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Psychosocial Factors Influencing Baby Blues Syndrome in Primiparous Mothers: A Systematic Literature Review

Mutiara Amalia[1*], I Gusti Ayu Agung Noviekayati[2], Suhadianto[3]
Faculty of Psychology, Universitas 17 Agustus 1945 Surabaya
Corresponding Author: Mutiara Amalia tiaraamalia74@gmail.com

A R T I C L E I N F O

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A B S T R A C T

The review was conducted using a systematic literature review following the PRISMA 2020 guidelines. Searches were performed on PubMed, DOAJ, Google Scholar, and GARUDA for articles published between 2020 and 2026 using combinations of keywords including postpartum blues, maternity blues, baby blues, primiparous, first-time mother, social support, anxiety, coping, and psychosocial factors. Anxiety, stress, unpreparedness for the maternal role, poor sleep quality, fatigue, low self-efficacy, marital dissatisfaction, economic pressure, unplanned pregnancy, negative birth experiences, and lack of knowledge increased vulnerability. These factors do not act independently but form a stress–adaptation–support pathway determining emotional stability during the first two postpartum weeks. Screening should begin during pregnancy and be repeated between days three and fourteen postpartum. Recommended interventions include partner education, shared caregiving responsibilities, support for sleep and physical recovery, brief counseling, and referral pathways for persistent or worsening symptoms.

INTRODUCTION

The postpartum period is a transitional phase characterized by rapid biological, psychological, social, and relational changes. After childbirth, mothers must recover physically while learning breastfeeding patterns, interpreting infant crying, adjusting sleep schedules, and forming a new parental identity. When these demands exceed available adaptive resources, mothers may experience mood changes such as tearfulness, sensitivity, anxiety, irritability, difficulty concentrating, and feelings of inadequacy. A cluster of mild symptoms typically appearing between days two and five and resolving before two weeks is known as maternity blues, postpartum blues, or baby blues syndrome (Tosto et al., 2023).

Baby blues differ from postpartum depression. Baby blues are usually brief, fluctuating, and do not severely impair functioning, whereas postpartum depression lasts longer, is more intense, and may include loss of interest, excessive guilt, functional impairment, or self-harm ideation. Distinguishing these conditions is crucial because assuming all postpartum sadness is normal can delay identification of more serious disorders. Longitudinal studies indicate that maternity blues symptoms may signal increased risk for perinatal depression, especially when symptoms are severe, persistent, or accompanied by anxiety and low social support (Landman et al., 2024; Luciano et al., 2021).

Primiparous mothers require special attention. The birth of a first child alters couples' lifestyles, domestic labor division, rest time, economic conditions, and self-expectations. Without prior infant care experience, uncertainty can easily develop into anxiety. Difficulties with breastfeeding, infant crying, postpartum pain, family comments, or social comparisons may be perceived as failure. Studies on primiparous mothers in Indonesia show that age, education, employment, readiness, husband's support, and birth characteristics relate to baby blues occurrence, though association strength varies by location and instruments used (Nadariah et al., 2021).

Vulnerability in primiparous mothers is not solely determined by parity. Psychosocial perspectives explain symptom emergence through interactions between internal stressors and environmental support. Internal factors include anxiety, stress management ability, maternal self-efficacy, pregnancy acceptance, role readiness, and birth expectations. External factors encompass partner and family support, marital quality, practical assistance, employment conditions, economic pressure, information access, and healthcare responses. Appropriate support reduces threat appraisal, while minimal or judgmental support increases helplessness.

Social support is a dominant theme in postpartum mental health literature. Emotional support makes mothers feel heard and accepted. Instrumental support reduces burden through help with infant care, meal preparation, and household chores. Informational support aids understanding of normal changes, breastfeeding techniques, infant sleep patterns, and warning signs. Appraisal support reinforces the belief that learning infant care takes time and perfection is not immediate. For first-time mothers, support quality often

outweighs quantity. Unsolicited, controlling, or critical support may increase pressure (Machado et al., 2020).

Anxiety plays a significant role. Primiparous mothers often worry about breast milk adequacy, infant safety, illness, body shape, caregiving ability, and family judgment. Anxiety heightens vigilance, disrupts sleep, and reduces restfulness during infant sleep. The anxiety–sleep deprivation–fatigue cycle lowers emotional tolerance, making mothers more tearful or irritable. Research at Universitas Airlangga Hospital found a link between postpartum anxiety levels and baby blues syndrome, highlighting anxiety screening as a tool to identify at-risk mothers before symptoms worsen (Zakia et al., 2024).

Fatigue and sleep quality, often considered physical factors, have strong psychosocial dimensions. Infant sleep patterns, night duty sharing, breastfeeding demands, family presence, and beliefs about maternal responsibility determine recovery opportunities. Fatigue impairs emotional regulation, problem-solving, and confidence. Postpartum mental health studies show fatigue and poor sleep correlate with increased depression risk, while resilience serves as a protective resource (Baattaiah et al., 2023).

Birth experiences can strengthen or weaken adaptation. Unexpected labor, emergency interventions, loss of control, severe pain, complications, or perineal trauma may cause fear and disappointment. For primiparous mothers, this first experience shapes body capability interpretation and maternal identity. Psychological impact of perineal trauma and physical recovery may extend into parenting adjustment, especially when pain limits mobility, breastfeeding, and sleep (Molyneux et al., 2024).

Indonesian research on baby blues has expanded but remains scattered across cross-sectional studies, narrative reviews, and small local samples. Some studies conflate baby blues with postpartum depression or use EPDS without consistent timing or cutoff explanations. Previous reviews mapped general risk factors but rarely focused on psychosocial dynamics in primiparous mothers or inter-factor relationships (Utami & Nurfita, 2022). Such focus is needed to move beyond vague "lack of support" mentions toward specifying support forms, stress mechanisms, screening timing, and intervention needs.

Addressing these gaps, this systematic literature review aims to identify psychosocial factors influencing baby blues syndrome in primiparous mothers, categorize risk and protective factors, explain inter-factor mechanisms, and formulate implications for maternity care services. The research questions are: Which psychosocial factors consistently relate to baby blues in primiparous mothers? How do these factors interact? What detection and prevention strategies can be applied in maternal care?

THEORETICAL REVIEW

Concept and Characteristics of Baby Blues Syndrome

Baby blues syndrome is a mild postpartum affective disturbance that typically occurs between the second and fifth day after childbirth and resolves spontaneously within two weeks. The condition is characterized by emotional instability, frequent crying, mood swings, anxiety, irritability, fatigue, and impaired concentration. Unlike postpartum depression, baby blues syndrome is

generally transient and involves relatively mild functional impairment. Nevertheless, persistent or severe symptoms accompanied by significant deterioration in daily functioning warrant careful clinical attention, as they may indicate the early development of more serious postpartum mood disorders (Tosto et al., 2023; Luciano et al., 2021).

Evidence from longitudinal studies suggests a developmental relationship between maternity blues, early postpartum anxiety, and subsequent perinatal depression. Landman et al. (2024) identified postpartum blues as an important predictor of postpartum depression, while Luciano et al. (2021) demonstrated that the severity of early postpartum symptoms and maternal anxiety can facilitate the identification of women who require continued psychological monitoring. Therefore, baby blues syndrome should be understood not merely as a temporary emotional response following childbirth but also as a critical period for early screening and preventive intervention aimed at reducing the risk of more severe postpartum psychological disorders.

Role Transition and Vulnerability among Primiparous Mothers

Primiparous mothers undergo substantial life transitions as they adapt to new identities, daily routines, marital dynamics, and parenting responsibilities. Because they lack previous experience in infant care, first-time mothers often encounter uncertainty, diminished maternal self-efficacy, and heightened anxiety when faced with breastfeeding difficulties, persistent infant crying, sleep deprivation, or challenges related to postpartum physical recovery. Nadariah et al. (2021) reported that maternal characteristics and preparedness among primiparous women were associated with the occurrence of baby blues syndrome. Likewise, Machado et al. (2020) emphasized that individualized support enables first-time mothers to develop confidence and a greater sense of competence in fulfilling their new maternal role.

However, primiparity should not be regarded as an inherently deterministic risk factor. The vulnerability associated with first-time motherhood may be mitigated when mothers receive realistic information regarding postpartum adjustment, adequate opportunities for rest, practical assistance with infant care, supportive communication from their partners, and accessible healthcare services. Conversely, unrealistic expectations of becoming an ideal mother, criticism from family members, conflicts over caregiving responsibilities, and negative childbirth experiences may impede successful adaptation. Accordingly, primiparity is better conceptualized as a transitional condition that may either strengthen or weaken the influence of other psychosocial determinants of maternal mental health.

Stress–Adaptation–Support Framework

This review adopts a stress–adaptation–support framework to explain the interrelationships among psychosocial factors associated with baby blues syndrome. Childbirth, postpartum physical recovery, breastfeeding demands, sleep deprivation, financial challenges, and infant caregiving responsibilities are conceptualized as major stressors experienced during the postpartum period. Their effects on maternal emotional well-being are influenced by mothers'

cognitive appraisal of their coping abilities, coping strategies, readiness for motherhood, and the availability of social support. Emotional, instrumental, informational, and appraisal support may reduce psychological distress, enhance maternal self-efficacy, and facilitate postpartum recovery, whereas inadequate social support increases feelings of loneliness, helplessness, and emotional vulnerability (Cho et al., 2022; Taylor et al., 2022).

Within this framework, anxiety, poor sleep quality, fatigue, marital conflict, financial strain, unplanned pregnancy, and negative childbirth experiences are identified as major risk factors. Conversely, resilience, maternal preparedness, self-efficacy, knowledge regarding postpartum care, and support from spouses and family members function as protective factors. Rather than acting independently, these variables interact dynamically to influence maternal psychological adjustment. For instance, supportive partner involvement may improve maternal sleep quality, reduce physical exhaustion, and simultaneously strengthen adaptive coping capacities during the postpartum period (Baattaiah et al., 2023).

Position and Contribution of the Review

Previous studies have identified numerous factors associated with baby blues syndrome; however, the available evidence remains fragmented across local studies, employs heterogeneous measurement instruments and assessment periods, and does not consistently distinguish baby blues syndrome from postpartum depression. This systematic literature review specifically focuses on primiparous mothers by integrating psychological, social, relational, and maternal experiential factors within a comprehensive analytical framework.

The primary contribution of this review lies in systematically mapping both risk and protective factors, elucidating the mechanisms through which these psychosocial factors interact, and identifying appropriate screening periods and supportive interventions that may be implemented within midwifery and maternal nursing practice. Through this synthesis, the review provides a more comprehensive understanding of the psychosocial processes underlying baby blues syndrome among first-time mothers and offers evidence-based implications for early detection and preventive maternal healthcare services.

METHODOLOGY

Study Design and Unit of Analysis

This study employed a systematic literature review with narrative synthesis. Reporting followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines emphasizing transparency in study identification, selection, appraisal, and synthesis (Page et al., 2021). Due to heterogeneity in study designs and outcome measures, meta-analysis was not conducted. Synthesis aimed to identify psychosocial factor patterns, relationship directions, consistency, and contextual influences.

This study employed a systematic literature review (SLR) as a form of secondary research, with individual research articles serving as the unit of analysis. The review population comprised all empirical studies investigating baby blues syndrome or early postpartum affective symptoms, whereas the review sample

consisted of studies that fulfilled the predefined eligibility criteria. As the study relied exclusively on secondary data, it did not involve direct participant recruitment, instrument administration, or statistical hypothesis testing. The review instruments included an article screening form, a standardized data extraction matrix, and the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for methodological quality assessment.

Review Question and Eligibility Framework

The research question was structured using the Population-Exposure-Outcome framework. Population: primiparous postpartum mothers, especially within the first two weeks after birth. Exposure: psychosocial factors including social support, anxiety, stress, maternal role readiness, coping, self-efficacy, marital relationship, economic pressure, knowledge, birth experience, and infant care demands. Outcome: baby blues, maternity blues, postpartum blues, or early postpartum affective symptoms assessed by structured instruments or clear research criteria.

Information Sources and Search Strategy

Literature searches were conducted on PubMed, DOAJ, Google Scholar, and GARUDA databases. Publication range was January 2020 to June 2026 to reflect current evidence, with limited exceptions for relevant 2019 journal issues indexed in 2021. Reference lists of reviews and key articles were also screened to identify additional studies.

English keyword combinations included ("postpartum blues" OR "maternity blues" OR "baby blues" OR "postnatal blues") AND (primiparous OR primipara OR "first-time mother") AND ("social support" OR husband OR family OR anxiety OR stress OR coping OR readiness OR "self-efficacy" OR psychosocial). Indonesian keywords included ("baby blues" OR "postpartum blues") AND (primipara OR "first-time mother") AND ("husband support" OR "family support" OR anxiety OR readiness OR adjustment OR psychosocial). Boolean operators and term variations were adapted per database features.

Eligibility Criteria and Study Selection

Inclusion criteria: (1) primary quantitative, qualitative, or longitudinal research; (2) postpartum mothers with specific primiparous data or findings directly addressing first-time motherhood transition; (3) baby blues or relevant early postpartum psychological symptoms; (4) reporting at least one psychosocial factor; (5) full text available; (6) published in Indonesian or English. Postpartum depression studies were included if psychosocial mechanisms explaining early symptom development were examined and discussed separately from baby blues.

Exclusion criteria: studies focusing solely on biological factors without psychosocial components, postpartum psychosis, combined pregnancy-postpartum periods without separation, opinion pieces without methods, lacking extractable data, or with low methodological quality. Pharmacological interventions and animal studies were also excluded.Selection involved four stages: identification, duplicate removal, title and abstract screening, and full-text

assessment. Extracted data included authors, year, country, design, sample size, participant characteristics, instruments, psychosocial factors, main findings, and limitations. Terminology discrepancies between baby blues and postpartum depression were examined based on symptom onset, duration, and measurement methods.

Data Extraction and Quality Assessment

The selection process yielded 15 studies for qualitative synthesis. PRISMA flow diagram numbers should be verified if searches are updated before journal submission, as Google Scholar and GARUDA results may change dynamically. Data extraction was performed using a standardized extraction matrix to ensure that all included studies were evaluated according to consistent criteria. Information extracted from each study included study characteristics, research objectives, study design, sample characteristics, postpartum assessment period, measurement instruments, psychosocial factors examined, direction of associations, principal findings, and study limitations. To minimize potential inconsistencies during the review process, study selection decisions and extracted data were re-evaluated against the predetermined eligibility criteria.

All records identified through the database search were documented in a study selection log. After duplicate records had been removed, titles and abstracts were screened for relevance, followed by a full-text assessment based on the established eligibility criteria. This process resulted in the inclusion of 15 studies in the qualitative synthesis, as illustrated in Figure 1.

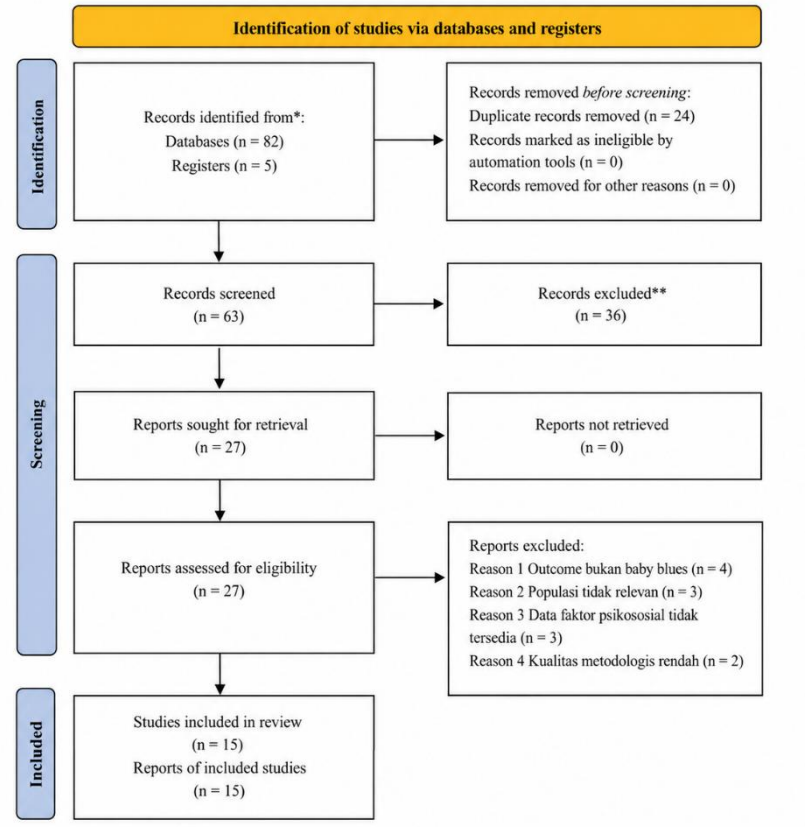

Figure. 1 resulted in the inclusion of 15 studies in the qualitative synthesis

Methodological quality was appraised using Joanna Briggs Institute criteria for cross-sectional, cohort, and qualitative studies. Aspects assessed included clarity of inclusion criteria, sample appropriateness, validity of exposure and outcome measures, confounder control, analysis accuracy, reporting completeness, and conclusion consistency with data (Aromataris et al., 2024). Studies were rated high if most criteria were met, moderate if limitations existed but results remained interpretable, and low if major bias compromised reliability.

RESULTS

Study Characteristics

Fifteen articles met inclusion criteria and were analyzed in this systematic literature review. Selected studies examined psychosocial factors related to baby blues syndrome and mood disturbances during the postpartum period. The most frequently studied factors included husband and family support, anxiety, maternal role readiness, sleep quality, fatigue, resilience, birth conditions, pregnancy planning, and maternal knowledge. Table 1 summarizes authors, article titles, studied factors, and main findings

Tabel 1. Characteristics and Main Findings of the Included Studies

Authors and Article Title	Factors Examined	Key Findings
Nadariah et al. (2021), Relationship Between Primiparous Mothers' Characteristics and the Occurrence of Baby Blues	Maternal characteristics and early postpartum adjustment	Primiparous mothers who were less prepared for their new maternal role and had limited social support were more likely to experience baby blues syndrome.
Luciano et al. (2021), The Transition from Maternity Blues to Full-Blown Perinatal Depression: Results from a Longitudinal Study	Maternity blues, anxiety, and perinatal depression	Maternity blues scores and anxiety during the early postpartum period predicted the subsequent development of perinatal depression symptoms.
Siallagan et al. (2022), Relationship Between Family Support and Baby Blues Among Postpartum Mothers in Pulau Terap Village	Family support	Family support was significantly associated with the occurrence of baby blues among postpartum mothers ($p = 0.001$).
Cho et al. (2022), Association Between Social Support and Postpartum Depression	Social support	Mothers with low or moderate levels of social support had a higher risk of postpartum mood disorders than those receiving high levels of support.
Taylor et al. (2022), The Relationship Between Social Support in Pregnancy and Postnatal Depression	Social support during pregnancy	Lower levels of social support during pregnancy were associated with increased postnatal depressive symptoms.

Baattaiah et al. (2023), The Relationship Between Fatigue, Sleep Quality, Resilience, and the Risk of Postpartum Depression	Fatigue, sleep quality, and resilience	Fatigue and poor sleep quality increased the risk of postpartum psychological problems, whereas resilience served as a protective factor.
Wahyuni et al. (2023), Characteristics of Postpartum Mothers with Baby Blues Syndrome	Maternal characteristics and husband support	Maternal characteristics and husband support were associated with the occurrence of baby blues syndrome during the postpartum period.
Wulan et al. (2023), Analysis of Factors Associated with Baby Blues Syndrome Among Postpartum Mothers	Maternal and social factors	Social support, maternal readiness, and postpartum conditions contributed to the development of baby blues syndrome.
Apriyanti et al. (2023), The Factors Related to the Event Baby Blues in Postpartum Mothers	Maternal age, husband support, parity, and employment	Maternal age, husband support, parity, and employment status were significantly associated with baby blues syndrome.
Landman et al. (2024), Postpartum Blues: A Predictor of Postpartum Depression, from the IGEDEPP Cohort	Postpartum blues and psychological factors	Approximately one-third of participants experienced postpartum blues, which emerged as a predictor of postpartum depression.
Molyneux et al. (2024), The Postnatal Effects of Perineal Trauma on Maternal Psychological and Emotional Wellbeing	Perineal trauma and postpartum adjustment	Perineal trauma and the physical consequences of childbirth influenced maternal emotional well-being and adjustment to the parenting role.
Ginting (2024), Factors Influencing Postpartum Blues at TPMB I	Maternal readiness and husband support	Husband support showed a significant association with postpartum blues, whereas maternal readiness was not significant after statistical adjustment.
Yolanda et al. (2024), Factors Associated with Baby Blues Syndrome Among Postpartum Mothers	Maternal age, parity, pregnancy status, and husband support	Maternal age, parity, and pregnancy status were associated with baby blues syndrome. Findings regarding husband support should be interpreted cautiously because of inconsistencies in reporting.
Zakia et al. (2024), Relationship Between Postpartum Anxiety and Baby Blues Syndrome at Universitas Airlangga Hospital	Postpartum anxiety	Postpartum anxiety was significantly associated with the occurrence of baby blues syndrome.
Yuhaeni & Indawati (2024), Analysis of Factors	Maternal readiness, husband support,	Maternal readiness, husband support, mode of delivery,

Associated with Baby Blues Syndrome Among Postpartum Mothers at Cempaka Medical Center Clinic	mode of delivery, knowledge, and pregnancy planning	knowledge, and pregnancy planning were all significantly associated with baby blues syndrome.

Husband and Family Support

Husband and family support emerged as the most consistent factor. Indonesian studies found significant associations between family support and baby blues occurrence, while husband support repeatedly correlated with lower symptom severity (Ginting, 2024; Siallagan et al., 2022; Wahyuni et al., 2023). These findings align with large population studies showing low social support increases postpartum mood disorder risk (Cho et al., 2022).

Effective support is multidimensional: emotional support involves listening without judgment, acknowledging maternal fatigue, and providing security; instrumental support includes sharing night duties, diaper changes, soothing the infant, meal preparation, and limiting exhausting visits; informational support helps mothers access accurate information and healthcare contacts; appraisal support reinforces that learning infant care takes time. For primiparous mothers, practical help is often a prerequisite for emotional support to be felt.

Support effectiveness depends on matching maternal needs and family actions. Presence of many family members is not automatically protective if accompanied by criticism, comparisons, parenting conflicts, or decision usurpation. Mothers may feel loss of control and incompetence. Optimal support is responsive, asks about needs, respects privacy, and allows mothers to learn independently. First-time mothers emphasize that access to self-chosen support is more meaningful than imposed help (Machado et al., 2020).

Psychological Factors, Role Adjustment, and Coping

Postpartum anxiety directly relates to baby blues. Worries about infant safety, milk sufficiency, crying, body image, birth wounds, and new role competence increase emotional activation. Zakia et al. (2024) demonstrated a significant link between anxiety levels and baby blues. Luciano et al. (2021) longitudinally showed that early maternity blues combined with anxiety predicted perinatal depression symptoms later.

Stress in primiparous mothers often arises from gaps between expectations and reality. Idealized images of childbirth, breastfeeding, mother–infant bonding, and postpartum happiness may cause negative emotions to be perceived as personal failure. Without explanations that ambivalence and fatigue are normal, guilt intensifies. Pressure to immediately manage infant care flawlessly reduces help-seeking.

Emotional readiness is not synonymous with planned pregnancy. Mothers may desire pregnancy but feel unprepared for sleep disruption, work changes, partner relationship shifts, and responsibilities. Yuhaeni & Indawati (2024) found readiness and pregnancy planning related to baby blues, while Ginting (2024) reported readiness was not significant but husband support

remained so. This suggests readiness is influenced by support quality, prenatal education, and birth conditions.

Motherhood transition requires identity adjustment. Primiparous mothers shift from personal responsibility to continuous infant care responsibility, potentially causing loss of freedom, personal time, and routine control. Maternal self-efficacy shapes challenge appraisal. High self-efficacy mothers view breastfeeding or soothing difficulties as learnable skills; low self-efficacy mothers interpret them as incompetence evidence.

Problem-focused coping helps mothers seek information, organize schedules, share tasks, and ask for help. Adaptive emotion-focused coping includes accepting emotions, communicating with partners, relaxation, and adjusting self-standards. Avoidant coping, emotional suppression, or excessive social comparison prolong stress. Resilience buffers fatigue and sleep disturbance impacts on postpartum mental health (Baattaiah et al., 2023).

Adjustment factors closely relate to partner communication. When partners understand postpartum psychological changes, mothers more easily express needs. Conversely, minimizing comments, early sexual demands, caregiving criticism, or assumptions that parenting is solely maternal reduce self-efficacy. Interventions educating only mothers are insufficient if family environments remain unchanged.

Physical, Social, and Maternal Experience Factors

Poor sleep quality and fatigue form critical pathways to emotional instability. Newborns frequently awaken while mothers endure pain, hormonal shifts, worries, and breastfeeding demands. Fragmented sleep impairs emotional regulation and magnifies minor problems. Fatigue also hinders use of previously effective coping strategies.

Though originating physically, sleep and fatigue are strongly shaped by social structure. Mothers with partners or family sharing duties have longer sleep opportunities. Norms expecting mothers to be constantly available, refusal to use expressed milk when appropriate, or unrestricted family visits reduce rest time. Sleep support should be viewed as a psychosocial intervention, not merely advice to "rest when the baby sleeps."

Recovery from birth wounds, perineal pain, complications, and mobility difficulties add burden. Studies on primiparous mothers show perineal trauma affects psychological health and parenting adjustment (Molyneux et al., 2024). Effects may be mediated by pain, activity disruption, body image changes, and dependency. Postpartum care should assess pain and physical function alongside mood.

Marital relationship quality influences security and burden sharing. Preexisting conflicts may worsen postpartum due to sleep deprivation, priority shifts, and added expenses. Mothers perceiving emotional absence from partners may feel lonely despite cohabitation. Partner support is protective when accompanied by communication, genuine involvement, and respect for maternal decisions.

Economic pressure increases risk via concerns about delivery costs, infant needs, income loss, and job return uncertainty. Employment status has mixed

effects; work may cause stress due to return demands and limited leave but also provide identity, social support, and financial security. Apriyanti et al. (2023) found employment related to baby blues in a local context, indicating the need to consider employment alongside economic conditions, leave policies, and caregiving support.

Primiparous mothers living far from family or with partners working long hours may lack assistance. Conversely, living with extended family can cause value conflicts. Interventions must be contextual. Simple questions about nighttime helpers, decision-makers, and maternal safety in expressing needs often yield more insight than marital status alone.

Unexpected or unplanned birth experiences may trigger loss of control feelings. Emergency procedures, prolonged labor, severe pain, complications, or poor healthcare communication increase stress. Delivery type is not always an independent factor as its meaning depends on readiness, medical indication, safety perception, and communication quality. Yuhaeni & Indawati (2024) found delivery type related to baby blues, but other literature shows mixed results.
Unplanned or unwanted pregnancies add adaptation burden. Pregnancy status related to baby blues in Yolanda et al. (2024). Effects may occur through limited preparation, partner conflict, economic pressure, or maternal role ambivalence. Healthcare providers should adopt nonjudgmental approaches as mothers may hide ambivalence fearing blame.

Infant conditions also affect psychological well-being. Feeding difficulties, low birth weight, special care needs, inconsolable crying, or irregular sleep patterns increase worry. Primiparous mothers lack experience distinguishing normal variations from danger signs. Clear information, skill demonstrations, and follow-up contacts reduce uncertainty.

Knowledge, Service Access, and Factor Summary

Knowledge about the postpartum period and baby blues serves as an adaptive resource. Mothers aware that emotional changes may occur are better able to recognize symptoms and seek help. Low knowledge increases negative interpretations, such as viewing crying as weakness or feeling uniquely unhappy. Yuhaeni & Indawati (2024) reported knowledge related to baby blues in postpartum mothers.

Family mental health literacy is equally important. Husbands and families need to understand the distinction between transient baby blues and symptoms requiring intervention. Symptoms lasting more than two weeks, severe functional impairment, refusal of self or infant care, self-harm thoughts, confusion, or psychotic symptoms require immediate evaluation. Education should include contact and referral pathways, not just definitions.

Service access is influenced by stigma, distance, cost, appointment schedules, and cultural beliefs. Mothers may attend wound or infant check-ups without disclosing emotional states. Active screening by midwives and nurses permits mothers to speak openly. Empathetic questioning and adequate privacy enhance disclosure.

Table 2. Synthesis of Psychosocial Factors in Primiparous Mothers

Factor	Direction of Evidence	Primary Mechanism
Husband and family support	Strong protective factor	Emotional, instrumental, informational, and appraisal support reduce maternal burden while strengthening confidence in the maternal role.
Anxiety and stress	Strong risk factor	Increase hypervigilance, sleep disturbance, and negative interpretations of infant-care challenges.
Maternal readiness and self-efficacy	Protective/risk factor	Greater readiness and confidence facilitate adaptation, whereas inadequate preparedness increases feelings of helplessness.
Sleep quality and fatigue	Moderate to strong risk factor	Fragmented sleep impairs emotion regulation, with its effects influenced by the distribution of caregiving responsibilities.
Marital relationship	Protective/risk factor	Effective communication and relationship satisfaction strengthen support, whereas conflict increases loneliness and psychological stress.
Economic pressure and employment	Context-dependent risk factor	Financial demands, maternity leave, and work-related responsibilities influence mothers' adaptive resources.
Childbirth experience	Context-dependent risk factor	Feelings of loss of control, pain, and birth-related trauma complicate postpartum adjustment.
Knowledge and mental health literacy	Protective factor	Accurate information improves symptom recognition and promotes appropriate help-seeking behaviors.

DISCUSSION

Main Patterns of Findings

The synthesis indicates that baby blues in primiparous mothers cannot be explained by a single factor. Symptoms arise when maternal role transition demands exceed psychological and social resources. Partner and family support are the most consistent protective factors, influencing multiple pathways: reducing workload, enabling sleep, enhancing self-efficacy, aiding problem-solving, and decreasing loneliness. Conversely, anxiety, fatigue, relational conflict, and unpreparedness mutually reinforce each other.

This pattern aligns with a stress–adaptation–support model. Childbirth and infant care are initial stressors. Mothers appraise whether demands are manageable, influenced by experience, knowledge, readiness, and self-efficacy. Social support provides resources to alter situations or mitigate emotional impact. Adequate resources keep symptoms mild and transient; high stress and low support intensify, prolong symptoms, and risk postpartum depression development.

Primiparity acts as context, not automatic cause. First-time mothers lack experience, but education, support, and healthcare access can compensate. Multiparous mothers may also experience baby blues amid family conflict,

unplanned pregnancy, complications, or multiple caregiving burdens. Care focus should extend beyond parity status to use primiparity as a marker for deeper assessment.

Dominance of Social Support

Consistent findings on social support have important implications. Prenatal education often targets mothers, yet partner behavior determines maternal rest and help-seeking. Prevention programs should involve husbands from pregnancy, with concrete content: emotional changes, listening skills, task sharing, breastfeeding support, visit limits, warning signs, and referral contacts. "Support the mother" messages must translate into observable actions.

Extended families can be support or stress sources. Collective cultures offer high assistance potential but also increase interference. Healthcare providers should teach need-based communication and respect maternal decisions. Mothers must have space to express desired help forms. Family approaches are vital when partners work remotely or husband support is limited.

Postpartum depression studies reinforce mechanisms found in baby blues. Cho et al. (2022) and Taylor et al. (2022) show low social support relates to postpartum depression symptoms. Though outcomes differ, these findings explain why early-phase support prevents worsening. Results should not conflate baby blues with depression but highlight risk continuity.

Anxiety, Sleep, and Fatigue Cycle

Anxiety, sleep, and fatigue form a cycle needing interruption. Anxiety hinders sleep despite infant rest. Sleep deprivation increases irritability and negative thoughts. Fatigue reduces help-seeking and problem-solving. When partners dismiss anxiety as excessive, mothers feel misunderstood and suppress emotions further.

Simple interventions can target multiple components: night shift scheduling, domestic help, visit restrictions, pain management, and relaxation techniques improve sleep. Education on normal infant patterns reduces uncertainty. Brief counseling helps challenge catastrophic thoughts and perfectionism. Resilience is not fixed; it can be strengthened through support and small successes.

Anxiety screening should be included since EPDS mainly detects depression. Questions about worries, tension, racing thoughts, and infant harm fears can identify mothers without dominant sadness. Zakia et al. (2024) support attention to anxiety as an early symptom.

Implications for Midwifery and Nursing Services

Services can implement staged screening. Stage one in the third trimester assesses mental health history, support, readiness, pregnancy planning, partner conflict, economy, and birth expectations. Stage two before discharge evaluates birth experience, pain, breastfeeding difficulties, and home support plans. Stage three between days three and seven targets peak baby blues symptoms. Stage four near two weeks ensures symptom improvement.

Screening alone is insufficient without response. Mild symptoms require validation, education, sleep support, and follow-up. Moderate symptoms need brief counseling, partner involvement, and scheduled reassessment. Persistent symptoms beyond two weeks, severe impairment, self-harm or infant harm ideation, confusion, hallucinations, or disorganized behavior require urgent referral. Referral pathways must be known by midwives, nurses, doctors, and families.

Home visits or telehealth can enhance detection as some mothers struggle to attend facilities. Brief phone or structured message contacts can assess mood, sleep, pain, breastfeeding, and support. Technology does not replace clinical evaluation but accelerates risk identification.

Interventions should not burden mothers with extra tasks. Relaxation or self-care advice may feel blaming if families do not help. Priority is reducing actual burden, meeting basic needs, and ensuring mothers have time to sleep, eat, bathe, and communicate without pressure.

CONCLUSIONS AND RECOMMENDATIONS

Psychosocial factors influencing baby blues syndrome in primiparous mothers form an interconnected network. Husband and family support are the most consistent protective factors. Anxiety, stress, unpreparedness for motherhood, low self-efficacy, poor sleep quality, fatigue, marital conflict, economic pressure, unplanned pregnancy, negative birth experiences, and limited knowledge increase vulnerability. Primiparity amplifies uncertainty due to lack of direct experience, but risks can be mitigated through education, responsive support, and healthcare access.

Screening should start during pregnancy and be repeated between days three and fourteen postpartum. Assessments should include mood, anxiety, sleep, fatigue, pain, support, readiness, and daily functioning. Prevention must involve partners and families, organize task sharing, support physical recovery, provide clear information, and ensure follow-up. Persistent, worsening, or safety-risk symptoms require professional evaluation and immediate referral.

Recommendation

Healthcare providers are encouraged to integrate psychosocial screening into routine antenatal and postnatal care, particularly during the third trimester of pregnancy, prior to hospital discharge following childbirth, between the third and seventh postpartum days, and again around the fourteenth postpartum day. Screening should comprehensively assess maternal mood, anxiety, sleep quality, fatigue, pain, readiness for the maternal role, perceived family support, and overall daily functioning. In addition, healthcare facilities should establish standardized follow-up procedures and clear referral pathways for mothers who exhibit symptoms persisting beyond two weeks, severe functional impairment, thoughts of self-harm or infant harm, confusion, hallucinations, or disorganized behavior.

FURTHER STUDY

Future research should adopt standardized definitions and assessment time points for baby blues syndrome, recruit more diverse samples of

primiparous mothers, employ longitudinal study designs, and evaluate the effectiveness of interventions involving partners and family members. Furthermore, future studies should clearly distinguish baby blues syndrome from postpartum anxiety and postpartum depression to improve the comparability and interpretability of research findings.

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