**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 anxiety and depression have been associated with poor outcomes for women and their children (Brouwers et al., 2001; Murray & Cooper, 1996), yet the etiology is unclear (Brockington, 1996). Identifying women at risk is essential in developing interventions that can prevent, or at least reduce, some of the negative 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, specifically focusing on perinatal depression and anxiety and the risk factors associated with both. In the second section, the focus will be narrowed down to provide a theoretical overview of the cognitive and metacognitive risk factors associated with perinatal depression and anxiety. In the third section, a summary of the theoretical lines of reasoning that led to the development of this research project, along with the aims of the project will be presented.

**Emotional Distress During the Perinatal Period**

***Prevalence***

Emotional distress is one of the most commonly experienced problems during the childbearing process. It can occur either during the pregnancy (antenatal period), up to 12 months after the birth of the child (postnatal period), or both (through the perinatal period). Estimates of perinatal depression range from 8% - 20%, commonly reported at an estimated 13% (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. Researchers also may use DSM-IV criteria to determine 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 & Swain, 1996). Recent research tells us that perinatal anxiety may be even more prevalent than depression (Heron et al., 2004).

Researchers have suggested that anxiety and depression 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, the rates of perinatal psychopathology increased by 57-100%. This 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 looking at prevalence rates suggests that both anxiety and depression occur more frequently in the antenatal period compared to the postnatal period and that perinatal anxiety is equally as prevalent, if not more prevalent (Lee et al., 2007), as 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 and reported the prevalence rates at 11.4%, 13.1%, 8.9%, and 7.8%. The prevalence rates for perinatal anxiety resulted in a similar pattern, but the prevalence was slightly higher in the antenatal period, reported at 14.6%, 15.6%, 8.2%, and 9%. 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%, with 56.3% of women with postnatal anxiety experiencing antenatal depression, as well as postnatal depression. Antenatal anxiety was experienced by 21.9% of the population and postnatal anxiety was experienced by 13.9% of the population. The percentage of new cases of postnatal anxiety were 35.7%, with 64.3% of women experiencing postnatal anxiety having previously experienced antenatal anxiety. These results suggest that 1) antenatal depression and anxiety may be even 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 seems to play a very large role in the well-being of many expectant and new mothers.

 Aside from the shortage of research on antenatal emotional distress and postnatal anxiety, research has shown that the rates of postnatal depression are similar to the rates of depression in the general population (Brockington, 1996). A review of the research on well-controlled studies examining the prevalence of postnatal depression revealed that, although prevalent, there is very little evidence that suggests that the postnatal period is a time of greater risk of depression than 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 is paramount.