**Chapter One**

**Scope and Overview**

Depression and anxiety during the perinatal period is a common problem, exacerbated by the fact that women often do not seek treatment during this time, due to stigma, shame, perceived unacceptability of taking pharmaceutical drugs during this period, etc. Both perinatal depression and anxiety have been associated with poor outcomes for women and their children (Brouwers et al. 2001; Murray and Cooper 1996), yet the etiology is unclear (Brockington 1996). Identifying women at risk is necessary, in order to develop interventions that can prevent, or at least reduce, some of the deleterious consequences of depression and anxiety during the childbearing period.

The focus of this thesis is to examine the role that cognitions and metacognitions play in predicting emotional distress during the perinatal period, after taking into account well-known predictors, such as past history of psychopathology and social support. This chapter is divided into three sections. In the first section, mood disorders in the perinatal period will be considered, with the focus on perinatal depression and anxiety and the risk factors associated with both. In the second section, the focus will be on 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 during the perinatal period.[[1]](#footnote-0) Estimates of perinatal depression range from 8% – 20%, commonly reported at an estimated 13% (Bennett et al. 2004; Josefsson et al. 2001; O'Hara and 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. Researchers also may use DSM-IV criteria to identify the presence of perinatal depression and anxiety. Prevalence rates are significantly, albeit slightly, higher when self-report measures are used, compared to interviews based on DSM-IV criteria (O’Hara and Swain 1996). Recent research suggests that perinatal anxiety may be even more prevalent than depression (Heron et al. 2004).

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). Research has shown 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, perinatal psychopathology increased by 57-100%. This suggests 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 and colleagues (2004) reported that 24.5% of the population experienced symptoms of depression at some point during the perinatal period and that 26.7% of the population experienced anxiety at some point during the childbearing process. The researchers measured levels of depression at 18 weeks gestation, 32 weeks gestation, 8 weeks postpartum, and 8 months postpartum; the prevalence rates were 11.4%, 13.1%, 8.9%, and 7.8%, respectively. The prevalence rates for perinatal anxiety demonstrated a similar pattern, but the prevalence was slightly higher in the antenatal period, reported at 14.6%, 15.6%, 8.2%, and 9%, respectively.

A total of 18.7% of the population 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, as well as postnatal depression. A reported 21.9% of the population experienced antenatal anxiety and 13.9% experienced postnatal anxiety. The percentage of new cases of postnatal anxiety were 35.7% and 64.3% of the women with postnatal anxiety previously experienced antenatal anxiety. These results suggest that 1) antenatal depression and anxiety may be more prevalent than postnatal symptoms, 2) more research on preventing antenatal depression and anxiety is vital, and 3) although perinatal anxiety is currently under-researched, it appears to play a large role in the well-being of many expectant and new mothers.

 Aside from the 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 there is very little evidence that the postnatal period is a time of greater risk of depression, compared to other times in life (O’Hara 1994). Due to the harmful consequences of perinatal depression and anxiety, for the woman, her family, and her child, understanding more about the prevalence and aetiology of this emotional distress would be paramount.

1. The perinatal period is broadly defined and varies widely across countries. For the purposes of this study, the period from conception to the birth of the baby is referred to as the antenatal period. The period from the birth of the baby up to 12 months after the birth is referred to as the postnatal period. The perinatal period encompasses the time frame from conception to 12 months after the birth of the baby (NHS, n.d.). [↑](#footnote-ref-0)