the need to do so. PA felt that she already had exceptional support from her mother, which made her think that she no longer needed to share her feelings. Contrary to PA, ASD chose not to share her feelings since the baby blues was suppressed whenever her husband or relatives were present.

Of the 16 participants who chose to share their condition, 11 of them chose to share it with their husbands, two participants chose to share it with their friends, two participants chose to share it with their relatives, and one participant chose to share it with homecare service. NNO, who chose to share her baby blues' condition with homecare service, lived apart from her husband, and she considered phone call insufficient.

For the question related to support – in any form – obtained from husbands, 15 participants stated that they received support from their husbands during baby blues period. This is consistent with the finding of Pilkington et al. (2016) that partner support is a major protective factor in dealing with mood problems during postpartum period. Three participants answered that they felt that their husbands did not provide enough support during their baby blues period. One of them (Is) even felt that her husband aggravated her baby blues by accusing her of not wanting to take care of her baby. According to Is, she did not want to take care of her baby

because she felt pain due to the delivery process. The experience of Is supports the finding by Anjum and Batool (2019) that violence, physical or verbal, is one of the strongest predictors of postpartum depression. Her experience also supports the results of Xie et al. (2010), which indicated that lack of support from family after childbirth, especially husband support, is the main risk factor of postpartum depression.

Regarding the question related to support – in any form – obtained from those within participants' immediate environment, five participants felt that they did not receive any support from those within their environment. R stated that instead of getting support, her mother-in-law mounted pressure on her during her baby blues. The condition of R is quite complicated compared with other participants. R had several risk factors of postpartum depression: 1) R gave birth to her child prematurely; 2) her baby had a respiratory problem; 3) she lived apart from her husband, who lived in another city; and 4) she was harassed by her mother-in-law regarding breastfeeding. This situation similar with Van Beusekom (2019) states that there is not a single cause but can arise because of biological, psychological, social, and sociocultural causes. In many cases, is induced by a combination of two or more factors.

Other participants stated that they did not receive any support from those within their environment since they did not ask for it. They worried that if they ask for support or assistance, it will be considered that they want others to pamper them or that they are exaggerating. Some of them also worried that they will be compared with others if they share how they feel (i.e. "other people also feel what you feel, but they are not complaining" or "all the women that gave birth also experienced the same thing, so stop acting like that"). Mustaffa et al. (2014) indicated that "low level of social support increased maternal depression and decreased the mental well-being of mothers".

Lastly, regarding the question about the most effective way to reduce the effects of baby blues, 11 of the 18 participants mentioned that speaking or communicating verbally with other people (such as husband, parent, friends) is the most effective way to reduce the effects of baby blues. This seems to be consistent with other related studies, which revealed that words have a great emotional impact on women (Bremner et al., 2001), and women speak more than men (Brizendine, 2006, p.59).

We found something interesting while interviewing R. Even though she shared her baby blues condition with her husband, communicating with husband was not effective in reducing the effects of baby blues for her. She, on the contrary, felt more relaxed when she talked with her coworkers when they came to visit her. For R, her mother-in-law was one of her stressors. So, she thought that sharing her condition with her husband would not be of any help. This finding is consistent with

Kim and Yang's (2018) study, which stated that postpartum depression is not only attributed to personal factors but is also family related.

Six of the 18 participants stated that they just let the condition resolve by itself. Their statements are consistent with many previous studies indicating that baby blues can resolve by itself without any treatment. In this regard, Rosinger and Kautz (2012) stated that after giving birth, some women experience postpartum depression, and in many cases, it subsides without treatment. However, one of the participants stated that the most effective way to reduce the effects of baby blues is for the woman to realise that what she did was indeed her responsibility as a mother.

In addition to the answers above, during the processes of searching for participants and interviewing them, we found that many people have never heard about baby blues. This finding shows lack of education regarding baby blues. As Gruen (1990) stated, "Postpartum Depression, which affects up to 20 percent of new mothers, is an illness often neglected or dismissed by health professionals, leaving the majority of such mothers and their families untreated and confused". As mentioned earlier, baby blues is a common condition for newborn mothers and is likely to lead to major depression.

Apart from education issues, we also found that some people are ashamed to admit that they were experiencing baby blues. The most common reason is because they experienced postpartum depression as a result of poverty and domestic violence. This finding is consistent with a similar study stating that economic condition and relationship conflict were discovered to be related to postpartum depression (Alvarado-Esquivel et al., 2006).

Discussion

This study was aimed at examining whether communicating with one's partner, or husband in this context, is effective in decreasing mood disorder for newborn mothers experiencing baby blues. We interviewed 18 of our female friends who claimed to have experienced baby blues. Some of our findings support those reported in previous studies related to postpartum depression. The supported finding are related to the symptoms of postpartum depression (Burt, 2006; Parekh, 2017; Robertson et al, 2003; Dalfen, 2009), some risk factors of postpartum depression (Alvarado-Esquivel et al, 2006; Khan et al, 2009; Hapgood et al, 1988; Miller, 2002), and the ability of baby blues to resolve itself without any treatment (Parekh, 2017; Robertson et al, 2003). Of the 18 participants who were interviewed separately, 11 stated that the most effective way to reduce their postpartum mood disorder was speaking or communicating verbally. Of the 11 participants, only eight (or 44 percent of the total participants) chose their husbands as communication partner.

Conclusion

Based on our result, we propose that even though communication is effective in reducing the effects of baby blues, the husband is not the determinant factor. Besides the findings based on the answers to our questions that were provided by the participants, during this study, we also found that many people have never heard about baby blues. They did experience it but were not aware that it was postpartum mood disorder. Also, they did not know that this disorder may lead to something more severe. Further, during the literature search, we found that the Indonesian government still has no regulation regarding postpartum depression, even though many tragic events have occurred as result of lack education regarding postpartum depression.

Although our research provides important information regarding postpartum blues, there are many limitations to this study, especially with respect to the number of participants and the questionnaire given to the participants. Thus, we recommend that future studies be conducted with increased number of participants and an improved questionnaire. Another limitation of this study is that we only interviewed working women; therefore, the generalized of the result to women of other statuses (such as housewives and business moms) might be another limitation. Hence, we suggest that future research examine and compare the data of different statuses.

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