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AWHONN Position Statement

Mood and Anxiety Disorders in Pregnant and Postpartum Women

Position

All pregnant and postpartum women should be screened for mood and anxiety disorders. Nurses are in key positions to screen women, provide education regarding perinatal mood and anxiety disorders to pregnant and postpartum women and their families, and ensure appropriate treatment referrals.

Background

Perinatal mood disorders include depression during pregnancy, postpartum depression, bipolar disorder, and postpartum psychosis. Perinatal anxiety disorders include generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, social anxiety disorder, specific phobias, and posttraumatic stress disorder (PTSD).

An estimated 10%–20% of women experience depression or anxiety during pregnancy or in the postpartum period. As a result, these conditions are the most common complications of childbirth (Josefsson, Berg, Nordin, & Sydsjö, 2001; O’Hara & Swain, 1996). Much attention has been given to postpartum depression; however, the prevalence of depression during pregnancy may be even greater than in the postpartum period. Perinatal anxiety disorders are likewise quite common (Goodman, Chenauskey, & Freeman, 2014). Comorbidity between perinatal anxiety and depression is also common, since many women suffer concurrently from major depression and one or more anxiety disorder (Grigoriadis et al., 2011; Wisner et al., 2013).

PTSD due to traumatic childbirth is not uncommon, and reported prevalence rates range from 1.5% (Ayers & Pickering, 2001) to 5.6% (Creedy, Shochet, & Horsfall, 2000). Risk factors for PTSD include perinatal depression or anxiety, a history of prior trauma, and a history of mental health problems (Beck, 2014). Women at risk to experience trauma during childbirth had high levels of medical intervention during labor, long and painful labors, or a perceived lack of support (Beck, 2014).

Perinatal mood disorders occur on a continuum. Extreme manifestations are life threatening for women and newborns. Even in their more common manifestations, perinatal mood and anxiety disorders can affect the woman’s health, her ability to connect with her child, her relationship with her partner, and her child’s long-term health and development. For example, women with untreated depression during pregnancy are more likely to have trouble sleeping; poor nutrition and inadequate weight gain; missed prenatal visits; and greater use of harmful substances like tobacco, alcohol, or illegal drugs. They are also less likely to follow a health care provider’s advice (Women’shealth.gov, 2012). For her child, a woman’s depression during pregnancy is associated with preterm birth, low birth weight, developmental and cognitive delays, increased crying, and problems with bonding (Beck, 2014; Steer, Scholl, Hediger, & Fischer, 1992). The short- and long-term effects of perinatal mood and anxiety disorders will continue to be discovered as nurses and other scientists conduct research in this area.

Screening and Treatment

Systematic screening in pregnancy and the postpartum period can help detect early symptoms of perinatal psychiatric distress. Early detection can lead to better management of perinatal mood and anxiety disorders, which helps promote the health and well-being of women and their children (O’Hara & Wisner, 2014). Screening for perinatal mood and anxiety disorders should be available in all facilities that provide care for new mothers, including obstetric, neonatal, and pediatric settings. Because perinatal mood disorders occur on a continuum, the importance of appropriate screening and early intervention strategies cannot be overstated. If a woman is contemplating suicide or contemplating harming her infant, emergency mental health interventions are necessary.
A variety of effective treatment options exist for women with perinatal mood and anxiety disorders (Sockol, Epperson, & Barber, 2011). Most of the researchers studying treatment have focused on depression, especially postpartum depression. Psychotherapy, particularly cognitive-behavioral and interpersonal psychotherapy, and antidepressant medication have all been shown to be effective in the treatment of postpartum depression (Sockol et al., 2011; Stuart and Koleva, 2014). Psychosocial interventions such as peer support and non-directive counseling have also been shown to be beneficial in decreasing depression symptoms in postpartum women (Dennis & Hodnett, 2007; Morrell et al., 2009). Whereas antidepressant treatment may be indicated and most effective for severe depression, psychosocial and/or psychological therapies may be a preferable option for mild to moderate depression (Brandon & Freeman, 2011; Yonkers, Vigod, & Ross, 2011). Psychotherapy combined with medication may be the treatment of choice for some women.

Research is limited regarding treatment for perinatal mood disorders other than depression. Psychological therapies, particularly cognitive behavioral therapy, have been shown to effectively reduce anxiety among the general population of patients with anxiety disorders (Otte, 2011). However, research regarding treatment of perinatal anxiety disorders is in its beginning stages, and only a handful of pilot studies are in existence. As a result, clinicians often extrapolate from the existing evidence base regarding treatment of psychiatric disorders at other times in women's lives in order to inform clinical management in the perinatal period.

Women's reluctance to take medication when pregnant or during the postpartum period, even if they are not breastfeeding (Goodman, 2009), along with potential concerns about fetal and infant health outcomes, makes non-pharmacological treatment options such as psychotherapy particularly important in the perinatal period (Battle, Salisbury, Schofield, & Ortiz-Hernandez, 2013; Goodman, 2009).

The Role of the Nurse

Given the potential negative effects of perinatal mood and anxiety disorders on the developing fetus, the mother-infant relationship, and early parenting, registered nurses should be alert for symptoms of depression and anxiety in the perinatal period. Further, nurses working with preg-

nant women and new mothers are well-positioned to perform routine screenings to identify at-risk women, initiate effective interventions to ensure the safety of the woman and newborn, and improve access to community-based, perinatal mental health providers and support groups. Nurses can optimize the level of care they provide in the following ways:

- Encourage women and new mothers to share negative emotions they may experience.
- Assess all women for risk factors during the perinatal period.
- Implement screening programs and perform screening for perinatal mood and anxiety disorders at various points during pregnancy and in the postpartum period.
- Take careful histories when women come in for their birth admission about their fears related to childbirth, and, for multiparous women, ask about past birth trauma.
- Prepare pregnant women and new mothers for self-monitoring for symptoms of perinatal mood and anxiety disorders and advise women of the steps they need to take if they experience such symptoms.
- Refer women, as appropriate, for follow up evaluation, diagnosis, and treatment with mental health provider.
- Stay current with evidence about medication safety and use during pregnancy and lactation.
- Develop and maintain a current list of community resources for treating perinatal mood and anxiety disorders and make women and their families aware of these resources.
- Serve as a champion for change to support delivery of high quality, evidence-based care for women experiencing perinatal mood and anxiety disorders.
- Advocate for the expansion of treatment resources in their communities.
- Encourage women to consult with their care providers before discontinuing medications due to pregnancy.

Recommendations

AWHONN supports the implementation of legislation, policies, and public health initiatives that help raise awareness, remove stigma, reduce barriers to treatment, and expand research related to perinatal mood and anxiety disorders. Such initiatives include

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- Assess all women for risk factors during the perinatal period.
- Implement screening programs and perform screening for perinatal mood and anxiety disorders at various points during pregnancy and in the postpartum period.
- Take careful histories when women come in for their birth admission about their fears related to childbirth, and, for multiparous women, ask about past birth trauma.
- Prepare pregnant women and new mothers for self-monitoring for symptoms of perinatal mood and anxiety disorders and advise women of the steps they need to take if they experience such symptoms.
- Refer women, as appropriate, for follow up evaluation, diagnosis, and treatment with mental health provider.
- Stay current with evidence about medication safety and use during pregnancy and lactation.
- Develop and maintain a current list of community resources for treating perinatal mood and anxiety disorders and make women and their families aware of these resources.
- Serve as a champion for change to support delivery of high quality, evidence-based care for women experiencing perinatal mood and anxiety disorders.
- Advocate for the expansion of treatment resources in their communities.
- Encourage women to consult with their care providers before discontinuing medications due to pregnancy.
• Culturally specific public health campaigns that help women and their families better understand perinatal mood and anxiety disorders and where to seek treatment, if needed.
• Increased access to perinatal mental health interventions, including psychotherapy, that are high-quality, affordable, and logistically feasible, including in the home or integrated into the obstetric setting.
• Insurance coverage in public and private plans for perinatal mood and anxiety disorder screening and for the full range of effective treatment options.
• Establishment of community support networks and community-based partnerships intended to support pregnant and postpartum women.
• Further research to discern more accurately the prevalence and course of anxiety over the perinatal period.
• Promotion of continuing education and training for nurses and other health care professionals.

REFERENCES


