Citation for published version (APA):
Correlates of Repetitive Negative Thinking in Postnatal First Time Mothers

Michelle L. Moulds¹, Melissa J. Black¹,², Jill M. Newby¹,², & Colette R. Hirsch³,⁴

¹ School of Psychology, The University of New South Wales, UNSW Sydney, Australia
² Black Dog Institute, The University of New South Wales, UNSW Sydney, Australia
³ King’s College London, Institute of Psychiatry, Psychology and Neuroscience, UK
⁴ South London and Maudsley NHS Foundation Trust, UK

Address for correspondence:
Michelle Moulds, School of Psychology, The University of New South Wales, UNSW Sydney NSW 2052, AUSTRALIA; phone: +612 9385 3041; Fax: +612 9385 3641; email: m.moulds@unsw.edu.au

Accepted for publication 16th June 2021 in Journal of Reproductive and Infant Psychology

Word count: 2933 (excluding references)

RUNNING HEAD: Repetitive Thinking
Abstract

**Background:** Despite the well-established role of repetitive negative thinking (RNT) in the prediction and maintenance of depression and anxiety, only minimal research to date has investigated RNT in the context of postnatal psychological adjustment. **Objective:** We examined the relationships between RNT, associated maladaptive cognitive processes, infant responsiveness and psychopathology in a sample of first-time mothers \((N = 235)\) with babies under 12 months. **Methods:** Participants completed an online battery of measures that indexed RNT, dampening of positive affect, metacognitive beliefs about RNT, infant responsiveness, depression and anxiety symptoms. **Results:** As predicted, RNT was correlated with depression. Controlling for depression, RNT was associated with anxiety, dampening positive affect and positive beliefs about RNT. RNT was inversely related to maternal responsiveness, but this relationship was accounted for by depression. **Conclusions:** Consistent with findings in the broader literature, RNT was associated with depression, anxiety and other unhelpful cognitive processes in the postnatal period, as well as with poor infant responsiveness. Whilst cross-sectional and preliminary, these data suggest there may be potential clinical utility in targeting RNT in first-time mothers.

**KEYWORDS:** postnatal; depression; anxiety; repetitive thinking; rumination
Introduction

Rumination and worry are both maladaptive cognitive processes evident across a range of psychological disorders. Rumination has primarily been studied in the context of depression, whilst worry has been most investigated in anxiety disorders. The key theoretical distinction between them is temporal focus: whilst rumination involves mulling over the past, worry involves considering possible adverse future outcomes.

Notwithstanding this difference, worry and rumination share numerous features, prompting some researchers to propose the value of considering both under the banner of RNT (e.g., McEvoy et al., 2010; McEvoy, Watson, Watkins, & Nathan, 2013). This broader RNT construct refers to thinking that is perseverative and difficult to control, irrespective of its specific content, temporal focus, or the emotional context/psychological disorder in which it occurs.

Despite the substantial body of evidence demonstrating the predictive and maintaining roles of rumination and worry in depressive and anxiety disorders, respectively, the nature, role and consequences of RNT have been less studied in the context of perinatal psychological adjustment (de Jong et al., 2016). The perinatal period is one of profound psychological, physiological and hormonal change. Given its distinctive and complex biological and social context, we cannot merely assume that the abovementioned relationships between RNT and psychological adjustment in non-perinatal samples also emerge in the postnatal period (Moulds et al., 2018). Poor postnatal mental health has a host of significant and long-term consequences; for example, predicting poor prognosis for offspring’s mental health (e.g., Pearson et al., 2013; Pawlby et al., 2008). As a transdiagnostic modifiable risk factor for depression and anxiety, a better understanding of
the role of RNT in predicting postnatal mental health problems will have the potential to
guide efforts to prevent their emergence.

To date, researchers have examined whether rumination in pregnancy predicts
postnatal depression, and reported conflicting findings (see de Jong et al., 2016 for review).
Whilst Barnum et al. (2013) reported that antenatal rumination predicted increased
depression from pregnancy to 8 weeks postpartum, Raes et al. (2014) found no evidence of
a predictive relationship. Similarly, whilst some studies documented a link between worry
during pregnancy and postnatal depression (e.g., Austin et al., 2007; Penacoba-Puente et al.,
2016), others have not (e.g., Mohammad et al., 2011). Experimental studies have shown
that rumination/worry reduce maternal responsiveness (Stein et al., 2012), and that rumination
compromises parenting problem-solving (O’Mahen et al., 2010) and has a
negative impact on mother-infant interactions (Tester-Jones et al., 2017). In addition,
O’Mahen et al. (2015) found that rumination decreased problem solving effectiveness in
dysphoric postnatal mothers.

Taken together, these studies provide some evidence of associations between
depression and both rumination and worry in the postnatal period. They also highlight the
fact that research on RNT in the perinatal context has predominantly examined worry or
rumination about specific content (e.g., worry about pregnancy-related concerns,
rumination about sad/depressed mood) – as opposed to investigating the process of RNT
generally. Such an approach makes it difficult to disentangle the presence and severity of
issues related to the content of worry/rumination content from the extent to which
respondents engage in the actual process of RNT. To date, a relatively small number of
studies have focused on the broader construct of RNT in the postnatal period.
In such studies, researchers have employed self-report measures which index the process of RNT (e.g., Perseverative Thinking Questionnaire, PTQ; Ehring et al., 2011; Repetitive Thinking Questionnaire, RTQ; McEvoy et al., 2010), rather than RNT about disorder-specific content. For example, Egan et al. (2017) found that antenatal RNT did not directly predict postnatal depression; however, antenatal perfectionism predicted postnatal depression via antenatal depression and antenatal RNT. Similarly, Muller et al. (2013) reported that antenatal RNT did not predict postpartum depression symptoms; however, the unproductive (but not repetitiveness) facets of antenatal RNT predicted impairments in mother-infant relationship (as reported by mothers) at 5 weeks postpartum. In another study, women with consistently high levels of RNT during both pregnancy and postpartum reported more depression and anxiety symptoms (Muller et al., 2019). In addition, infants with mothers with high levels of RNT spent more time examining their environment, and protested less frequently, relative to infants of low RNT mothers. Harrison et al. (2021) found that high levels of social support from friends (but not family or significant others) buffered the effects of RNT on postnatal depression and anxiety. Collectively, these studies provide preliminary evidence of an interrelationship of RNT and depression in the postnatal period. Notably, their findings demonstrate that this relationship is not always direct, with other factors playing a role in their association.

However, many questions remain. One of these concerns the link between RNT and postnatal anxiety. While Vossbeck-Elsebusch et al. (2014) investigated RNT in a sample of new mothers and found it predicted childbirth-related PTSD symptoms specifically, to our knowledge, the relationship between general postnatal anxiety symptoms and RNT has not been examined (Moulds et al., 2018). Indeed, postpartum anxiety is common but has received far less research attention than depression (Goodman et al., 2016), despite
evidence of its prevalence (e.g., Dennis et al., 2017; Viswasam et al., 2019). Should RNT and postnatal anxiety be related, it will also be important to determine whether their association is independent of postnatal depression symptoms.

The extent to which postnatal RNT is associated with other maladaptive processes which play a role in depression, such as the tendency to dampen positive affect (Feldman, Joormann, & Johnson, 2008), is also unknown. Dampening refers to responding to positive experiences/emotions in ways that are likely to reduce their positive emotional intensity and impact (e.g., by thinking that positive feelings won’t last or are too good to be true; Feldman et al., 2008). Studies with non-clinical samples have demonstrated that the tendency to engage in dampening in response to positive affect is associated with depression symptoms (e.g., Feldman et al., 2008), and that dampening prospectively predicts depression symptoms at 3 and 5 months, controlling for baseline depression (Raes et al., 2012). Raes et al. (2014) reported that dampening reported in the third trimester predicted postpartum depression, even when antenatal depression symptoms (indexed in the third trimester) and depression history were controlled. However, no study has examined the extent to which new mothers engage in dampening postpartum, and if they do, the extent to which it is related to RNT, as well as depression and anxiety.

Metacognitive beliefs about the benefits of RNT (e.g., the belief that engaging in RNT helps one to solve their problems) have been linked to rumination in depression. Formerly depressed individuals continue to endorse these beliefs when their depressive episode has remitted, and to a comparable level as currently depressed individuals (Watkins & Moulds, 2005). As an important maintaining factor, positive beliefs about RNT warrant investigation in the context of postnatal psychological adjustment (Egan et al., 2017). In a comparison of
pregnant women with and without depression, Isa Alfaraj et al. (2009) found that depressed expectant mothers were more likely to endorse positive metacognitive beliefs about rumination relative to their non-depressed counterparts. Further, such beliefs predicted depression over and above perceived social support. To our knowledge, no study in the published literature has examined positive metacognitive beliefs about RNT in the context of postnatal depression.

Finally, Stein et al. (2009) argued for the importance of investigating maternal cognitive processes as potential mechanisms through which maternal postnatal mental health influences children’s development. They conceptualized maternal preoccupation as a ‘core process of repetitive thinking’ (p.13), and proposed that it compromises a mother’s capacity to be present and responsive to a child’s cues. Indeed, antenatal RNT predicts impairments in the mother-infant relationship at 5 weeks postpartum, controlling for pre- and postnatal depression (Muller et al., 2013). Further, Tester-Jones et al. (2015) found that in a sample of new mothers with infants high in negative temperament, rumination was related to maternal depression and infant responsiveness. Interestingly, for mothers of infants who were low in negative temperament, rumination mediated the relationship between maternal depression and infant responsiveness. However, the link between postnatal RNT and infant responsiveness requires further examination.

In order to understand and treat postnatal psychological distress, we need to better understand the way in which RNT is related to postnatal depression and anxiety, as well as other unhelpful cognitive processes. Accordingly, we recruited a sample of first-time mothers with babies under 12 months old. We predicted positive associations between RNT, depression and anxiety; and hypothesized that the association between RNT and anxiety

would remain when controlling for depression. We also hypothesized that RNT would be positively correlated with dampening of positive affect, positive metacognitive beliefs about RNT, and infant responsiveness.

Materials and Methods

Participants and Procedure

Women whose first child was born within the last 12 months were recruited via online sources (e.g., social media groups, relevant websites) and advertisements. Participants were given the option of providing contact details to be entered into a draw to win one of five $AUD50 shopping gift cards (or an Amazon voucher of equivalent value for overseas participants). The study received ethical approval from xxx\textsuperscript{1} Human Research Ethics Advisory Panel C (HREAP – Behavioural Sciences; application file number 2765). Given the online format of the study, participants provided informed consent by ticking a box. All participants provided consent prior to commencing the study.

A total of 251 new mothers commenced the survey\textsuperscript{2}. Participants were excluded if they did not complete any of the questionnaires, or their baby was outside the specified age range (i.e., > 12 months). The final sample included 235 participants (who completed at least one questionnaire); average age was 32.0 years (SD = 4.5, range = 21-44). A post hoc power analysis indicated that the study was sufficiently powered (i.e., using Cohen’s formula, power was estimated to be 99%, entering the parameters of 236 participants per group, effect size at 0.3 (medium), and alpha at p = .05, two-tailed).

See Table 1 for all participant details.

Measures
Demographic Questions and Personal Background Information. Participants indicated their age, ethnic background, relationship status, social support (i.e., how many people they can rely on for support), educational level, and employment status. Participants Cron indicated that they had their first child in the past 12 months and noted the child’s age. In addition, they indicated whether they had experienced any complications with falling pregnant/carrying a child to term, pregnancy, the labour/childbirth, or whether they or their child had experienced any problems in the postnatal/neonatal period.

Participants also completed the following self-report measures:

**Depression Anxiety Stress Scales – 21-item version** (DASS-21; Lovibond & Lovibond, 1995): A measure of depression, anxiety and stress over the past week. The DASS-21 subscales have excellent internal consistencies (depression: $\alpha = 0.94$; anxiety: $\alpha = 0.87$; stress: $\alpha = 0.91$; Antony et al., 1998). In the current sample, Cronbach’s alpha = .87 and .78 for the depression and anxiety subscales, respectively.

**Edinburgh Postnatal Depression Scale** (EPDS; Cox et al., 1987): A measure of postnatal depression symptoms with excellent internal consistency ($\alpha = 0.87$; $\alpha = 0.87$ in the current sample). Owing to the online format of our study and in order to meet the requirements of our ethics committee we removed the suicidality item.

**Repetitive Thinking Questionnaire – 10-item version** (RTQ-10; McEvoy et al., 2010): A transdiagnostic measure of perseverative thinking developed from the items of existing measures of rumination, worry, and post-event processing with disorder-specific content (e.g., references to depression) removed. Participants were instructed to answer the questions in relation to thinking about your day-to-day experience of being a new mother and thinking about your baby. An example of one of the items is as follows: *Once I started*
thinking about the situation, I couldn’t stop. RTQ-10 scores are highly correlated with those on the full (31-item) RTQ (McEvoy et al., 2010), and the RTQ-10 possesses excellent internal consistency ($\alpha = .89$). Cronbach’s alpha = .95 in the current sample.

**Ruminative Response Scale** (RRS) of the Response Styles Questionnaire (RSQ; Nolen-Hoeksema & Morrow, 1991): A 22-item instrument assessing the trait tendency to engage in depressive rumination; i.e., rumination in response to depressed mood. The RRS has two subscales, brooding and reflection (Treynor et al., 2003). We administered the full RRS but report the brooding subscale here, given evidence its capacity to predict rumination over time (Schoofs et al., 2010). Internal consistency of the RRS is $\alpha = 0.90$ (Treynor et al., 2003) ($\alpha = .95$ in the current sample).

**Dampening subscale of the Response to Positive Affect Scale** (RPAS; Feldman et al. 2008). The dampening subscale is an 8-item measure that asks respondents to indicate the extent to which they experience thoughts/responses that likely dampen positive moods (e.g., ‘Think “This is too good to be true”’) when they feel happy, excited, or enthused. Internal consistency of the dampening subscale is acceptable ($\alpha = 0.72$; $\alpha = .84$ in the current sample).

**Positive Beliefs about Rumination Scale** – Adapted (PBRS-A; Watkins & Moulds, 2005). A questionnaire assessing beliefs about the helpfulness of repetitive thinking, with high internal consistency ($\alpha = 0.89$; $\alpha = .92$ in the current sample).

**Maternal Infant Responsiveness Scale** (MIRI; Amankwaa & Pickler, 2006): A 22-item measure assessing maternal responsiveness to infant cues. It includes items assessing a mother’s feelings and beliefs about how she responds when caring for and spending time with her baby (e.g., *I believe my baby responds well to my holding him/her*). It possesses
good internal consistency ($\alpha = 0.87$; Amankwaa et al., 2007). Cronbach’s alpha = .83 in the current sample.

**Procedure**

The survey was open from 18/2/17 to 1/6/17. All study information, consent forms and measures were presented via an online survey platform (Qualtrics; Provo, UT). Participants provided informed consent online before completing the questionnaire battery. They were given the option to complete the measures in more than one sitting; in total, the measures took approximately 30-45 minutes to complete. All participants were provided with written debriefing information and were given contact details for mental health resources and services.

**Results**

*Associations between RNT and depression, anxiety.* We conducted Spearman correlations as questionnaire scores (particularly DASS scores) were skewed. RNT was positively associated with depression (i.e., EPDS: $r_s = .65, p = .000$; DASS-D: $r_s = .55, p = .000$) and anxiety (DASS-A: $r_s = .46, p = .000$). Interestingly, the associations between RNT and anxiety (i.e., DASS-A) remained when depression was controlled; i.e., when both EPDS and DASS-D scores were entered as covariates ($r_s = .17, p = .01$ and $r_s = .27, p = .000$, respectively). In addition, depressive rumination (RRS-brooding) was associated with both depression (i.e., EPDS: $r_s = .40, p = .000$; DASS-D: $r_s = .37, p = .000$) and anxiety (DASS-A: $r_s = .24, p = .000$).

*Associations between RNT and related cognitive processes.* As predicted, RNT was positively associated with dampening (i.e., RPAS-D: $r_s = .54, p = .000$) and positive beliefs
about rumination (PBRS-A; \( r_s = .31, p = .000 \)), and inversely related to maternal infant responsiveness (MIRI; \( r_s = -.26, p = .000 \)). Controlling for depression, the relationships between RNT and both dampening (controlling for EPDS: \( r_s = .36, p = .000 \); controlling for DASS-D: \( r_s = .41, p = .000 \)) and positive beliefs about rumination (PBRS; controlling for EPDS: \( r_s = .27, p = .000 \); controlling for DASS-D: \( r_s = .31, p = .000 \)) persisted. However, the partial correlations between RNT and maternal infant responsiveness (MIRI) were no longer significant (controlling for EPDS: \( r_s = -.06, p = .40 \); controlling for DASS-D: \( r_s = -.11, p = .13 \)).

**Discussion**

As predicted, RNT was significantly correlated with depression. RNT was also associated with anxiety, dampening of positive affect and positive beliefs about RNT, and these associations remained even when depression was controlled. Finally, RNT was inversely related to maternal responsiveness, but this association was accounted for by depression. Together, these findings confirm that the well-established relationships between RNT and both depression and anxiety are also evident in the postnatal period. Further, they extend our understanding of psychological functioning in postpartum by demonstrating that RNT is associated with both the endorsement of unhelpful metacognitive beliefs and the tendency to dampen positive affect – again, replicating findings in non-perinatal samples.

The findings speak to potential implications for clinical practice. Specifically, they raise the possibility that targeting RNT in new mothers may reduce postnatal anxiety and depression. Indeed, in a sample of pregnant women, a single training session targeting interpretation bias reduced RNT in the short-term (Hirsch et al., under review). Further evaluations of the effectiveness of such interventions in reducing RNT, and in turn
postpartum depression and anxiety symptoms, will be an important next clinical step. To our knowledge, whilst there is some evidence that cognitive behavioural interventions for anxiety reduce worry in postnatal women (e.g., Green et al., 2015, 2020), to our knowledge no randomised controlled trials to date have evaluated the effectiveness of an intervention for RNT specifically in postpartum.

Whilst providing an initial understanding of RNT in the postnatal period, we acknowledge that our findings are preliminary and limited by the cross-sectional design. More longitudinal investigations of the capacity of RNT to predict later symptom levels, assessed via studies in which RNT and psychological symptoms are sampled multiple times throughout the postnatal period, are needed. For example, Muller et al. (2019) sampled RNT at multiple timepoints throughout pregnancy and postpartum, enabling examination of the trajectory of RNT, as well the opportunity to distinguish women who were consistently high versus consistently low in RNT throughout the perinatal period. More studies adopting such a design will enable us to better understand the course and predictive role of postnatal RNT.

In addition, experimental studies are needed to determine the directionality of the associations reported here. For example, whilst there is evidence that rumination is causal in reducing maternal responding (e.g., Tester-Jones et al., 2017; Stein et al., 2012), the converse (i.e., that mothers who respond less to their infant engage in more rumination as a result) is also plausible, and warrants empirical test. Another possible research direction will be to shed light on whether temporal associations have the potential to explain the relationship between RNT and dampening. There are a number of seemingly plausible possibilities: that engaging in RNT in turn leads to dampening responses, that the tendency to dampen positive affect results in RNT, and/or the two cognitive processes act in concert and result in depression and anxiety symptoms, to name a few. There have been few
experimental studies of RNT in the perinatal period. More such investigations will be theoretically informative and will highlight key areas of focus for psychological interventions for postnatal women.

Finally, we acknowledge that our study would have been strengthened by the use of a measure which specifically indexes anxiety in postpartum (e.g., Postpartum Specific Anxiety Scale, PSAS; Fallon et al., 2016). Whilst the DASS-21 has been used as a general measure to assess postnatal anxiety symptoms (e.g., Miller et al., 2006), in future studies researchers could consider administering measures which index postpartum-specific anxiety features in order to better capture the way in which anxiety manifests in this population.

In sum, despite a wealth of studies that have developed our understanding of how RNT maintains depression and anxiety, we cannot assume the same relationships in the perinatal context - as it is feasible that the unique and fluctuating characteristics and challenges which accompany the perinatal period interact with cognitive processes in critical ways. Replicating findings in the broader literature, we found that RNT is associated with postnatal depression symptoms; and further, with postnatal anxiety and other maladaptive cognitive processes, independently of depression. Whilst high RNT was linked to low maternal responsiveness, this relationship was driven by depression. Further work is needed to broaden understanding of the role of RNT in postpartum, and will inform clinical efforts to prevent and treat postnatal psychological distress.
Footnotes

1. Omitted for the purpose of blind peer review.

2. We attempted to collect follow-up data from participants 6 months post-baseline, to investigate the extent to which RNT at baseline predicted depression and anxiety. Response rate was poor (i.e., 25%) and not representative of the initial sample (i.e., participants who completed follow-up measures had lower depression and anxiety symptoms at baseline). We therefore opted not to report these data.

3. We also asked participants whether they had experienced any two week periods of low mood and/or anhedonia, in an attempt to obtain information about possible depression history. However, given the absence of diagnostic interviews to confirm veracity, and for the sake of brevity, we opted not to report these data.
Declarations

Consent to participate
Participants provided electronic consent prior to taking part in the study.

Consent for publication
All participants consented to their data being published in an anonymised format

Disclosure statement
The authors declare that they have no competing interests.

Funding
This work received some support from UNSW Sydney PLuS Alliance Fellows funding awarded to Michelle Moulds. UNSW PLuS Alliance had no role in the study design, the collection, analysis or interpretation of the data, or the writing of the manuscript.

Authors’ contributions
This study was conducted as part of a larger collaboration amongst all authors. MM and MB designed the study. MB programmed the survey content. JN, MM, MB and CH all contributed to writing the manuscript; all authors read and approved the final version.

Acknowledgements
Dr. Colette Hirsch receives salary support from the National Institute for Health Research (NIHR), Mental Health Biomedical Research Centre at South London and Maudsley NHS Foundation Trust and King’s College London. The views expressed in this article are those of the author(s) and not necessarily those of Kings College London, NIHR or the Department of Health.

Ethical approval
The study received ethical approval from the UNSW Sydney Human Research Ethics Advisory Panel C (HREAP – Behavioural Sciences; application file number 2765).

Authors’ information
CH receives salary support from the National Institute for Health Research (NIHR), Mental Health Biomedical Research Centre at South London and Maudsley NHS Foundation Trust and King’s College London. JN receives support from the Australian Medical Research Future Fund/National Health and Medical Research Council (MRFF/NHMRC). The views expressed in this article are those of the author(s) and not necessarily those of King’s College London, NIHR, or NHMRC.
References


a systematic review and meta-analysis. *Journal of Affective Disorders, 203*, 292-331.


postnatal psychiatric disorder on child development: Is maternal preoccupation one of the key underlying processes? *Psychopathology, 42*, 11-21.


Table 1. Participant Characteristics and Self-Report Measures ($N = 235$)

<table>
<thead>
<tr>
<th>Age</th>
<th>32.02 (4.48)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>% Caucasian</td>
<td>70.9</td>
</tr>
<tr>
<td>% European</td>
<td>10.3</td>
</tr>
<tr>
<td>% Asian</td>
<td>8.1</td>
</tr>
<tr>
<td>% other</td>
<td>10.7</td>
</tr>
<tr>
<td><strong>Relationship status</strong></td>
<td></td>
</tr>
<tr>
<td>% partnered/co-habiting/married</td>
<td>97.4</td>
</tr>
<tr>
<td>% single</td>
<td>1.7</td>
</tr>
<tr>
<td>%divorced</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>% high school</td>
<td>6.4</td>
</tr>
<tr>
<td>% diploma/TAFE</td>
<td>18.9</td>
</tr>
<tr>
<td>% undergraduate</td>
<td>35.6</td>
</tr>
<tr>
<td>% postgraduate</td>
<td>38.2</td>
</tr>
<tr>
<td>% other</td>
<td>0.920.6</td>
</tr>
<tr>
<td><strong>Current employment status</strong></td>
<td></td>
</tr>
<tr>
<td>% full-time or part-time</td>
<td>12.4</td>
</tr>
<tr>
<td>% currently on maternity leave</td>
<td>4.7</td>
</tr>
<tr>
<td>% full-time student</td>
<td></td>
</tr>
<tr>
<td>% unemployed</td>
<td></td>
</tr>
<tr>
<td>% other</td>
<td></td>
</tr>
<tr>
<td>Perceived social support (no. of people can rely on for support)</td>
<td>17.96 (28.88)</td>
</tr>
<tr>
<td><strong>Age of child</strong> (months)</td>
<td>5.91 (3.05)</td>
</tr>
<tr>
<td><strong>Birth/pregnancy complications</strong></td>
<td></td>
</tr>
<tr>
<td>% complications with pregnancy</td>
<td>19.3</td>
</tr>
<tr>
<td>% complications with labour/birth</td>
<td>14.0</td>
</tr>
<tr>
<td>% postnatal or neonatal difficulties</td>
<td>11.3</td>
</tr>
<tr>
<td>EPDS</td>
<td>7.06 (4.73)</td>
</tr>
<tr>
<td>DASS-D</td>
<td>6.45 (6.63)</td>
</tr>
<tr>
<td>DASS-A</td>
<td>5.21 (5.84)</td>
</tr>
<tr>
<td>RTQ-10</td>
<td>21.40 (10.53)</td>
</tr>
<tr>
<td>RRS-brooding</td>
<td>7.75 (3.13)</td>
</tr>
<tr>
<td>MIRI</td>
<td>99.04 (7.89)</td>
</tr>
<tr>
<td>RPA-dampening</td>
<td>14.79 (5.11)</td>
</tr>
<tr>
<td>PBRS-A</td>
<td>21.51 (6.43)</td>
</tr>
</tbody>
</table>
Note. Mean values reported, with standard deviations in parentheses. EPDS = Edinburgh Postnatal Depression Scale; DASS-21 depression = Depression Anxiety Stress Scales – depression subscale; DASS-21 anxiety = Depression Anxiety Stress Scales – anxiety subscale; RTQ-10 = Repetitive Thinking Questionnaire – 10 item version; Ruminative Response Scale – brooding subscale; MIRI = Maternal Infant Responsiveness Scale; RPA-dampening = Responses to Positive Affect-dampening subscale; PBRS-A = Positive Beliefs about Rumination Scale-Adapted. Owing to missing data, ns vary across measures. Where percentages are reported, they refer to the proportion of participants who responded to the relevant item.