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COMPREHENSIVE INTERVENTION FOR BABY BLUES: A CASE REPORT

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Abstract

Introduction: Baby blues is an emotional condition that commonly occurs in postpartum mothers. This condition affects about 50–80% of women worldwide and around 50–70% in Indonesia. Symptoms may include low mood, anxiety, reduced appetite, and sleep disturbances. Although symptoms usually resolve within two weeks, assessment is needed to distinguish them from postpartum depression and other psychiatric emergencies. **Case presentation:** A 21-year-old primiparous woman developed sleep disturbance, anxiety, reduced appetite, fatigue, reluctance to breastfeed, and feelings of being unprepared for motherhood during the first three postpartum days. Contributing circumstances included perineal pain, delayed lactation, newborn-care demands, and concerns about her maternal role. Her Edinburgh Postnatal Depression Scale (EPDS) score was 12, indicating a mild risk of postpartum depression. Interventions were provided over five weeks and included: Spiritual—listening to Qur'anic recitations and practicing dzikir; Psychological deep-breathing relaxation and psychoeducation on postpartum adaptation; Physical lactation management and personal hygiene education. At the end of follow-up, the EPDS score was 7. The patient reported less anxiety, improved appetite and sleep, stronger mother-infant bonding, and greater confidence in her maternal role. Family involvement was a key factor in supporting her sustained recovery. **Conclusion:** Early and comprehensive interventions that address spiritual, psychological, and physical aspects may be effective in managing baby blues and preventing progression to more severe postpartum mental health problems.

Keywords: baby blues, comprehensive interventions, primiparous mother

Abstrak

Latar Belakang: *Baby blues adalah kondisi emosional yang umum terjadi pada ibu pascapersalinan. Kondisi ini memengaruhi sekitar 50–80% wanita di seluruh dunia dan sekitar 50–70% di Indonesia. Gejalanya dapat meliputi suasana hati yang buruk, kecemasan, penurunan nafsu makan, dan gangguan tidur. Meskipun gejala biasanya mereda dalam dua minggu, penilaian diperlukan untuk membedakannya dari depresi pascapersalinan dan keadaan darurat psikiatri lainnya.* ***Presentasi kasus:*** *Seorang wanita primipara berusia 21 tahun mengalami gangguan tidur, kecemasan, penurunan nafsu makan, kelelahan, keengganan untuk menyusui, dan perasaan tidak siap menjadi ibu selama tiga hari pertama pascapersalinan. Faktor-faktor yang berkontribusi meliputi nyeri perineum, keterlambatan laktasi, tuntutan perawatan bayi baru lahir, dan kekhawatiran tentang peran keibuannya. Skor Edinburgh Postnatal Depression Scale (EPDS) adalah 12, menunjukkan risiko ringan depresi pascapersalinan. Intervensi diberikan selama lima minggu dan meliputi: aspek spiritual—mendengarkan bacaan Al-Qur'an dan berlatih zikir; aspek psikologis—relaksasi pernapasan dalam dan psikoedukasi tentang adaptasi pascapersalinan; aspek fisik—manajemen laktasi dan edukasi kebersihan pribadi. pada akhir masa tindak lanjut, skor EPDS adalah 7. Pasien melaporkan berkurangnya kecemasan, peningkatan nafsu makan dan tidur, ikatan ibu-bayi yang lebih kuat, dan kepercayaan diri yang lebih besar dalam peran keibuannya. Keterlibatan keluarga merupakan faktor kunci dalam mendukung pemulihan berkelanjutan.* ***Kesimpulan:*** *Intervensi dini dan komprehensif yang membahas aspek spiritual, psikologis, dan fisik mungkin efektif dalam mengelola baby blues dan mencegah perkembangan menjadi masalah kesehatan mental pascapersalinan yang lebih parah.*

Keywords: *baby blues, intervensi komprehensif, ibu primipara*

INTRODUCTION

The postpartum period is a complex phase for mothers as it involves significant physical and emotional changes. Mood fluctuations during this stage are influenced by a combination of biological, psychological, and social factors. Baby blues, or postpartum blues, are characterized by feelings of sadness, mood swings, and anxiety that usually appear within a few days after childbirth. This condition affects approximately 15–85% of mothers within the first ten days postpartum[1–3]. Baby blues is generally considered a milder condition compared to postpartum depression. It is temporary in nature and typically resolves spontaneously within two weeks[2,4,5.]

Although often perceived as a normal part of the transition to motherhood, the high prevalence of baby blues underscores its importance in maternal mental health. The overall prevalence varies widely, ranging from 0.5% to 60%[6]. In Asia, the prevalence is reported between 26% and 85%[7,8], while in Indonesia, it reaches 50% to 70%. Unfortunately, this condition is frequently overlooked, which may lead to more severe psychological problems such as postpartum depression or even postpartum psychosis[1,4,11,12].

Research on baby blues continues to evolve with the aim of identifying prevalence, risk factors, and effective interventions. Psychosocial factors, such as lack of family support, have been shown to significantly contribute to its occurrence[13,14]. While baby blues is generally a self-limiting condition, failure to recognize or manage its symptoms may lead to more serious postpartum disorders, such as postpartum depression, with long-term consequences for both mother and child[1,4]. The impact extends beyond maternal mental health, influencing mother–infant bonding, breastfeeding practices, and the child's emotional development[2,5.]

Therefore, early intervention is essential to prevent the progression of baby blues into more severe mental health conditions. Effective screening procedures and timely interventions are important responsibilities of healthcare providers[4]. These steps can significantly reduce psychological distress, creating a healthier condition for both mother and baby[3]. Pharmacological interventions remain a consideration for more severe postpartum psychological disorders. However, for baby blues, non-pharmacological approaches are safer for both mother and infant and are often easier to implement [12,15]. A structured combination of strategies—such as psychoeducation, emotional and spiritual support, and additional therapeutic

measures—forms a comprehensive intervention. This approach not only alleviates symptoms but also empowers mothers throughout the postpartum period[3,12,14.]

Comprehensive intervention is an approach that is often used to address health and social issues by offering health improvements through collaboration among various disciplines. This intervention is a multidimensional approach that systematically integrates psychological, behavioral, and environmental aspects[16]. Comprehensive intervention is an approach frequently applied in health and social care, aiming to improve health outcomes through collaboration across various disciplines. It is a multidimensional strategy that systematically integrates psychological, behavioral, and environmental aspects[17].

Over time, this approach has become increasingly utilized and sustained, considering other relevant aspects that may influence patient health[17,18]. Spirituality is believed to be an important factor in health. Several studies suggest that spirituality may serve as a preventive factor against postpartum depression by fostering resilience and helping mothers find meaning during difficult times. Other research highlights that spiritual practices provide emotional support through stronger social connections and encouragement of positive coping strategies[20]. Encouraging mothers to engage in spiritual activities can complement therapeutic interventions and holistically improve maternal mental health during the postpartum period.

Incorporating spiritual elements such as dzikir (remembrance of God) and listening to Qur'anic recitations is not merely a religious ritual but also holds profound therapeutic significance. These practices have been shown to balance brain waves, reduce stress hormones, and enhance emotional stability[21–23]. Non-pharmacological support for mild postpartum emotional disturbance may include psychoeducation, emotional support, breastfeeding assistance, physical care, family involvement, and coping strategies aligned with patient preferences

This study presents a case report of baby blues. Case reports play an important role in providing an in-depth understanding of specific conditions by linking theory with practice and gradually building clinical competence. Beyond supporting the development of flexibility, case studies also strengthen ethical reasoning, making them highly relevant as a tool for learning in psychotherapy research and practice[24].

METHODS

The research design applied in this study was a descriptive qualitative approach using a case study of postpartum blues at Sitti Khadijah 1 Mother and Child Hospital, Makassar. Data collection was obtained Information was obtained through history-taking, direct observation, clinical examination, and the EPDS. The Edinburgh Postnatal Depression Scale (EPDS) was used as an instrument to assess the patient's baby blues condition. The score was interpreted alongside the clinical interview, timing of symptom onset, functional impairment, and the observed course. Data were presented narratively and supported by clinical examination findings. This case study implemented an integrative intervention across psychological, physical, social-family, and spiritual domains over five weeks. The data obtained and the interventions carried out were then analyzed by comparing them with existing theories to draw conclusions.

CASE PRESENTATION

A 21-year-old primiparous woman who had completed senior high school delivered her first child at Sitti Khadijah 1 Mother and Child Hospital, Makassar. The delivery was uncomplicated, and both the mother and newborn were initially in good condition. The patient had no history of mental health disorders, obstetric complications, or chronic physical illness She lived with her husband and extended family. Her husband had children from a previous marriage. During the first three years of marriage, she used condoms as contraception because her stepchildren were still young. The patient stated that she did not feel emotionally prepared for motherhood, although family members helped with infant care.

On postpartum day 1, the patient experienced difficulty moving due to perineal pain. Her baby cried frequently, and lactation had not yet begun. She reported headaches, reduced appetite, and discomfort with her new role as a mother. She expressed feelings of unpreparedness, highlighting the challenges of simultaneously caring for three stepchildren while not having a home of her own. On day 2, lactation had still not started, and the patient considered formula milk feeding. She reported poor sleep due to frequent nighttime crying, reduced appetite, and increased anxiety.

By the third day, lactation began but remained insufficient. The patient continued to complain of headaches and stress when the baby cried. Appetite remained poor, and she persistently stated that she did not feel capable of being a mother. Activity patterns were limited due to perineal pain. She reported difficulty

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sleeping, fatigue, and reluctance to breastfeed, raising concerns about potential breast engorgement. The Edinburgh Postnatal Depression Scale (EPDS) score was 12, indicating a mild risk of postpartum depression. Given the onset during the first postpartum days and the clinical pattern, the symptoms were considered consistent with postpartum blues, with close monitoring required to ensure that they did not persist or progress to postpartum depression.

The patient subsequently received a comprehensive intervention addressing three dimensions: spiritual (listening to Qur'anic recitations and practicing dzikir), psychological (deep-breathing relaxation and psychoeducation on postpartum adaptation), and physical (lactation management and personal hygiene education). The intervention was conducted over five weeks, with ongoing monitoring of maternal progress and adaptation to her new role.

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Table 1. Comprehensive intervention schedule

No.	Week	Intenvention			Result
		Psychological	Physical	Spiritual	
1.	Week I	- Psychoeducation about baby blues - Deep breathing relaxation	- Early mobilization - Personal hygiene	- Dhikr - Practice du'a for baby	- Trust build - Anxiety reduced
2.	Week II	- Family Counseling	- Breast massage - Correct breastfeeding technique	- Listening to dhikr /murottal	- Family support increased
3.	Week II	Monitor each intevention			Controlled
4.	Week IV	Bonding facilitation (skin to skin, eye contact)	- Monitor Lactation - Daily activity adjustment	- Dhikr - Gratitude Practice	Stronger building Less anxiety
5.	Week V	- Positive self talk - Problem-solving skills	Final postpartum check,	Family support through prayer	- Greater emotional resilience - Improved Social support
6.	Follow Up	EPDS reassessment			- EPDS decreased from 12 to 7 - Stable mood - Readiness for maternal role

INTERVENTION AND FOLLOW UP

Psychological support comprised psychoeducation about postpartum emotional changes, deep-breathing exercises, positive self-talk, problem-solving, and bonding facilitation. Physical support included early mobilization, personal hygiene, lactation assistance, breast massage, correction of breastfeeding technique, and adjustment of daily activities. Family counselling addressed practical support. In accordance with the patient's preference, spiritual support included dhikr, prayer, listening to Qur'anic recitation, and gratitude practice. Spiritual components were optional and served as additional coping strategies.

At the end of week 5, the EPDS score had decreased from 12 to 7. The patient reported less anxiety, improved appetite and sleep, stronger closeness to her infant, and greater confidence in her maternal role. No adverse events were reported during the support period.

DISCUSSION

Based on the above description, the patient experienced symptoms of postpartum blues characterized by reduced appetite, lack of interest in caring for her baby, fatigue, sleep disturbances, and feelings of anxiety. Baby blues, or postpartum blues, is a common phenomenon among postpartum mothers, marked by mood fluctuations, fatigue, anxiety, and sadness during the puerperal period. It affects approximately 50–80% of postpartum women, typically emerging within the first few days after delivery and lasting up to two weeks. [25–27].

The patient was married at the age of 18 and gave birth to her first child at the age of 20. The marriage was arranged by her parents, and her husband was a widower with three children aged 14, 7, and 4 years. The patient reported that she was not ready to have children; therefore, she used condoms as contraception to prevent pregnancy. In the third year of marriage, however, her husband requested that she conceive and bear a child.

Baby blues is influenced by multiple factors, including maternal age, educational background, family dynamics, and early marriage. [2,10,28]. A woman must also have the readiness and willingness to take on the maternal role, including breastfeeding and caring for the newborn. Studies have shown that maternal age is an important factor associated with the occurrence of baby blues. Younger mothers, particularly those under the age of 20, as well as older mothers above the age of 35, are reported to be at higher risk of

experiencing baby blues symptoms. [29,30]. Furthermore, research indicates that primiparous mothers, those giving birth for the first time, are at a higher risk of experiencing this condition compared to multiparous mothers who have given birth previously. [7,9].

Before the intervention, the husband was not fully supportive due to his work responsibilities and the care of his other children. At the same time, the patient perceived her condition as something unfamiliar and reported having no knowledge of what should be done. Studies have shown that limited emotional support and social pressures can exacerbate the condition of mothers in the postpartum period. [13,14,31,32].

Untreated baby blues in postpartum mothers highlight the need for comprehensive interventions that address maternal well-being from physical, psychological, and spiritual dimensions. Effective postpartum management involves a range of strategies, including psychoeducation, psychological support, and physical interventions. Childbirth takes a lot of physical energy from the mother. Therefore, her body also needs attention in a comprehensive postpartum intervention. Proper nutrition, personal hygiene, breastfeeding, physical activity, and enough rest are the main factors that support a mother's mental well-being[33]. Furthermore, several studies highlight that breastfeeding can strengthen the bonding between mother and baby, which may increase maternal self-efficacy and reduce anxiety. Mothers who receive support during the breastfeeding process are generally more emotionally prepared for motherhood[34].

Providing education can help create a supportive environment for mothers. It also encourages them to prioritize physical, mental, and spiritual health to build resilience in their new role as mothers [35]. Various interventions have been practiced in managing baby blues. Studies show that interventions adapted to the patient's cultural background are more effective. Therefore, integrating cultural aspects into comprehensive care strategies is essential to enhance their effectiveness across different populations [36].

In addition, family involvement as a source of support can strengthen the effectiveness of interventions. Providing education and maintaining communication with the family can improve insight and awareness, which in turn facilitates early detection and intervention, thereby significantly improving the health condition of mothers experiencing baby blues[25]. Healthcare providers play an important role in ensuring that postpartum

care receives adequate support from both family and community structures.

Enhancing psychological and spiritual aspects can strengthen resilience, while physical care strategies that emphasize self-care and community support are equally important. These elements should work synergistically to provide a strong support system for mothers as they adjust to their new role, ultimately having a significant impact on the mental well-being of both the mother and her family. By prioritizing comprehensive intervention strategies, the risk of baby blues progressing into postpartum depression can be minimized, and the quality of life of both mother and child can be improved.

CONCLUSION

Comprehensive interventions to address baby blues and postpartum depression should include psychological, physical, and spiritual dimensions. Symptoms improved and the EPDS score decreased during five weeks of multidimensional psychological, physical, family, and spiritual support. This approach is supported by a growing body of research, emphasizing the importance of integrating multiple strategies to promote the holistic well-being of mothers during the postpartum period.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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