

# Epidemio-clinical Profile of the Baby Blues in Cameroonian Women

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**Abstract:** Background: The baby blues may be defined as a mild and transient depressive state occurring in newly delivered women. It is considered as the most precocious and benign emotional disorder of the puerperium. Objective: This study aimed at describing the epidemiological and clinical aspects of this condition in Cameroonian women. Method: A cross-sectional analysis of women recruited from January to April 2015 in two teaching hospitals of Yaoundé, Cameroon was done. The survey covered 321 newly delivered women who answered the Kennerley and Gath blues questionnaire within the first ten days of postpartum. Demographic information, medical, obstetrical, psychosocial and neonatal data were equally obtained. Results: The prevalence of baby blues in our series was 33.3%, the greatest number of affected women experienced the condition after 4 days into postpartum. The most occurring symptoms were women being tearful (91 patients, 85%), ups and downs in the mood (89 patients, 83.2%), changeable in spirit (84 patients, 78.5%), being mentally tensed (70 patients, 65.4%), depressed (69 patients, 64.5%), and being anxious (65 patients, 60.7%). Conclusion: The baby blues is common in Cameroonian women, occurring in close to one mother out of three. Newly delivered women manifest with mild depressive symptoms which are transient, generally lasting for less than 10 days. The maximum incidence was reported on the 4<sup>th</sup> day of postpartum. It therefore appears that depressive states in mothers beyond 10 days after delivery may correspond to more serious psychiatric disorders of postpartum such as postpartum depression or psychosis and should be promptly managed. However, maternity preparatory classes should be implemented, prenatal counselling and psychological support reinforced, as prevention against the baby blues.

**Keywords:** Baby Blues, Maternity Blues, Postpartum, Cameroon

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## 1. Introduction

The baby blues also known as the postpartum blues or maternity blues is one of three major entities of postpartum psychic disorders, alongside postpartum depression and postpartum psychosis [1, 2]. The condition was first mentioned by Hippocrates in the 16<sup>th</sup> century before JC as part of “mother’s madness” but was later on clearly individualised, with clinical distinction made from other psychiatric disorders of postpartum [1]. The greatest values of baby blues’ incidences, over 50% or more within the first ten days following delivery were reported by the early researchers [3]. Most recently, with the development of adequate assessment tools, lower incidences are progressively documented [3, 4]. However, there are

controversies about a global prevalence and continental variability [5, 6]. Health personnel counselling of mothers before and after delivery as part of preparation to maternity has been suggested as a good method for prevention [5, 6]. However, such measures are not always implemented nor properly undertaken. As such, the baby blues as an emotional impairment of early onset may impact mother and baby welfare with considerable effects on bonding [5, 6]. The incidence of the baby blues has been described as varying from one population to another and from one country to another with a possible influence of cultural background [6]. The very high incidences reported in some studies have led researchers to suggest that it may be a physiological process related to hormonal fluctuations in mothers during the perinatal period [7]. Nevertheless, the narrowness of the boundary with pathological conditions such as postpartum

depression might lead to a reconsideration of the baby blues as a transitional state, a hazard or an impairment to be closely monitored rather than a sickness per se [3, 6, 8]. This study aimed at describing the epidemiological and clinical aspects of the baby blues in Cameroonian women.

## 2. Methodology

A descriptive study was done on a sample of 321 newly delivered women out of which 107 presented emotional swings within the first 10 days of postpartum. The study was carried out in two teaching hospitals of Yaoundé, Cameroon namely the Yaoundé Gynaeco-Obstetric and Paediatric Hospital and the Yaoundé Central Hospital. After approval of the protocol by the ethical committee, newly delivered women were enrolled, after their consent was obtained. A pretested questionnaire was administered and information retrieved from the patients' files. Data collected included socio-demographic characteristics, newborn parameters, medico-obstetrical enquiries, psychosocial information and the administration of Kennerley and Gath's blues questionnaire within the first ten days of postpartum. The Kennerley and Gath blues questionnaire is a validated self-rating scale consisting of 28 items concerning the emotional state of newly delivered women. The available answers are "yes" or "no" corresponding respectively to the marks of 1 and 0 with a maximum possible score of 28 and a minimum of 0. The scale served as a diagnostic and explorative tool. Women who had an overall score greater than the mean peak score of the sample were considered positive for baby blues. The recruitment of subjects was consecutive and exhaustive over a period of four months. Statistical analyses were done using CSpPro version 4.1 and SPSS version 22.0 software.

## 3. Results

Out of the 321 newly delivered women surveyed, 107 were diagnosed with baby blues, thus an overall prevalence of 33.3%. Having submitted subjects in various study sites to the blues questionnaire, the mean peak score at the Yaoundé Gynaeco-Obstetric and Paediatric Hospital was 9/28, with scores ranging from 4 to 16/28. Forty-five (45) cases were diagnosed out of 139 subjects making a prevalence of 32.4% at this study site. Whereas at the Yaoundé Central Hospital the mean peak score calculated was 8/28, with scores ranging from 4 to 15/28. Sixty-two (62) cases were diagnosed out of 182 subjects, making a prevalence of 34.1% at this study site. The mean age of affected women was 29±6 years, 64.5% of the affected women were foreigners to the hosting region, the majority 58 (54.2%) were of catholic obedience. Most affected women 93 (86.9%) had at least secondary education level, 59 (55.1%) had a job, but 85 (79.5%) estimated themselves between average to low socioeconomic level. Seventy-four (69.2%) of women presenting the baby blues were in couple relationship, 45 (42.1%) of them expressed low satisfaction. Sixty-eight (63.1%) of women with baby blues had desired and planned their pregnancies, 84 (78.5%)

were not satisfied with the progress of the pregnancy, 66 (61.7%) of them were already mothers of more than one child. Seventy-four (69.2%) were satisfied with the baby's state. Thirty-seven (34.6%) of affected women had already experienced such symptoms after previous deliveries, 46 (43%) had relatives who have suffered such condition and 50 (47.1%) had histories of consultation for a psychological upset.

The most occurring symptoms were being tearful (91 patients, 85%), ups and downs in the mood (89 patients, 83.2%), changeable in spirit (84 patients, 78.5%), being mentally tensed (70 patients, 65.4%), depressed (69 patients, 64.5%), anxious (65 patients, 60.7%), overemotional (60 patients, 56.1%). Day 4 of postpartum registered the greatest number of cases (21 women, 19.6%).

*Table 1. Clinical characteristics of baby blues.*

Symptoms	Cases (n=107)	
	n	%
Tearful	91	85.0
Anxious	65	60.7
Mentally tensed	70	65.4
Overemotional	60	56.1
Up and down your mood	89	83.2
Changeable in your spirits	84	78.5
Depressed	69	64.5

## 4. Discussion

The overall prevalence of the baby blues in our series was 33.3%, which is considerable but lower than the average found in the literature, though close to the latest reported incidences [6, 9, 10]. However, it is quite close to 31.1% prevalence found in a similar context by Adewuya et al in Nigeria [11]. In Europe the prevalence of the baby blues may be rather increased, with values as high as 80% according to Handley et al [2, 12, 13]. The lowest prevalence of the baby blues was found in Asia with May et al who obtained 7% in China and Yuki Takahashi et al who found a prevalence of 15% among Japanese women [14-16]. In southern America, Alexander et al registered values which are similar to those of Africa in Brazilian women (32.7%) [17]. These values are consistent with the hypothesis which suggests that the baby blues' prevalence may vary across cultures and traditions [11]. On the other hand, variability with race may equally be suggested on a similar basis. The baby blues may thus be higher in European women, lower in Africans and south Americans, and lowest in Asian women.

The slight difference in the incidence value of the baby blues between our two study sites could be due to the fact that the Yaoundé Central Hospital receives a greater number of parturients with lower socioeconomic standards, which is a known risk factor for developing the baby blues [11, 15, 17]. The mode of delivery was not taken into consideration given that the prevalence of the baby blues after caesarean section is believed not to differ fundamentally from that obtained after vaginal delivery [18, 19].

Studies carried out by Hamilton and Robin based on

simple clinical interviews, later on followed by Yalom's review permitted to analyse the symptoms of the baby blues [20, 21]. They revealed that the baby blues may be brief in some cases, lasting for few hours or days. It was equally noticed that the maximum frequency and intensity of the signs and symptoms characterising the baby blues are often reached between the 3<sup>rd</sup> and 5<sup>th</sup> day of the puerperium. A decrease and eventually the disappearance of the signs was then noted after 10 days into postpartum [3]. In this survey, the greatest number of affected women experienced the condition after 4 days into postpartum, which is consistent with the description of the baby blues, as occurring within the first ten days of immediate postpartum [3, 4]. The most occurring symptoms in this series were women being tearful, ups and downs in the mood, changeable in spirit, being mentally tensed, feeling depressed, and being anxious.

Although the baby blues has been studied for many years now, earlier assessments relied on scales not specifically designed for it [22, 23]. Most of them were adapted for postnatal depression which may comprise confounding symptoms different from those of the baby blues [20]. This may be another reason for the difference in the prevalence of the condition worldwide [4, 6]. A number of postnatal depression scales fit for assessing the baby blues were subsequently developed, including the Edinburgh Postnatal Depression Scale EPDS and the Bromley Postnatal Depression Scale-(BPDS) [20, 21]. However, blues-specific scales such as Pitt's, Stein's, Kennerley and Gath scales have been developed over the years and seem more reliable for the diagnosis of the baby blues [3, 6].

## 5. Conclusion

The baby blues is common in Cameroonian women, occurring in close to one mother out of three. Newly delivered women manifest with mild depressive symptoms which are transient, generally lasting for less than 10 days. The maximum incidence was reported on the 4<sup>th</sup> day of postpartum with tears shedding being the commonest sign. It therefore appears that depressive states in mothers beyond 10 days after delivery may correspond to more serious psychiatric disorders of postpartum such as postpartum depression or psychosis and should be promptly managed. However, maternity preparatory classes should be implemented, prenatal counselling and psychological support reinforced, as prevention against the baby blues.

## Author Contributions

The author participated in all steps of the study.

## Conflict of Interest

The author declares there is no competing interest.

## Ethical Approval

The study was approved by the Institutional Ethics Committee.

## Acknowledgements

All collaborators to the project.

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