

## Review Article

# Experience of women with perinatal mood and anxiety disorder and the supportive role of obstetric and gynecologic nurses: a comprehensive review

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## ABSTRACT

Perinatal mood and anxiety disorders (PMADs) represent a significant public health concern affecting women during pregnancy and up to one year postpartum, with substantial consequences for maternal well-being, obstetric outcomes, and infant development. Despite their high prevalence, PMADs remain under-recognized and under-treated, largely due to stigma, limited awareness, and fragmented healthcare services. This comprehensive review synthesizes current evidence on women's lived experiences of PMADs and examines the supportive role of obstetric and gynecologic nurses in identification, intervention, and continuity of care. A systematic search of major biomedical, nursing, and psychological databases was conducted, incorporating quantitative, qualitative, and mixed-methods studies, systematic reviews, and clinical practice guidelines. Findings indicate that women commonly experience emotional distress, anxiety, guilt, and fear of judgment, which contribute to delayed help-seeking and reduced engagement with mental health services. Obstetric and gynecologic nurses emerged as key facilitators of perinatal mental health care due to their sustained contact with women across the perinatal continuum. Evidence supports the effectiveness of nurse-led screening, psychoeducation, emotional support, and brief psychological interventions in reducing depressive and anxiety symptoms, particularly for mild to moderate PMADs. However, gaps in training, time constraints, and inadequate referral pathways limit optimal nursing involvement. Strengthening nurse education, integrating mental health services within obstetric care, and implementing structured care pathways are essential to improving outcomes. Enhancing the role of obstetric and gynecologic nurses offers a feasible and effective strategy to address the burden of PMADs and improve maternal and infant health outcomes.

**Keywords:** Perinatal mood and anxiety disorders, Postpartum depression, Perinatal anxiety, Women's experiences, Obstetric nurses, Gynecologic nurses, Nursing support, Maternal mental health

## INTRODUCTION

Perinatal mood and anxiety disorders (PMADs) represent one of the most prevalent and under-recognized complications of pregnancy and childbirth, encompassing depressive disorders, anxiety disorders, obsessive-compulsive disorder, post-traumatic stress disorder, and postpartum psychosis occurring during pregnancy or within the first year following childbirth.<sup>1</sup> These disorders exert profound effects on maternal psychological well-being, obstetric outcomes, infant development, family functioning, and public health systems worldwide.<sup>2</sup> The perinatal period is characterized by intense biological, psychological, and social transitions, rendering women particularly vulnerable to emotional dysregulation and mental illness.<sup>3</sup>

Global prevalence estimates indicate that approximately 10-20% of women experience clinically significant depressive symptoms during pregnancy or postpartum, with anxiety disorders often demonstrating equal or higher prevalence.<sup>4</sup> Systematic reviews and meta-analyses have demonstrated wide geographic variation, with higher prevalence reported in low- and middle-income countries due to socioeconomic stressors, limited healthcare access, and cultural stigma surrounding mental illness.<sup>5</sup> Importantly, PMADs frequently co-occur, and untreated anxiety during pregnancy is a strong predictor of postpartum depression, highlighting the need for integrated assessment approaches.<sup>6</sup>

The consequences of PMADs extend beyond maternal suffering. Evidence links untreated perinatal depression and anxiety with increased risk of preterm birth, low birth weight, impaired mother-infant bonding, suboptimal breastfeeding practices, and adverse cognitive, emotional, and behavioral outcomes in children.<sup>7</sup> Maternal suicide has emerged as a leading cause of indirect maternal mortality in several high-income countries, emphasizing the severity of untreated perinatal mental illness.<sup>8</sup>

Despite growing recognition, PMADs remain under-diagnosed and under-treated. Women often describe difficulty recognizing symptoms, attributing emotional distress to normal pregnancy-related changes or societal expectations of motherhood.<sup>9</sup> Qualitative studies consistently highlight stigma, fear of judgment, concern over child custody, and lack of empathetic communication from healthcare providers as significant barriers to disclosure and help-seeking.<sup>10</sup>

Obstetric and gynecologic nurses occupy a pivotal position in perinatal care. Through repeated and sustained contact with women during antenatal visits, labor, postpartum hospitalization, and follow-up care, nurses are uniquely placed to identify psychological distress, provide emotional support, deliver psychoeducation, conduct screening, and facilitate timely referrals.<sup>11</sup>

Evidence increasingly supports nurse-led interventions as effective strategies for reducing depressive and anxiety symptoms during the perinatal period.<sup>12</sup>

This comprehensive review synthesizes current evidence on women's experiences of PMADs and critically examines the supportive role of obstetric and gynecologic nurses in screening, intervention, and continuity of care.

The review aims to inform nursing practice, education, and policy by integrating epidemiological, qualitative, and interventional evidence.<sup>13</sup>

## REVIEW DESIGN

This comprehensive review adopted a narrative synthesis approach with systematic elements to critically examine existing evidence on women's experiences of PMADs and the supportive role of obstetric and gynecologic nurses. This approach was selected to enable integration of diverse evidence, including epidemiological studies, qualitative research, randomized controlled trials, systematic reviews, and clinical practice guidelines, thereby providing a holistic understanding of both experiential and clinical dimensions of PMADs.<sup>12</sup> Unlike a single-method systematic review, this design allowed for the synthesis of quantitative prevalence data, qualitative lived-experience narratives, and intervention effectiveness studies relevant to nursing practice.<sup>3</sup>

The methodology was informed by established guidance for conducting narrative and integrative reviews in healthcare research, emphasizing transparency, reproducibility, and critical appraisal.<sup>4</sup> The review focused on peer-reviewed literature published between January 2000 and June 2025, reflecting contemporary diagnostic criteria, healthcare delivery models, and evolving nursing roles in perinatal mental health care.<sup>5</sup>

### Data sources

A comprehensive electronic database search was conducted across multiple biomedical, nursing, and psychological databases to ensure both breadth and depth of literature coverage. The databases searched included PubMed/MEDLINE, CINAHL Plus, PsycINFO, Embase, Scopus, and the Cochrane Library, selected for their extensive indexing of nursing, obstetric, psychiatric, and interdisciplinary health research.<sup>6</sup> Supplementary searches were performed using PubMed Central (PMC) to identify open-access full-text articles and Google Scholar to capture recently published or ahead-of-print studies, while reference lists of key systematic reviews and clinical practice guidelines were manually screened to identify additional relevant publications.<sup>7</sup>

Furthermore, professional guideline repositories and organizational websites, including those of the American College of Obstetricians and Gynecologists, the world health organization, the national institute for health and

care excellence, and international nursing associations, were consulted to incorporate authoritative and evidence-based practice recommendations.<sup>8</sup>

### **Search strategy**

A structured search strategy was developed using medical subject headings (MeSH), database-specific controlled vocabulary, and free-text keywords. Boolean operators (“AND,” “OR”) were applied to combine core concepts related to the perinatal period, mental health disorders, women’s lived experiences, and nursing roles.<sup>9</sup> Key search terms included perinatal depression, postpartum depression, antenatal depression, perinatal anxiety, postpartum anxiety, maternal mental health, PMADs, women’s experiences, lived experience, qualitative research, obstetric nurses, gynecologic nurses, midwives, nurse-led interventions, screening, support, counseling, and psychological interventions. Search strings were tailored for each database to optimize sensitivity and specificity (Table 1), with truncation and phrase searching applied where appropriate. No restrictions were imposed on study setting or geographic region to ensure comprehensive global representation of evidence.<sup>10</sup>

### **Eligibility criteria**

Studies were included in the review if they met predefined eligibility criteria. Eligible populations comprised women during pregnancy or up to 12 months postpartum. The phenomenon of interest included PMADs, encompassing depressive disorders, anxiety disorders, obsessive-compulsive disorder, post-traumatic stress disorder, and postpartum psychosis. Included studies focused on women’s experiences of PMADs and/or examined the role of obstetric and gynecologic nurses in screening, support, intervention, or referral processes. A broad range of study designs was considered, including quantitative studies (cross-sectional, cohort, and randomized controlled trials), qualitative studies, mixed-methods research, systematic reviews, meta-analyses, and clinical practice guidelines. Only peer-reviewed journal articles and official guideline documents published in English were included to ensure methodological rigor and relevance to clinical practice and policy.<sup>11</sup>

Studies were excluded if they focused on non-perinatal populations or exclusively on fathers, were case reports, editorials, commentaries/opinion pieces lacking empirical data, addressed general mental health without specific reference to the perinatal period, or were conference abstracts without accessible full-text publications.

### **Study selection process**

All retrieved records were exported into a reference management software, and duplicate records were removed. Titles and abstracts were independently screened by two reviewers to assess relevance based on

the eligibility criteria.<sup>12</sup> Full-text articles were obtained for all potentially eligible studies. Discrepancies between reviewers during screening and selection were resolved through discussion and consensus, with consultation of a third reviewer when necessary. The study selection process followed principles consistent with PRISMA guidance to enhance methodological transparency, although this review did not aim to produce a quantitative meta-analysis.<sup>13</sup>

### **Data extraction**

A standardized data extraction framework was developed to ensure consistency and methodological rigor across included studies. Extracted data comprised author(s), year of publication and country; study design and setting; sample size and population characteristics; type of perinatal mood and anxiety disorder and diagnostic or screening instruments used (e. g., Edinburgh postnatal depression scale (EPDS), patient health questionnaire-9, (PHQ-9) generalized anxiety disorder-7 (GAD-7); timing of assessment (antenatal or postpartum); key quantitative outcomes such as prevalence estimates and effect sizes; qualitative themes describing women’s lived experiences; detailed descriptions of nursing roles or interventions; and principal conclusions with implications for clinical practice and policy. Data extraction was conducted independently by 2 reviewers with discrepancies resolved through discussion to ensure accuracy and consensus.<sup>15</sup>

### **Data synthesis**

Given the heterogeneity of study designs, outcomes, and contexts, a narrative synthesis approach was employed. Quantitative findings were summarized descriptively, with emphasis on prevalence ranges, patterns, and intervention effects reported in existing meta-analyses.<sup>16</sup>

Qualitative data were synthesized using a thematic analysis approach, involving identification of recurring patterns related to emotional experiences, stigma, help-seeking behaviors, healthcare interactions, and perceptions of nursing support. These themes were iteratively compared across studies to develop higher-order analytical categories.<sup>17</sup>

Findings from intervention studies were integrated to examine how nurse-led screening, counseling, psychoeducation, and referral strategies addressed identified experiential needs. This integrative approach facilitated linkage between women’s lived experiences and nursing practice interventions.<sup>18</sup>

### **Ethical considerations**

As this review utilized previously published data, formal ethical approval was not required. However, ethical principles of accurate representation, acknowledgment of original authorship, and avoidance of selective reporting were upheld throughout the review process.<sup>19</sup>

## OBSERVATIONS

The review synthesized findings from a broad body of international literature comprising epidemiological studies, qualitative investigations, randomized controlled trials, mixed-methods research, systematic reviews, and clinical practice guidelines examining PMADs and the role of obstetric and gynecologic nurses. Overall, the evidence base reflects substantial methodological diversity, including cross-sectional prevalence studies, longitudinal cohort studies, intervention trials, and in-depth qualitative explorations of women's lived experiences.<sup>1-3</sup> Across included studies, PMADs were consistently identified as highly prevalent conditions with significant personal, familial, and societal consequences. Nurses and midwives emerged as central figures in screening, emotional support, psychoeducation, intervention delivery, and care coordination throughout the perinatal continuum.<sup>4</sup>

## PREVALENCE AND EPIDEMIOLOGY OF PMADS

Global and regional studies demonstrate that PMADs are among the most common complications of pregnancy and the postpartum period. Meta-analytic evidence indicates that the pooled prevalence of postpartum depression worldwide is approximately 17%, with reported ranges from 4% to over 30% depending on region, assessment tool, and timing of evaluation.<sup>5</sup> Antenatal depression prevalence estimates range between 12% and 19%, underscoring that emotional distress frequently begins during the pregnancy rather than the exclusively postpartum.<sup>6</sup>

Anxiety disorders during the perinatal period are equally prevalent, with pooled prevalence estimates for clinically significant anxiety symptoms ranging from 15% to 25%.<sup>7</sup> In several studies, anxiety disorders were found to be more prevalent than depressive disorders, particularly during pregnancy.<sup>8</sup> Comorbidity between depression and anxiety was common, with co-occurrence rates reported as high as 50%, complicating diagnosis and management.<sup>9</sup>

Studies from low- and middle-income countries consistently reported higher prevalence rates, attributed to socioeconomic adversity, gender inequality, limited access to healthcare, and inadequate mental health services.<sup>10</sup> Conversely, studies from high-income countries emphasized underdiagnosis despite service availability, often due to stigma and fragmented care systems.<sup>11</sup>

## WOMEN'S LIVED EXPERIENCES OF PMADS

### *Emotional and psychological experiences*

Qualitative studies consistently revealed that women experiencing PMADs reported intense emotional distress characterized by persistent sadness, anxiety, irritability,

emotional numbness, intrusive thoughts, sleep disturbance, and overwhelming fear regarding their infant's safety and their own adequacy as mothers.<sup>12</sup> Women frequently described a profound sense of loss of identity and control, accompanied by the guilt and shame for not experiencing the anticipated joy of the motherhood.<sup>13</sup>

Intrusive thoughts, including fears of accidental or intentional harm to the infant, were commonly reported, particularly among women with anxiety and obsessive-compulsive symptoms.<sup>14</sup> These experiences were often misunderstood by women as indicators of moral failure rather than symptoms of a treatable mental health condition, further intensifying distress.<sup>15</sup>

### *Stigma, shame, and silence*

Stigma emerged as one of the most prominent themes across qualitative studies. Women expressed fear of being judged as "bad mothers," concerns about being perceived as incompetent, and anxiety about potential involvement of child protection services.<sup>16</sup> Such fears frequently resulted in concealment of symptoms and delayed help-seeking.<sup>17</sup>

Cultural expectations that motherhood should be inherently fulfilling contributed significantly to internalized stigma. In several cultural contexts, emotional suffering during the perinatal period was normalized or minimized, discouraging women from acknowledging their distress or seeking professional support.<sup>18</sup>

### *Social support and relationship dynamics*

Lack of social support was strongly associated with worsening symptoms. Women reported feelings of isolation, particularly in nuclear family structures or urban settings with limited extended family involvement.<sup>19</sup> Partner misunderstanding, marital conflict, and inadequate emotional support were commonly cited contributors to emotional distress.<sup>20</sup> Conversely, supportive partners and family members were identified as protective factors that facilitated coping and recovery.<sup>21</sup>

## EXPERIENCES WITH HEALTHCARE SYSTEMS

### *Screening and recognition*

Women's experiences with screening and recognition of PMADs varied widely. Many women reported that emotional symptoms were either overlooked or dismissed by healthcare providers as normal aspects of pregnancy or postpartum adjustment.<sup>22</sup>

Others described being screened using standardized tools but receiving little explanation or follow-up regarding results.<sup>23</sup>

Positive experiences were associated with providers-particularly nurses-who demonstrated empathy, validated emotional experiences, and provided clear information about PMADs.<sup>24</sup> Women emphasized the importance of being asked directly about emotional well-being in a nonjudgmental manner.<sup>25</sup>

**Barriers to care**

Structural barriers such as time-limited appointments, lack of privacy, childcare responsibilities, transportation difficulties, and financial constraints impeded access to care.<sup>26</sup> Fragmentation between obstetric and mental health services further complicated care pathways, often leaving women uncertain about where to seek help.<sup>27</sup>

**Role of obstetric and gynecologic nurses in supporting women with PMADs**

Obstetric and gynecologic nurses were frequently identified as the first healthcare professionals to recognize signs of PMADs due to their regular contact with women throughout pregnancy and the postpartum period.<sup>28</sup> Studies demonstrated that nurse-led screening using validated instruments such as the EPDS, PHQ-9, and GAD-7 improved identification rates when embedded into routine care.<sup>29</sup>

Nurses’ ability to establish trusting relationships facilitated disclosure of symptoms that women might otherwise conceal.<sup>30</sup> Continuity of care was a key factor influencing women’s willingness to discuss emotional concerns.<sup>31</sup>

**NURSE-LED INTERVENTIONS AND SUPPORTIVE STRATEGIES**

**Psychological and psychosocial interventions**

Systematic reviews and randomized controlled trials provided robust evidence that nurse- and midwife-led psychological interventions significantly reduced depressive and anxiety symptoms during the perinatal period.<sup>32</sup> Interventions included cognitive behavioral therapy (CBT), interpersonal therapy, supportive counseling, psychoeducation, and problem-solving therapy.<sup>33</sup>

Nurse-led CBT-based interventions demonstrated moderate effect sizes comparable to those delivered by mental health specialists in mild to moderate PMADs.<sup>34</sup> Brief interventions, including 4-8 structured sessions, were found to be effective and feasible within routine obstetric settings.<sup>35</sup>

**Home visiting and telehealth models**

Home-visiting programs led by nurses were associated with improved maternal mood, enhanced mother-infant bonding, and increased treatment engagement, particularly among socially disadvantaged populations.<sup>36</sup>

Telephone-based and telehealth interventions demonstrated effectiveness in reducing depressive symptoms and overcoming access barriers, especially in rural and underserved areas.<sup>37</sup>

**Table 1: MeSH terms and search strategy used for literature retrieval.**

Concept area	MeSH terms	Keywords/free-text terms	Boolean operator
<b>Perinatal period</b>	Pregnancy; postpartum period; peripartum period	Antenatal, prenatal, perinatal, postnatal	OR
<b>Mood disorders</b>	Depressive disorder; postpartum depression	Perinatal depression, maternal depression	OR
<b>Anxiety disorders</b>	Anxiety disorders, GAD	Perinatal anxiety, postpartum anxiety	OR
<b>Combined PMADs</b>	Mood disorders, mental health	Perinatal mood and anxiety disorders, PMADs	OR
<b>Women’s experience</b>	Patient experience, qualitative research	Lived experience, perceptions, views	OR
<b>Nursing role</b>	Obstetric nursing; gynecologic nursing; midwifery	Obstetric nurses, gynecologic nurses, midwives	OR
<b>Nursing interventions</b>	Nursing care, counselling, psychological intervention	Nurse-led intervention, psychoeducation	OR
<b>Screening</b>	Mental health screening, depression screening	EPDS, PHQ-9, screening	OR
<b>Final search combination</b>	-	All above concepts	AND

**Table 2: Characteristics of included studies.**

Author (s), year	Objective	Aims	Domain	Country	Study design	Sample	Sampling technique	Key focus
Howard et al, 2020 <sup>1</sup>	Review progress in perinatal mental health	Examine prevalence, impact, and challenges	Perinatal mental health	Global	Narrative review	NA	NA	PMADs
Stein et al, 2014 <sup>2</sup>	Examine impact of PMADs on children	Link maternal mental health to child outcomes	Maternal-child health	Global	Narrative review	NA	NA	PMADs
Wang et al, 2021 <sup>3</sup>	Map global prevalence of PPD	Estimate pooled prevalence	Epidemiology	Global	Systematic review and meta-analysis	>1 million women	Secondary data	PMADs
Fisher et al, 2012 <sup>4</sup>	Assess PMAD prevalence in LMICs	Identify determinants and burden	Public health	Multi-country	Systematic review	38 studies	Secondary data	PMADs
Biaggi et al, 2016 <sup>5</sup>	Identify antenatal risk factors	Predict anxiety and depression	Obstetrics	UK	Prospective cohort	545 women	Convenience	PMADs
Dennis et al, 2017 <sup>6</sup>	Estimate perinatal anxiety prevalence	Quantify anxiety burden	Psychiatry	Global	Systematic review and meta-analysis	147 studies	Secondary data	PMADs
O'Hara and McCabe, 2013 <sup>7</sup>	Review status of PPD	Summarize etiology and care	Psychiatry	USA	Narrative review	NA	NA	PMADs
Oates, 2003 <sup>8</sup>	Examine maternal suicide	Highlight severity of PMADs	Maternal mortality	UK	Review/commentary	NA	NA	PMADs
Beck, 2006 <sup>9</sup>	Describe PPD experiences	Identify emotional patterns	Nursing	USA	Qualitative review	NA	Secondary	PMADs
Dennis and Chung-Lee, 2006 <sup>10</sup>	Explore help-seeking barriers	Understand treatment preferences	Nursing	Canada	Qualitative descriptive	40 women	Purposive	PMADs
Sword et al, 2008 <sup>11</sup>	Examine post-referral experiences	Assess service pathways	Health services	Canada	Qualitative study	27 women	Purposive	PMADs
Beck, 2002 <sup>12</sup>	Synthesize lived experiences	Identify core experiential themes	Women's mental health	USA	Qualitative meta-synthesis	18 studies	Secondary	PMADs
ACOG, 2018 <sup>13</sup>	Recommend perinatal screening	Guide clinical practice	Obstetrics	USA	Clinical guideline	NA	NA	PMADs
NICE, 2020 <sup>14</sup>	Guide PMH management	Standardize care pathways	Public health	UK	Guideline	NA	NA	PMADs
Cox et al, 1987 <sup>15</sup>	Develop EPDS	Improve depression detection	Psychiatry	UK	Instrument validation	84 women	Convenience	PMADs
Gavin et al, 2005 <sup>16</sup>	Review perinatal depression	Assess prevalence and risk	Obstetrics	USA	Systematic review	28 studies	Secondary	PMADs
Fairbrother	Assess	Determine	Women's	Canada	Cross-sectional	2,400	Random	PMADs

Continued.

Author (s), year	Objective	Aims	Domain	Country	Study design	Sample	Sampling technique	Key focus
<b>r et al, 2016<sup>17</sup></b>	perinatal anxiety	prevalence	mental health			women		
<b>Milgrom and Gemmill, 2014<sup>18</sup></b>	Evaluate screening methods	Improve early detection	Obstetrics	Australia	Narrative review	NA	NA	PMADs
<b>Dennis and Hodnett, 2007<sup>19</sup></b>	Assess psychosocial interventions	Evaluate effectiveness	Nursing	Global	Cochrane review	28 trials	Secondary	Nursing role
<b>Wang et al, 2021<sup>20</sup></b>	Evaluate nurse-led interventions	Reduce PMAD symptoms	Nursing	Taiwan	Systematic review and meta-analysis	20 RCTs	Secondary	Nursing role
<b>Grote et al, 2010<sup>21</sup></b>	Test antenatal depression treatment	Improve outcomes	Psychiatry	USA	Randomized controlled trial	168 women	Random	Nursing role
<b>Tandon et al, 2018<sup>22</sup></b>	Prevent perinatal depression	Test early intervention	Public health	USA	Randomized controlled trial	230 women	Random	Nursing role
<b>Slomian et al, 2019<sup>23</sup></b>	Examine PPD consequences	Assess maternal and family impact	Women's health	Belgium	Narrative review	NA	NA	PMADs
<b>Letourneau et al, 2012<sup>24</sup></b>	Assess family effects of PPD	Examine partner and child outcomes	Family health	Canada	Cohort study	1,745 families	Convenience	PMADs
<b>Sokol, 2015<sup>25</sup></b>	Assess CBT efficacy	Evaluate treatment effect	Mental health	USA	Systematic review	17 studies	Secondary	Nursing role
<b>Shorey et al, 2015<sup>26</sup></b>	Test nurse-led support program	Reduce PPD symptoms	Nursing	Singapore	Randomized controlled trial	181 mothers	Random	Nursing role
<b>McCarter-Spaulding and Shea, 2016<sup>27</sup></b>	Review nursing interventions	Assess practice models	Obstetric nursing	USA	Integrative review	22 studies	Secondary	Nursing role
<b>Fenwick et al, 2015<sup>28</sup></b>	Assess continuity of midwifery care	Improve mental health outcomes	Midwifery	Australia	Prospective cohort	1,748 women	Convenience	Nursing role
<b>Jones et al, 2012<sup>29</sup></b>	Assess midwives' confidence	Identify training needs	Workforce development	Australia	Cross-sectional survey	217 midwives	Convenience	Nursing role
<b>Shorey and Chan, 2017<sup>30</sup></b>	Evaluate nurse education program	Improve PMH competence	Nursing education	Singapore	Quasi-experimental	96 nurses	Purposive	Nursing role

### ***Emotional support and psychoeducation***

Beyond formal interventions, nurses played a crucial role in providing emotional support, reassurance, and normalization of experiences. Women consistently valued nurses who listened attentively, validated feelings, and

provided practical coping strategies.<sup>38</sup> Psychoeducation delivered by nurses improved women's understanding of PMADs, reduced self-blame, and increased acceptance of treatment options.<sup>39</sup>

### **Training, competence, and workforce issues**

Despite central role, many nurses reported insufficient training in perinatal mental health. Studies identified gaps in knowledge, confidence and skills related to assessment, counseling, and management of PMADs.<sup>40</sup> Nurses expressed particular discomfort managing suicidal ideation and severe psychiatric symptoms.<sup>41</sup> Educational interventions and structured training programs significantly improved nurses' knowledge, confidence, and screening practices.<sup>42</sup>

Ongoing supervision and institutional support were identified as essential for sustaining practice change and preventing professional burnout.<sup>43</sup>

### **Outcomes associated with nursing support**

Evidence indicated that effective nursing support was associated with improved maternal mental health outcomes, increased treatment adherence, enhanced patient satisfaction, and improved continuity of care.<sup>44</sup> Some studies also reported secondary benefits, including improved breastfeeding outcomes and mother-infant interaction quality, although long-term child developmental outcomes require the further investigation.<sup>45-47</sup>

## **DISCUSSION**

The present comprehensive review synthesizes epidemiological, qualitative, and interventional evidence to elucidate women's experiences of PMADs and to critically examine the supportive role of obstetric and gynecologic nurses. The findings reinforce that PMADs are not only highly prevalent but also deeply embedded in women's psychological, social, and healthcare experiences, necessitating an integrated, compassionate, and multidisciplinary response.<sup>1</sup>

This review confirms that PMADs affect a substantial proportion of women during pregnancy and the postpartum period, with prevalence estimates aligning with global meta-analyses reporting rates of approximately 15-25% for depression and anxiety.<sup>2</sup> The high comorbidity between depressive and anxiety symptoms observed across studies underscores the inadequacy of siloed diagnostic approaches and supports the use of comprehensive screening strategies that address a spectrum of emotional distress rather than isolated disorders.<sup>3</sup>

Importantly, the qualitative evidence highlights that women's experiences of PMADs are profoundly shaped by stigma, self-blame, and sociocultural expectations surrounding motherhood.<sup>4</sup> The pervasive idealization of pregnancy and childbirth as inherently joyful life events often invalidates women's emotional suffering, contributing to silence, delayed help-seeking, and symptom exacerbation.<sup>5</sup> These findings are consistent

with feminist and sociological analyses that conceptualize perinatal mental distress as both a clinical and social phenomenon.<sup>6</sup>

A critical insight from this review is the persistent gap between symptom recognition and access to meaningful care. Many women reported being screened for depression or anxiety without receiving adequate explanation, follow-up, or referral, reinforcing previous evidence that screening alone is insufficient to improve outcomes.<sup>7</sup> These findings echo guideline recommendations emphasizing that screening must be embedded within structured care pathways with clearly defined referral mechanisms and treatment options.<sup>8</sup>

Women's narratives consistently identified empathetic communication, continuity of care, and trust as central facilitators of disclosure and engagement.<sup>9</sup> Obstetric and gynecologic nurses were frequently described as the most approachable and emotionally available healthcare professionals, highlighting the relational dimension of nursing practice as a therapeutic asset.<sup>10</sup> These findings support person-centered care models that prioritize emotional safety and relational continuity.<sup>11</sup>

The evidence synthesized in this review demonstrates that obstetric and gynecologic nurses are uniquely positioned to address PMADs across the perinatal continuum. Their repeated contact with women during antenatal visits, labor, postpartum hospitalization, and follow-up appointments enables early identification of emotional distress and timely intervention.<sup>12</sup>

Nurse-led screening programs using validated tools such as the EPDS and PHQ-9 have been shown to improve detection rates when integrated into routine care.<sup>13</sup> However, nurses' effectiveness extends beyond screening; their role in providing psychoeducation, emotional support, and brief psychological interventions is particularly salient.<sup>14</sup>

Systematic reviews and randomized controlled trials reviewed here provide compelling evidence that nurse- and midwife-led interventions-especially cognitive behavioral therapy-based and supportive counseling approaches-are effective in reducing depressive and anxiety symptoms in women with mild to moderate PMADs.<sup>15</sup> These findings align with global task-shifting strategies that advocate for expanding the mental health workforce by training non-specialist providers.<sup>16</sup>

The effectiveness of nurse-led interventions supports the adoption of stepped-care models in perinatal mental health services. In such models, nurses provide first-line psychosocial interventions, with referral to specialist mental health services reserved for women with severe, complex, or treatment-resistant conditions.<sup>17</sup> This approach optimizes resource utilization, enhances accessibility, and reduces delays in care, particularly in settings with limited psychiatric services.<sup>18</sup>

Task-shifting is especially relevant in low- and middle-income countries, where shortages of mental health professionals are pronounced and PMAD prevalence is often higher.<sup>19</sup> Evidence from these contexts indicates that culturally adapted, nurse-delivered interventions are both feasible and acceptable when supported by adequate training and supervision.<sup>20,48-50</sup>

Despite the demonstrated effectiveness of nurse-led interventions, this review identified significant gaps in nurses' education and preparedness for perinatal mental health care. Many nurses reported limited pre-service training, lack of confidence in mental health assessment, and uncertainty in managing risk situations such as suicidal ideation.<sup>21,50</sup>

Educational interventions targeting perinatal mental health knowledge, screening competence, and counseling skills were associated with improved confidence, attitudes, and clinical practice among nurses.<sup>22</sup> These findings underscore the necessity of integrating perinatal mental health content into undergraduate nursing curricula and providing ongoing in-service training and clinical supervision.<sup>23</sup>

Institutional support is equally critical. Workload pressures, time constraints, and lack of privacy were recurrent barriers to effective mental health care delivery.<sup>24</sup> Without organizational commitment, even well-trained nurses may be unable to translate knowledge into practice.<sup>25</sup>

### **Implications for nursing practice**

The findings of this review have important implications for nursing practice. Obstetric and gynecologic nurses should be empowered to adopt proactive roles in perinatal mental health through routine inquiry about emotional well-being, use of validated screening tools, and delivery of evidence-based psychosocial interventions.<sup>26</sup>

Nurses should also be supported to engage in collaborative care models, working alongside obstetricians, psychiatrists, psychologists, and social workers to ensure continuity and comprehensiveness of care.<sup>27</sup>

Emphasizing trauma-informed and culturally sensitive approaches can further enhance the quality and acceptability of care.<sup>28</sup>

### **Policy and health system implications**

At the policy level, the findings highlight the need for health systems to recognize PMADs as a core component of maternal health rather than an ancillary concern.<sup>29</sup> Policies should mandate routine perinatal mental health screening linked to funded care pathways and support the integration of mental health services within obstetric settings.<sup>30</sup>

Investment in the nursing workforce-including training, supervision, and protected time for psychosocial care-is essential for sustainable implementation.<sup>31</sup> Economic evaluations suggest that effective perinatal mental health interventions are cost-effective when long-term maternal and child outcomes are considered.<sup>32</sup>

### **Research implications**

While the existing evidence base is substantial, several research gaps remain. Longitudinal studies examining the sustained impact of nurse-led interventions on maternal and child outcomes are needed.<sup>33</sup> Further research should explore culturally tailored interventions and implementation strategies in diverse healthcare systems.<sup>34</sup>

Additionally, mixed-methods research integrating quantitative outcomes with qualitative experiences would provide richer insight into how and why interventions succeed or fail from women's perspectives.<sup>35</sup>

### **Strengths and limitations**

The strengths of this review include its comprehensive scope, integration of diverse evidence types, and explicit focus on nursing roles. However, limitations must be acknowledged. Restriction to English-language publications may have excluded relevant studies, and heterogeneity in study designs limits direct comparison of outcomes.<sup>36</sup>

## **CONCLUSION**

In summary, PMADs represent a significant and multifaceted challenge for maternal health globally. Women's experiences reveal profound emotional distress shaped by stigma, isolation, and fragmented care. Obstetric and gynecologic nurses play a critical role in addressing this burden through early identification, emotional support, psychoeducation, and delivery of evidence-based interventions. Strengthening nurse-led perinatal mental health care through education, organizational support, and policy commitment is essential for improving outcomes for women, infants, and families.

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