# Chapter One

Depression and anxiety can be experienced by pregnant women during the perinatal period. These ailments are often exacerbated by the fact that women who find themselves in this position do not seek treatment because of the stigma, shame, and perceived unacceptability of taking pharmaceutical drugs whilst pregnant or breastfeeding. Whilst it is widely recognised that perinatal depression and anxiety are associated with poor outcomes for women and their children (Brouwers et al., 2001; Murray & Cooper, 1996), the etiology remains unclear (Brockington, 1996). It is important, therefore, to be able to identify pregnant women most at risk to developing perinatal mood disorders and associated aliments, so that effective strategies for intervention can be developed to help prevent, or at least reduce, some of the deleterious consequences of depression and anxiety during the child bearing period.

This thesis focuses on the role that cognitions and metacognitions play in predicting emotional distress during the perinatal period. This chapter is divided into three sections. In the first section, mood disorders in the perinatal period will be considered, with a focus on perinatal depression and anxiety and the risk factors associated with both. The second section will provide a theoretical overview of the cognitive and metacognitive risk factors associated with perinatal depression and anxiety. In the third section, the aims of the project will be presented along with a summary of the theoretical lines of reasoning that led to the development of this research project.

## Emotional Distress During the Perinatal Period

### Prevalence

Emotional distress is commonly experienced by pregnant women. It can occur either during pregnancy (the antenatal period), up to 12 months after child birth (the postnatal period), or during both periods (the “perinatal” period). Perinatal depression rates amongst women are estimated at 13% (and range between 8% to 20%; Bennett et al., 2004; Josefsson et al., 2001; O'Hara & Swain, 1996). Depression and anxiety can be measured through self-report instruments, such as the Edinburgh Postnatal Depression Scale, the Beck Depression Inventory, and the State-Trait Anxiety Inventory. Scientists also may use DSM-IV criteria to identify the presence of perinatal depression and anxiety. Prevalence rates are significantly, higher, albeit only slightly, when self-report measures are used, compared to when people use interviews based on DSM-IV criteria (O’Hara & Swain, 1996). Recent research suggests that perinatal anxiety may be even more prevalent than depression (Heron et al., 2004).

Some researchers have reported that depression and anxiety are more likely to be comorbid than non-comorbid in pregnant women (Field et al., 2003; Glover et al., 1999). It has been shown, however, that many women who do not suffer from perinatal depression, do suffer from perinatal anxiety (Matthey et al., 2003). By including a diagnosis for generalised anxiety disorder (without taking into account duration) and panic disorder, over and above a depression diagnosis, the rates of perinatal psychopathology increased by 57%–100%. This finding suggests that it is equally as important to screen for postnatal anxiety as it is to screen for postnatal depression, and that anxiety and depression are not always co-existing, as has been previously assumed (Cox et al., 1989).

Recent research on prevalence rates suggests that both depression and anxiety occur more frequently in the antenatal period compared to the postnatal period, and that perinatal anxiety is equally as prevalent as, if not more prevalent than (Lee et al., 2007), perinatal depression (Heron, et al., 2004; Josefsson et al., 2001; Ritter et al., 2000; Verkerk, et al., 2005). In a large-scale longitudinal study, Heron et al. (2004) reported that 24.5% of the female participants experienced symptoms of depression at some point during the perinatal period and that 26.7% of them experienced anxiety at some point during the perinatal period. The researchers involved in this study measured levels of depression at 18 weeks gestation, 32 weeks gestation, 8 weeks postpartum, and 8 months postpartum, and reported prevalence rates of 11.4%, 13.1%, 8.9% and 7.8%, respectively. The prevalence rates for perinatal anxiety exhibited a similar profile, but prevalence was slightly higher in the antenatal period, and were reported at 14.6%, 15.6%, 8.2% and 9%, respectively.

A total of 18.7% of the participants studied by Heron et al. (2004) experienced antenatal depression and 13.3% experienced postnatal depression. The percentage of new cases of postnatal depression was 43.7% and 56.3% of women with postnatal anxiety experienced antenatal depression. A reported 21.9% of the study participants experienced antenatal anxiety and 13.9% experienced postnatal anxiety. The percentage of new cases of postnatal anxiety was 35.7% and 64.3% of the women with postnatal anxiety previously experienced antenatal anxiety. These findings suggest that 1) antenatal depression and anxiety may be more prevalent than postnatal symptoms, 2) more research on preventing antenatal depression and anxiety is required, 3) although perinatal anxiety is currently under-researched, it appears to play an important role in the well-being of many expectant and new mothers.

Aside from a lack of research on antenatal emotional distress and postnatal anxiety, research suggests that the rates of postnatal depression are similar to the rates of depression in the general population (Brockington, 1996). A review of several well-controlled studies examining the prevalence of postnatal depression revealed that very little evidence exists to support the notion that mothers are at greater risk of suffering from depression during the postnatal period than during other times of their lives (O’Hara, 1994). Due to the harmful consequences of perinatal depression and anxiety, for the mother, her family, and her child, understanding more about the prevalence and aetiology of this emotional distress is paramount.