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HUSBAND'S SOCIAL SUPPORT ON THE INCIDENCE OF BABY BLUES MATERNAL IN SOUTH BOGOR WOMEN GOING THROUGH THEIR PUERPERIUM IN 2024

Rina Afrina[1*], Nining Rukiah[2]
[1,2]Program Study in Bachelor of Nursing, Faculty of Public Health Indonesia Maju University, Jakarta

**Corresponding: ns.rinaafrina@gmail.com*

Abstract

Maternal baby blues is a mood disorder that often occurs in postpartum mothers in the 14-day period and worsens in the third and fourth days. The cause of maternal baby blues is not known for certain but it is suspected that the husband's social support factor is a contributing factor to maternal baby blue. The purpose of this study was to analyze the frequency distribution of respondents' characteristics, mothers age, length of marriage, parity history, education history, economic status, and birth history; the independent variable of husband's social support and the dependent variable of maternal baby blues and to determine the relationship between husband's social support and maternal baby blues in postpartum mothers. The sample size of 60 postpartum mothers selected accidental sampling technique. The results of the study showed 29 mothers had low husband support and 33 mothers had baby blues maternal. The results of bivariate analysis using the Chi square test and found a relationship between husband's social support with maternal baby blues with a p-value <0.05 (0.000). Prevention of maternal baby blues can be improved by increasing the social support of mothers' husbands after childbirth so that it does not develop into severe psychological disorders, which will have an impact on the quality of life of women and their families.

Keywords: Baby Blues Maternal, Husband Support, Postpartum.

1. INTRODUCTION

The postnatal period is a phase of vulnerability for mothers to experience mood disorders and anxiety [1]. Mood disorders include baby blues, postpartum depression, and postpartum psychosis [1] . Data from the Indonesia National Adolescent Mental Health Survey (I-NAMHS, 2023) report that mental health disorders are highest in the population of pregnant women, breastfeeding mothers, and mothers with young children [2] . World Health Organization (WHO) in 2019, as many as 13% of postpartum mothers worldwide experience postpartum depression. Postpartum depressive disorder in developing countries shows a higher number, which is 19.8% of the number of postpartum mothers [3] .

Postpartum blues is considered by the public as a mild disorder that can heal by itself in the postpartum period, but postpartum blues that are not healed will risk turning into postpartum depression and worsening into postpartum depression psychosis [4] Lazar & Fuller (2020) stated that 1 in 7 postpartum mothers detected maternal baby blues [5] . This will affect the mother's bounding with the baby so that the mother fails to care for the baby and refuses to breastfeed the baby [6]. Postpartum Blues is a mild and temporary disorder that occurs in the first week after childbirth, with symptoms of crying easily, confusion, swing mood, anxiety, and depression [7] . Symptoms that can also occur are irritability, headache, mild dysphoria and fatigue [8]. Postpartum blues include sleep and appetite disturbances [9] . Postpartum blues will worsen from day three to day five and last for 14 days or two weeks after delivery [10] . The percentage risk of postpartum depression is 4 to 11 times more frequent in mothers who experience the baby blues first [11]. Hormonal changes such as a drastic decrease in progesterone and estrogen after childbirth are believed to be associated with the incidence of postpartum blues [12]. Wulandari

(2011) in Anggraeni et al (2017) states that factors such as low social support from husband, family, or neighbors can make baby blues easily occur[12] . In addition, the factor of physical fatigue after postpartum and baby crying can trigger the occurrence of postpartum blues [13] .

House (1989) in Utami et al (2018) that social support is in the form of providing emotional support, assessment support, instrumental support, and information support [14]. Social support helps individuals in regulating individual thoughts, feelings, and behaviors, which are useful for overcoming the pressure response faced by a person[14] . Utami et al (2018) emphasized that one of the social supports that can be given to postpartum mothers is husband's social support. Physical fatigue in mothers is the most common complaint that occurs in postpartum. Physical fatigue is caused by the mother's activities to take care of the baby, lack of sleep and recovery due to breastfeeding or waking up at night, lack of motivation and always anxious and depressed, coupled with the mother's lack of focus in carrying out daily activities [15]. The results of Susanti's research in 2017 on Psychological Factors Affecting Postpartum Blues on 41 postpartum mothers found that there was a relationship between social support with postpartum blues (0.000, p <0.005)[16] . The results of Saragih et al's 2015 study on the Relationship between Fatigue Level and Postpartum Blues in Post-Earthquake Postpartum Mothers in the Jetis Health Center Area, Bantul Regency to 45 postpartum mothers. The results showed that there was a relationship between the level of maternal fatigue and postpartum blues p<0.005 [17].

This study aimed of risk factors of baby blues maternal therefore sociodemographic characteristics mothers were include mothers age, length of marriage, parity history, education history, mother's occupation, Economic Level of family, and delivery types history and. analyze differences in husband support with baby blues maternal.

2. METHODOLOGY

This was a quantitative research conducting once at a time as it used a cross-sectional design. This study conducted in South Bogor, West Java with 126 population. The sample size was reduceed to 60 mothers using accidental sampling. Ccharacteristics mothers were mothers age, length of marriage, parity history, education history, mother's occupation, Economic Level of family, and delivery types history. Independent variable was husband support and dependent variable was baby blues maternal. Husband support used 35 statements and baby blues maternal used the Kennerley and Gath Questionnaire with 28 statement. The Kennerley and Gath Questionnaire had validity and reability test in Tegal Gundil Primary Health in Bogor City. The result of validity and reability had 8 items invalid with r-count >0,468, questionnaire remaining 18 from 28 items and for husband social support used from Priscilla and Afrina research (2023) with 35 items (r-count 0,512-0,917). This study has passed the ethical test as one of the data collection requirements. The ethics test wasused to guarantee no ethical errors during data collection and ensure no disadvantaged parties in the research. Ethical testing becamea requirement for research that involve human respondents. This research hadreceived ethical approval by the Ethics Commission of the Faculty of Health, Universitas Indonesia Maju with certificate number 8376/Sket/Ka-Dept/RE/UIMA/IV/2024.

3. RESULTS

3.1 Postpartum Maternal Age and Length of Marriage

Tabel 1. *Frequency Distribution of maternal age and length of marriage (n=60)*

No.	Characteristics	Frequency	Percent
Maternal Age			
1.	Age (15-20 years)	3	5 %
2.	Age 21-30	39	65%
3.	Age 31-35	9	15%
4	Age>35	9	15%
	Total	60	100 %
Length of Marriage			
1	< 1 years	3	5%
2	1-2 years	21	35%
3	3-5 years	13	21.7 %
4	>5 years	23	38.3 %
	Total	60	100%

Based on the frequency distribution of respondent characteristics in Table 1, it was found that most mothers' ages were in (21-30 years) with 39 mothers (65%). For the length of marriage of mothers, most of them are more than 5 years as many as 23 mothers (38.3%) and as many as 21 mothers (35%) have been married for 1-2 years. The frequency distribution of educational history, work history, and economic status of mothers in Table 2 shows that most mothers' education history was from high school 29 mothers (48.3%), while most mothers' occupations were housewives 43 mothers (71.7%), and for economic level of family mostly in the high category (income >Rp.3,000,000) as many as 41 mothers (68.3%).

3.2 Postpartum Maternal of Education History, Mother's Occupation, and Economic Level of family

Tabel 2. *Frequency Distribution of Education History, Mother's Occupation, and Economic Level of family (n=60)*

No.	Characteristics	Frequency	Percent
Education History			
1.	Primary School	6	10%
2.	Middle School	6	10%
3.	Senior High School	29	48.3%
4.	Diploma	10	16.7%
5.	Bachelor	9	15%
	Total	60	100 %
Mother's Occupation			
1.	Housewife	43	71.7%
2.	Employee	15	25%
3.	Self-employed	2	3.3%
	Total	60	100 %
Economic Level of family			
1.	Low (<Rp.1.000.000)	8	13.3%
2.	Middle (Rp. 1.000.000-2.000.000)	11	18.3%
3.	High (>Rp. 3.000.000)	41	68.3%
	Total	60	100%

3.3 Postpartum Maternal Parity and Birth History

Tabel 3. *Frequency Distribution of Parity and Birth History (n=60)*

No.	Characteristics	Frequency	Percent
Parity History			
1.	Primiparous	30	37 %
2.	Multiparous	30	37 %
	Total	60	100 %
Type of Delivery History			
1	Vaginal Birth	30	37 %
2	C-section	30	37 %
	Total	60	100%

Table 3 shows that the history of maternal parity and type of delivery found that mothers with primiparous and multiparous in the same category, namely as many as 30 mothers (37%) and the type of normal delivery and cesarean section amounted to the same, namely 30 mothers (37%).

3.4 Husband Social Support and Baby Blues Maternal

Tabel 4. *Frequency Distribution of Husband Social Support and Baby Blues Maternal (n=60)*

No.	Characteristics	Frequency	Percent
Husband Social Support			
1.	Supportive	31	51.7%
2.	No supportive	29	48.3%
	Total	60	100 %
Baby Blues Maternal			
1.	*Baby Blues*	33	55%
2.	No *Baby Blues*	27	45%
	Total	60	100%

Based on the frequency distribution of variables of Husband's Social Support and Maternal Baby Blues in Table 4, it was found that Husband's social support in postpartum mothers was found supportive category as many as 31 (51.7%) mothers who received support and 29 mothers (48.3%) who did not receive husband's social support. Mothers with maternal baby blues occurred in 33 mothers (55%) and mothers who did not have maternal baby blues were 27 mothers (45%).

3.5 Differences in Baby Blues Maternal Mothers Rates Based on Husband Support

Tabel 5. *Differences in Baby Blues Maternal Mothers Rates Based on Husband Support (n=60)*

Variabel		*Baby Blues Maternal*		Total (n)	P-value
		No Baby Blues	***Baby Blues***		
Husband Social Support	No Support	N/A	29	29	0,000
	Support	27	4	31	
Total		27	33	60	

The results of the analysis of the relationship between Husband's Social Support with Maternal Baby Blues using the Chi-Square test in table 5 showed that there was a relationship between Husband's Social Support with Maternal Baby Blues with a p-value <0.05 (p=0.000). From table 4.6 it is also found that mothers who do not get social support from their husbands experience maternal baby blues.

Based on the frequency distribution of respondent characteristics in Table 1, it was found that most mothers' ages were at 21-30 years with 39 mothers (65%), under 21 years was 3 mothers, and >35 was 9 mothers. For the length of marriage of mothers, most of them are more

than 5 years old as many as 23 mothers (38.3%) and as many as 21 mothers (35%) have been married for 1-2 years. Sloane & Bendict (2009) in Handini & Puspitasari (2021) that age affects maternal readiness in pregnancy and childbirth [18] . Age affects uterine condition and this is related to maternal baby blues. Age under 20 years makes it difficult for mothers to adapt to childcare and needs help and information about infant and maternal care[18] . Meanwhile, the old age of the mother has an impact on the increasing burden that causes health problems in postpartum. In addition, the increased task load will result in physical and mental changes. [18]

The results of Handini & Puspitasari's research on Differences In Postpartum Maternal Depression Levels Based On Characteristics Of Maternal Age And Husband Support with 70 postpartum mothers and found that most respondents were over 21 years old with a total of 65 mothers (67.8%). The age factor cannot be changed but maternal baby blues can be prevented through a mature marriage so that a stable condition is obtained for the physical and mental mother and her partner .[18]

Dewi et al (2013) explained that one of the factors causing maternal baby blues is the length of marriage of a mother. Length of marriage is associated with the closeness or quality of a marriage relationship. The results of Vidayati and Albariroh's research in 2021 on the Relationship between Length of Marriage and Age at Pregnancy with Baby Blues in Primiparous Postpartum Mothers to 26 postpartum mothers and it was found that mothers with a length of marriage of more than 2 years were at risk of maternal baby blues as many as 20 mothers (76.9%) compared to mothers with a length of marriage under 2 years . [19]

Based on the frequency distribution of respondent characteristics in Table 1, it was found that most mothers' ages were in (21-30 years) with 39 mothers (65%). For the length of marriage of mothers, most of them are more than 5 years as many as 23 mothers (38.3%) and as many as 21 mothers (35%) have been married for 1-2 years. The frequency distribution of educational history, work history, and economic status of mothers in Table 2 shows that most mothers' education history was from high school 29 mothers (48.3%), while most mothers' occupations were housewives 43 mothers (71.7%), and for economic level of family mostly in the high category (income >Rp.3,000,000) as many as 41 mothers (68.3%). Marshal (2004) in Rachman (2022) said that education level can be one of the factors that can affect the incidence of maternal baby blues [20] . Low educated mothers are associated with individual perceptions in accepting technology and new ideas and Education also affects decision making [21].

Stuart (2019) in Musyaffa et al (2024) explains that low education has an impact on a person's anxiety due to lack of knowledge. Hawari (2013) in Musyaffa et al (2024) states that a person's education will have the potential for anxiety due to a lack of knowledge about information or validation of the receipt of information received[22] . Highly educated women have a feeling of wanting to play a role as a mother in caring for their baby and also related to the career they want to achieve. This will be a vulnerability to the mother because if both roles are not carried out properly. Hutagaol (2010) explains that family economic status and employment are associated with an increase in family income and the role of mothers who increase after giving birth[23] . The results of Purnamaningrum et al's research in 2018 on Young Age Pregnancy and Postpartum Blues Incidences to 90 postpartum mothers found that mothers who did not work were associated with the incidence of baby blues as many as 35 mothers (38.9%) compared to mothers who worked[24] . The results of research by Purwati, Fitria, and Aifa in 2023 on Factors affecting Postpartum Blues at BPM Elizabet Pekan Baru to 33 postpartum mothers found a relationship between family income status and maternal baby blues p-value <0.05 (0.000) . [25]

Table 3 shows that the mother's parity history and type of delivery found that mothers with primipara and multipara in the category were the same number, namely 30 mothers (37%) and the types of normal and cesarean section delivery were the same number, namely 30 mothers (37%). Parity history or childbirth history affects maternal baby blues complaints, this is because mothers who have given birth before or have previous childbirth experience tend to be able to overcome the mood disorders experienced by mothers[26] . Hung (2007) in Sari et al (2020) added that primiparous mothers have not had experience in caring for babies before so it is reported that primiparous mothers will have a greater level of concern than multiparous mothers [27] .

The type of delivery is associated with maternal baby blues because vaginal delivery and cesarean section surgery cause painful effects during labor and postpartum. Curtis (2011) explains that the normal labor process can last for 3 days and the vaginal area to the perineum and abdominal area experiences contractions that cause pain. Wegner & Berstein (2000) in

Rajagukguk (2013) added that the impact of pain caused not only lasts to the physical mother but also to the mother's psychology [28] . This will have an impact on the mother's bonding and attachment process with the baby, so that this impact will stimulate the maternal baby blues [29] . In addition, Henderson & Jones (2006) in Nugraheni (2017) labor with actions such as using labor assistance tools makes changes in the mother's confidence in carrying out her role and this also affects attachment so that it has an impact on maternal baby blues. Childbirth with cesarean section has an impact on the length of the process of taking in a mother after giving birth. This is due to the pain of post-cesarean section surgery and complications due to anesthesia such as nausea and vomiting which causes the mother to experience delayed breastfeeding [30].

Table 4 showed that Husband's social support in postpartum mothers was found to be in the supportive category as many as 31 (51.7%) mothers who received support and 29 mothers (48.3%) who did not receive husband's social support. The results of this study are in accordance with the results of research from Priscilla and Afrina (2023) on Husband Support with Early Detection of Postpartum Blues in Postpartum Mothers at BPM Yunitasari, Paragradin Village, Bogor that as many as 18 mothers (45%) did not receive husband support [35] . The results of this study are in line with the results of Jayanti and Wijayanti's research on the Incidence of Postpartum Blues in Postpartum Mothers in 2022 to 20 postpartum mothers found that 12 mothers (60%) received low support from their husbands or families [36]

Lowdermilk et al (2013) mentioned that in positive adjustment during postpartum requires social support[13] . Family is one of the main sources of social support and is a key factor when individuals experience problems or illness [37]. According to Cobb (1976) in Swarjana (2022) social support is information that states that a person is loved, valued, and included in a network of mutual obligations[37] . Social support according to Thoits (1995) in Swarjana (2022) is a social resource that an individual can rely on when facing life problems and stress. House divides social support into four components, namely emotional support (attention), instrumental support, information support, and assessment support[37] . The existence of special support from the family, especially the husband, can provide special situation support such as assisting in the physical needs of the mother, baby care, reducing anxiety in the mother, and making time for the mother and her baby [13].

The results of research on husband's social support for mothers in the South Bogor Health Center area found that 29 mothers (48.3%) did not receive husband's social support. From the results of the questionnaire, it was found that most of the husband's support that was not obtained was support in the form of emotional support related to husbands who rarely took the time to listen to the problems experienced by mothers, husbands rarely asked about the condition of mothers and children by telephone, and husbands rarely comforted mothers when mothers felt sad. As for appreciation support, it is found that husbands rarely give advice that mothers need, husbands also rarely praise mothers if mothers can do good activities for babies such as breastfeeding, bathing, or carrying babies. Instrumental support that is rarely done by the husband is to take the mother to do an examination of the mother and baby. In instrumental support, it was also found that some mothers rarely made food when the mother was hungry and could not cook food for the mother, some mothers also answered that the husband rarely cared about the desire to buy things needed by the mother.

Mothers with maternal baby blues occurred in 33 mothers (55%) and mothers who did not have maternal baby blues were 27 mothers (45%). The results of this study are in line with the results of Kumalasari and Hendawati's 2019 research on Risk Factors for Postpartum Blues in Palembang City with 90 respondents found that 42 mothers (46.7%) experienced the blues[38] . These results are in line with the results of research from Sari, Rossita, and Putri in 2022 on The Relationship of Mother Characteristics and Family Support With The Event of Post Partum Blues in BPM Listiorini with 30 respondents found that as many as 11 mothers experienced baby blues [39]. Maternity blues or baby blues or better known as postpartum blues is a disorder that occurs within a 2-week period after childbirth, which can last from a few hours to a few days. The etiology of the postpartum blues causes a drastic decrease in the hormones estrogen and progesterone after childbirth.

According to Toren et al (1996) in Maliszewska et al (2016) decreasing estrogen levels will have an impact on decreasing dopamine, serotonin, norepinephrine, and GABA (Gamma-aminobutyric acid) as regulators of emotions, concentration and feelings of comfort, and regulate sleep[4] . Gath & Kennerley (1989) in O'Hara (2012) explain that the postpartum blues period often occurs on the third or fifth day after childbirth characterized by mood changes, crying easily,

fatigue, confusion, and decreased concentration. Hamilton (1962) in O'Hara (2012) added that mothers with postpartum blues symptoms experience eating and sleeping disorders.

The results of the study were obtained when the researchers collected data, as many as 5 postpartum mothers cried by themselves when the researchers asked whether since having a baby the mother felt happy. Some mothers said that since having a baby, mothers are easily sad, easily cry for things that are not important or trivial. One mother even said she wanted to be alone for just one day in caring for her baby. The results of the Gath & Kennerley questionnaire (1989) in Natsiou et al (2022) found that mothers with maternal baby blues felt excessive emotions, irritable or offended, sometimes crying which was difficult to stop[40] . Some mothers also said that they often forget what they are doing and even suddenly feel nervous or anxious. One mother said that since having a baby, she felt helpless with her current condition. The mother also said that when she was alone, she sometimes cried easily and did not know why she was crying.

The results of the analysis of the relationship between Husband's Social Support with Maternal Baby Blues in table 5 showed that there is a relationship between Husband's Social Support with Maternal Baby Blues with a p-value <0.05 (p=0.000). From the results of the study it was also found that mothers who did not get social support from their husbands experienced maternal baby blues. The results of this study are in line with the results of Priscilla and Afrina's research in 2023 on Husband Support with Early Detection of Postpartum Blues in 40 postpartum mothers at BPM Yunitasari, Paragradin Village, Bogor, it was found that there was a relationship between husband support and early detection of postpartum blues with a p-value <0.05 (p-value = 0.002) where mothers who did not get husband support detected postpartum blues. This is in line with the results of Harini Anggraeni and Kusuma Estu Werdani's research on Supported Conditions for Baby Blues Mothers After Postpartum in Surakarta in 2017 to 63 postpartum mothers and found a relationship between husband support and baby blues and a p-value of 0.009 <0.05.

When mothers adapt or make adjustments to the new roles experienced, mothers need social support (Lowdermilk et al, 2013). Hung (2004) in Ningrum (2019) explains that support is a concern given by individuals to the closest person, to provide support for the problems faced and aims to make individuals feel valued and loved [16] . Social support according to Thoits (1995) in Swarjana (2022) is a social resource that an individual can rely on when facing life problems and stress (Swarjana, 2022).Support can be done by the family and one of them is the husband [37].

House divides social support into four components, namely emotional support (attention), instrumental support, information support, and assessment support [37] . Lowdermilk et al (2013) state that the existence of special support from the family, especially the husband, will have an impact on the mother, especially if the mother experiences special situations such as pregnancy, childbirth, and postpartum. Forms of support provided by husbands to mothers in postpartum can be in the form of helping with the physical needs of the mother, baby care, reducing anxiety in the mother, and taking time for the mother and her baby [13].

The results showed that the support that was rarely provided by husbands was a form of emotional support where husbands rarely took the time to listen to the problems experienced by mothers every day. The mother said that after doing activities all day with the baby, the mother wanted the husband to listen to the activities or things that happened to the mother but the husband rarely wanted to do this and the husband also felt tired when meeting with the mother. The mother also said that the husband rarely asked about the condition of the mother and child over the phone, and sometimes the mother would contact the husband first by calling or making a video call or even just sending a message.

Mothers also said that their husbands rarely comforted them when they felt sad and rarely gave them the advice they needed. Some mothers even said that their husbands rarely praised them even though they had done their part in caring for the baby from the time they left for work until they returned home. Mothers also said that when the mother can breastfeed well, can bathe the baby, or even hold the baby properly, the husband's response is normal. Mothers also said that some husbands rarely take mothers to the health center for baby control or for maternal check-ups. Some mothers said that their husbands worked when the mother wanted to have a check-up, however, husbands rarely took leave or vacation during certain moments when the mother needed the husband to accompany the mother to have a baby or maternal check-up.

In fact, most mothers said that when they wanted something to eat, their husbands rarely wanted to make food. Some mothers even said that when their mothers made food for them, their

husbands asked for it too. Some mothers said that their husbands would buy their baby's needs but for the mother's needs, their husbands rarely wanted to buy them. From the results of the study, the researcher concluded that the form of support provided by the husband in a simple form is needed by the mother to reduce the burden of the routine that the mother does every day. Support in the form of responding to the mother or just asking about the mother's condition every day, can convince the mother that she is still cared for by her husband. Forms of attention such as taking the mother to the health center or just making a simple meal when the mother is hungry, can make the mother feel less depressed and make the mother's mood improve

4. CONCLUSIONS

Based on the results of the research that has been conducted, it is found that most respondents are over 21 years old (95%) with most respondents having a history of marriage over 5 years (38.3%). The results also illustrate that most respondents with a history of high school education (48.3%) with most of the mothers' occupations are housewives (71.7%) and the majority of respondents with high economic status (68.3%). The number of mothers with a history of primiparous and multiparous parity in the same amount (37%) and the number of mothers with the type of normal delivery and cesarean section surgery in the same amount, namely 37%. The most mothers getting husband support (51.7%). Meanwhile, most mothers experienced maternal baby blues (55%).

The results of the study used chi-square statistical test analysis and found that there was a relationship between husband's social support with maternal baby blues, sig value of 0.000 (<0.005). The results of the study can be concluded that the level of baby blues maternal caused by the lack of husband support in simple things. Researchers also concluded that primiparous and multiparous mothers have the same risk for maternal baby blues.

Thus, nurses can take early prevention when mothers with symptoms of maternal baby blues are found at the Puskesmas or in the environment around the South Bogor Puskesmas area. Nursing interventions, especially independent nursing interventions, are needed to reduce and overcome the blues that occur in mothers so that the prevention of blues into depression can be done as early as possible by nurses.

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