Perinatal Wellbeing for New and Expectant Parents

THE TALKING THERAPIES UK SELF-HELP SERIES



Perinatal Wellbeing for New and Expectant Parents

An eight-module programme for the mental health of pregnancy and the year that follows birth, covering the body, the identity shift, the losses, the cognitive patterns, the behavioural realities, the intrusive thoughts, the relationships, and the maintenance plan

A self-help workbook · 8 modules · about 8 weeks

TALKING THERAPIES UK

First edition · 2026

Published by Talking Therapies UK, talkingtherapies.co.uk.

Copyright © 2026 Talking Therapies UK. All rights reserved.

The moral right of the author has been asserted. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means without the prior written permission of the publisher, except for brief quotations in a review, and except that the purchaser may copy or print the worksheets for their own use.

First edition, 2026.

This workbook accompanies the Perinatal Wellbeing for New and Expectant Parents programme on the Talking Therapies UK self-help platform. Its text is drawn from the programme and is kept current with it: whenever the programme changes, the workbook is set again.

Revision 13. This printing was set on 15 November 2026 from the programme as it stood that day.

A note on using this workbook. It offers self-help based on established psychological approaches for difficulties of mild to moderate severity. It is not a substitute for assessment or treatment by a qualified professional and is not designed for use in a crisis. The examples in it are fictional; no real person appears in them. If you are worried about your safety, or your difficulties are getting worse, the page headed “When self-help is not enough” says where to turn.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

Contents

How to use this workbook 1

Part 1 Understanding Perinatal Mental Health 4

1. Welcome to the programme 4
2. Why the perinatal period is mentally demanding 6
3. The spectrum: from normal adjustment to clinical presentation 8
4. Closing Module 1 15

Part 2 The Body, the Hormones, and the Mind 18

5. Why the body comes first 18
6. Hormones and mood, in plain terms 19

How to use this workbook

Pregnancy and the year following birth is one of the most psychologically demanding periods of an adult life. The literature is clear that the perinatal period is a window of elevated mental-health risk: roughly one in five women and a smaller but significant proportion of fathers and non-birthing partners experience clinically meaningful anxiety or depression during this time, and the period also carries specific presentations such as postnatal OCD with intrusive harm thoughts, birth trauma, and postnatal psychosis that do not appear with the same incidence at any other time of life. Most of what people experience is normal, transient, and responsive to good information and skilled self-help; some of what people experience is more serious and needs specialist support. This programme is designed for the first category and tells you very clearly when the second category applies. The approach is grounded in the NICE clinical guideline on antenatal and postnatal mental health (CG192), the Beck cognitive model adapted for perinatal contexts, behavioural-activation work scaled to the realities of early parenthood, the matrescence and patrescence frameworks developed by Aurélie Athan and others for the developmental transition to parent, and acceptance and commitment therapy for the identity shift the period requires. The model and the methods are drawn from clinical practice in perinatal mental health services; the format is self-directed rather than therapist-led, which means it sits alongside any other care you are receiving rather than replacing it. The perinatal period in context. Becoming a parent is a developmental transition, not a single event. The body changes, the relationship changes, the sense of self changes, sleep changes, work changes, and the social environment around you changes. Anthropologists have a term for the equivalent transition in adolescence (puberty) but the parallel transition into parenthood was historically unnamed. Recent work calls it matrescence (for birthing mothers) and patrescence (for fathers and non-birthing partners), and naming it gives you a frame that explains why so many things feel different in this period: the difficulty is not personal failure, it is the experience of a profound developmental transition without much social acknowledgement that it is happening. Postnatal depression and anxiety. The most common perinatal mental health presentations are depressive and anxious episodes that emerge in pregnancy or in the first year after birth. The picture is recognisable: persistent low mood or excessive anxiety that does not lift, difficulty bonding with the baby in some cases, intrusive worry about the baby's safety, sleep disturbance beyond what the baby's schedule explains, loss of interest in things that previously mattered, and the sense that something is wrong that goes beyond ordinary adjustment. The programme covers the standard CBT approaches adapted specifically for perinatal contexts, including behavioural activation calibrated for the reality of caring for an infant. Intrusive harm thoughts. A specific and often deeply distressing perinatal presentation is intrusive thoughts about harming the baby or about something terrible happening to the baby. These thoughts arrive uninvited, feel horrifying, and are typically a feature of postnatal OCD rather than an indication of actual risk. The research is consistent: intrusive harm thoughts in postnatal OCD are accompanied by intense distress about having them and by behaviours designed to prevent the feared outcome. This is the opposite pattern from situations where actual risk is present. The programme covers this presentation explicitly, including the cognitive and behavioural work that the perinatal OCD literature supports. Birth trauma. For people whose birth experience involved medical complications, perceived loss of control, threat to the baby's safety,

or events processed as traumatic at the time, the resulting symptoms can include post-traumatic stress responses: intrusive re-experiencing of the birth, avoidance of birth-related material, hyperarousal, and emotional numbing. The programme covers the recognition of birth trauma, the specific work that helps in the early stages, and the clear criteria for when specialist trauma-focused therapy is the appropriate route. Postnatal psychosis. Postnatal psychosis is a psychiatric emergency, not a self-help condition. The presentation includes confusion, severely disturbed sleep, marked mood instability, hallucinations or unusual perceptual experiences, and beliefs that are clearly out of contact with reality. If you or someone you love is experiencing anything resembling this picture in the perinatal period, please contact your GP urgently, call 111, or attend A&E; do not wait. The programme covers the recognition criteria explicitly and reiterates throughout that postnatal psychosis is a medical emergency requiring immediate specialist input. Practical reality of the early months. A substantial part of the programme is dedicated to the practical reality of the early months: sleep deprivation interacting with mental health, the relationship strain of two adults trying to function on disrupted sleep with new demands, the loss of identity that many parents experience and that is rarely talked about, the specific challenges for fathers and non-birthing partners whose experience is often invisible in perinatal services, and the realistic boundaries of what self-help can do in a period dominated by physical exhaustion. The maintenance plan. The final module covers maintenance: the early warning signs that mental health is deteriorating, the specific strategies that work at each level of intensity, and the conditions under which stepping up to perinatal mental health services, your GP, or A&E is the right move. Perinatal specialist services exist in most areas and can be accessed through your GP, health visitor, or midwife. Who this is for and what it is not. The programme is suitable for adults experiencing perinatal mental health difficulties at NHS Talking Therapies Step 2 equivalent: anxiety, low mood, adjustment difficulty, or intrusive thoughts that are interfering with the perinatal experience but where capacity to engage with structured material remains. It is not a substitute for specialist perinatal mental health services where these are indicated. It is not appropriate for postnatal psychosis (medical emergency), severe postnatal depression with thoughts of harming yourself or the baby (urgent GP or A&E), or severe birth trauma (specialist trauma therapy). If you are in crisis, please contact Samaritans on 116 123, text SHOUT to 85258, NHS 111, or your local A&E. Specific perinatal support is available through PANDAS (0808 1961 776), the Association for Post-Natal Illness (020 7386 0868), and your local NHS perinatal mental health service through your GP or health visitor.

This workbook is the written form of the Perinatal Wellbeing for New and Expectant Parents programme on the Talking Therapies UK self-help platform. It follows the programme module by module: each part of the book is one module, and each chapter is one piece of the module’s teaching, set in the order the programme presents it.

Read the chapters of a part in order, then turn to the worksheets that follow them. The worksheets are the part of the work that changes things, so give them the time they ask for and come back to them as the weeks go on. You may copy or print the worksheets for your own use, as often as you need.

Most people work through one module a week, which takes the whole programme about 8 weeks. Go at the pace that suits you: a module done properly is worth more than two done quickly.

The check-in questionnaires let you see how things are changing. Complete each one when you

reach it, note the date and your total, and compare it with the last.

When self-help is not enough

- If you are in danger now, or have seriously harmed yourself, call 999 or go to your nearest accident and emergency department.
- If you need help urgently but it is not an emergency, call NHS 111 or contact your GP surgery.
- Samaritans are there day and night, every day of the year: call 116 123 free from any phone.
- If you would rather not talk, text SHOUT to 85258 for free, confidential support at any hour.
- If your difficulties are getting worse as you work through this book, or you find yourself thinking about ending your life, stop and speak to your GP or a mental health professional. A workbook can be a good start, and some difficulties need more help than a book can give.

What this workbook will help you to do

- By the end of this module you will:
- Understand the perinatal period as a developmentally distinct phase, not just an unusually difficult few months
- Know the difference between baby blues (transient and normal) and perinatal anxiety or depression (clinical and treatable)
- Recognise the warning signs that warrant specialist input rather than self-help alone
- Have set three concrete goals for what you want this programme to change
- Understand how the perinatal hormonal environment affects mood and emotional reactivity
- Know the relationship between sleep deprivation and mental-health symptoms in this period
- Have a realistic, perinatal-specific definition of self-care that fits the constraints you actually face
- Have a small set of body-first practices you can apply within the realities of your week
- Understand matrescence and patrescence as developmental transitions rather than personal failures to adjust quickly enough

PART 1

Understanding Perinatal Mental Health

What the perinatal period actually is, why it carries elevated mental-health risk, and the difference between baby blues and the conditions that need more support

CHAPTER 1

Welcome to the programme

This is an eight-module programme for the mental health of pregnancy and the year that follows birth. It is written for women in pregnancy and the postnatal period, for fathers and non-birthing partners, and for anyone whose sense of themselves and their wellbeing has been reshaped by becoming a parent. The phrase perinatal mental health is not always familiar even to people who are presently in it, and one of the first things this programme does is name the territory clearly so that what you are experiencing has a frame it can sit inside.

The perinatal period covers the time from conception (or, in clinical practice, from the first antenatal contact) through to the first birthday of the baby. It is psychologically distinct from any other period of adult life. The body is undergoing the largest physical changes since adolescence. The hormonal environment is shifting on a scale that affects mood, sleep, appetite, and memory. The relationships around you are being renegotiated. Your sense of who you are, who you have been, and who you are becoming is in active reconstruction. The night is no longer a period of recovery, and may not have been for some time. The professional life that anchored your week may be paused, altered, or carrying you through a period when your capacity for it is reduced. The cumulative effect of all of these changes happening at once, in the same body, in the same person, is genuinely large.

Most people experience some level of distress during this period. The figures from the published epidemiology are roughly that one in five women experience clinically meaningful anxiety or depression at some point in pregnancy or the first postnatal year; rates among fathers and non-birthing partners are lower but significant, with around one in ten meeting the same threshold. The numbers vary depending on which study you read and how the threshold is set, but the underlying point is consistent: perinatal mental health difficulty is normal, common, and treatable.

This first module sets out what the perinatal period is, what the spectrum of distress looks like, and how to tell when something is in the normal range and when it warrants specialist input. Modules two through seven build the working content: the body and the hormones, the identity shift, the cognitive patterns, the behavioural reality, the intrusive thoughts that affect many new parents and that very few people talk about, and the relationships that are simultaneously the

source of the demand and the resource for getting through it. Module eight closes by helping you build a personal plan and identifying very clearly the situations where you should be in touch with a perinatal mental health service or your GP rather than relying on self-help.

A note on what this programme is and is not. It is a self-directed step-2 programme, similar in scope to those offered by NHS Talking Therapies. It is appropriate for mild-to-moderate antenatal and postnatal anxiety and depression, and for the adjustment difficulties that come with the transition to parenthood. It is not appropriate as a primary intervention for postnatal psychosis (which is rare but a medical emergency), severe postnatal depression, suicidal thoughts, or significant birth trauma with active post-traumatic symptoms. If any of these apply, the programme can still be useful, but only alongside specialist perinatal mental health support and not in place of it. The criteria are spelled out in detail in Module 8 and there is a clear summary in this module's third block.

A NOTE

A line you can save. If at any point during this programme you have thoughts of harming yourself or your baby, or you start to feel that things are not real, that you are receiving messages others cannot hear, or that you are at risk in ways you cannot quite articulate, please contact your GP or call 111 today. If you cannot wait, call 999 or go to your nearest A&E. Specialist perinatal mental health services exist, they are accessible through your GP or maternity team, and the response is taken seriously and treated as urgent. You will not be judged for asking; the people who staff these services are there because they know what the period requires.

CHAPTER 2

Why the perinatal period is mentally demanding

Several systems are under simultaneous strain during pregnancy and the first postnatal year. The strain is cumulative rather than additive; each of the systems compounds the others, and the cumulative effect is what makes the period so demanding even when no single element of it would be unmanageable on its own.

The hormonal system. Pregnancy involves the largest sustained hormonal shift the adult body undergoes. Oestrogen and progesterone rise to many times their non-pregnant levels and then fall sharply within days of birth, the steepest hormonal cliff in the human life course. Cortisol, prolactin, oxytocin, and thyroid hormones all shift. Mood, sleep, appetite, memory, and emotional reactivity are all affected by this hormonal environment, and the changes happen whether or not anything else in life is going well. The hormonal context is the reason that baby blues exists: the brief period of weepiness, mood swings, and emotional sensitivity that affects most women in the first ten days postnatally is the brain's response to the rapid hormonal recalibration after birth.

The sleep system. Sleep architecture is disrupted in late pregnancy by physical discomfort, frequent waking to use the bathroom, and the body's anticipatory wakefulness in preparation for the baby. After birth, sleep is fragmented for months by feeding cycles, often with the longest unbroken stretch being three or four hours. Sleep deprivation has measurable effects on emotional regulation, cognitive performance, and the capacity to absorb everyday demands without distress; the body's response to sustained fragmentation is similar to the response to chronic stress, and the threshold for everything else drops correspondingly.

The physical recovery system. Birth is a major physical event whether it is vaginal or caesarean. Healing takes weeks. Pelvic-floor function, abdominal-wall function, and breast tissue (whether or not feeding is established) all undergo recovery. Pain, fatigue, and the felt unfamiliarity of one's own body are part of the postnatal context for everybody, and for some people they are substantial.

The identity system. The transition to parent is a developmental phase, not just a role change. Module 3 covers this in more detail. The shift involves the loss of the pre-baby self, the reconstruction of the relationship to one's own parents, the renegotiation of the partnership, and the gradual emergence of a new self that includes the parental identity. The transition is psychologically substantial, and it tends to happen at the same time as everything else in this list.

The relational system. Partnerships are renegotiated. Friendships shift, especially friendships with people whose lives are at a different stage. Extended family relationships often intensify, sometimes helpfully and sometimes not. The professional relationships that were a daily part of the previous life are paused or altered. The relational context that had been stable is recomposed at the same time as the person inside it is being recomposed.

The contextual system. The financial pressure of a baby is real and is often higher than expected. Housing situations sometimes need to change. Maternity and paternity leave have their own dynamics. The wider social context of being a parent in the 2020s, with the pressures from social

media comparison, the access to information that becomes information overload, and the cost of childcare relative to wages, all add to the load.

The point of listing these systems is not to depress you with how much is going on. The point is to validate the experience that the period is hard. People in the perinatal period often blame themselves for finding it hard, comparing themselves unfavourably to imaginary other parents who appear to be coping. The actual research finds that the period is demanding for most people, much more demanding than the typical pre-baby narrative implies, and that the difficulty is the normal response to the demand rather than evidence of personal inadequacy.

A NOTE

The difficulty is the system responding to the demand, not a sign of personal failure. This is one of the most consistent findings in perinatal mental health research, and it is one of the most important things to know if you are presently in the period and finding it hard. The skills in this programme are about supporting the system through the demand, not about fixing something that is wrong with you.

CHAPTER 3

The spectrum: from normal adjustment to clinical presentation

Distress in the perinatal period sits on a spectrum, and one of the most useful early skills is reading where on the spectrum your own experience presently is. The categories below are clinical, but they are described in plain terms and they map onto experiences that are usually recognisable to the person living them.

Normal adjustment. Tiredness, occasional weepiness, moments of overwhelm, ordinary doubts about competence, a felt sense that everything is harder than expected, periods of frustration with the partner, occasional thoughts that everything was easier before. These come and go, are responsive to rest and support, do not persist for weeks, and do not interfere with the basic functioning of the family. Most people in the perinatal period experience adjustment of this kind. It is not a problem to be solved; it is the period being what it is. The skills in this programme will still be useful, both for managing it more skilfully and for noticing if it shifts into something larger.

Baby blues. A specific phenomenon affecting most women in the first ten days postnatally. The mood is markedly more changeable than usual: weepy in the morning, fine in the afternoon, suddenly tearful at a piece of music. It is the brain responding to the hormonal cliff after birth and is not a clinical condition. It typically resolves spontaneously within two weeks. If it does not resolve by the end of the second week, or if it intensifies rather than easing, that is the signal to consider whether the picture has shifted into postnatal depression or anxiety, which the next category covers.

Mild-to-moderate perinatal anxiety or depression. A more sustained pattern of low mood, persistent anxiety, loss of interest in things that previously gave pleasure, sleep difficulty beyond what the baby's pattern explains, appetite changes, irritability that exceeds the situation, persistent worry about the baby's wellbeing or your own competence as a parent, feeling disconnected from the baby or from yourself, or feeling that you are going through the motions rather than being present in your own life. The symptoms have lasted at least two weeks. They interfere with daily functioning to a noticeable but not catastrophic degree. This category is what the present programme is designed to help with, alongside good GP support and the routine perinatal-mental-health checks that the maternity team and health visitor offer.

Severe perinatal anxiety or depression. The same symptoms but at higher intensity, persisting for longer, interfering substantially with daily functioning, and accompanied by thoughts of self-harm, of not wanting to be alive, of being unable to care for the baby, or of the baby being better off without you. This category is beyond the scope of self-help. It is treatable, often very effectively, but the treatment needs to involve a specialist perinatal mental health team alongside the GP. If this category fits where you are, please make a same-day appointment with your GP and tell them clearly what is happening. Module 8 covers this in more detail.

Postnatal OCD. A specific presentation in which intrusive thoughts about harm coming to the baby (sometimes including thoughts that the parent themselves might harm the baby) become

frequent, distressing, and difficult to dismiss. The thoughts are ego-dystonic, meaning they feel deeply at odds with what the parent actually wants and would do. They are not a sign that the parent will harm the baby; the research is very clear that intrusive thoughts of this kind are an anxiety presentation, not a precursor to action, and they affect a large minority of new parents to some degree. Module 6 covers this in detail because it is so common, so distressing, and so under-discussed. If the intrusive thoughts are causing significant distress or are affecting your ability to care for the baby, the next step is a perinatal mental health team rather than self-help alone.

Postnatal psychosis. A rare but emergency presentation, affecting one or two women in every thousand births, in which the person experiences disturbance of reality (visual or auditory hallucinations, delusional beliefs, severe confusion, rapidly fluctuating mood). The onset is usually within the first two weeks postnatally and is often dramatic. This is a medical emergency. If you, your partner, or someone close to you is showing signs of postnatal psychosis, contact 999 or your local mental health crisis team immediately. Treatment is effective when it is started promptly. This is not a self-help condition.

Birth trauma. Active post-traumatic symptoms following a traumatic birth experience: intrusive memories of the birth, nightmares, hypervigilance around anything that resembles the birth setting, avoidance of medical contexts, emotional numbness. The symptoms typically appear in the weeks after the birth. Birth trauma is treatable, and the treatments (typically trauma-focused CBT or EMDR) work well, but they are not self-help interventions. If birth trauma symptoms are present, the programme can sit alongside specialist trauma therapy but should not replace it.

A NOTE

Where on the spectrum are you? A useful question to ask yourself, honestly, before going further with this programme. If you are in the first two categories (normal adjustment or baby blues), this programme is well-pitched for you. If you are in the third category (mild-to-moderate perinatal anxiety or depression), the programme is designed for exactly this presentation and your GP and health visitor are appropriate alongside support. If you are in any of the last four categories, please make sure you have specialist support in place; the programme can still be useful but only as a supplement, not as a primary intervention.

Three women, all at four months postnatal with their first baby, each in a different place on the spectrum. The vignettes illustrate the discrimination the categorise exercise asks you to practise.

Hannah, thirty-one, is in the normal-adjustment-to-baby-blues territory. She is exhausted; she cried at the John Lewis advert last week; she has had two nights in the past month when she lay awake at 3am convinced she was failing at motherhood. She has also had whole days where she felt steady, days when the baby's first social smile lifted her completely, and several occasions where she has been able to leave the baby with her partner for a couple of hours and felt better for the break. Her appetite is reasonable; her mood, while tender, returns to baseline within hours or a day; she is enjoying the baby most of the time. She is not in clinical territory; she is in the normal range of a fundamentally well-adjusted first-time mother in a demanding life phase. This programme would be useful for her as a way to build skills before any deterioration; she does not need clinical input.

Sarah, twenty-nine, is in mild-to-moderate postnatal depression. Her low mood has been continuous rather than coming and going for the past six weeks. She has lost interest in things that used to give her pleasure, including her relationship with her partner. She feels disconnected from the baby and is troubled by a persistent sense that she should be enjoying motherhood more than she is. She has lost weight she did not need to lose. She is sleeping poorly even when the baby is sleeping (which has been good for the past three weeks). She has not had thoughts of self-harm or of harming the baby. She manages the daily tasks of caring for the baby but the felt-quality of being a mother is largely absent. She has not yet spoken to her GP. Sarah is exactly the target zone of this programme, alongside a GP appointment and the ongoing health-visitor contact. The programme will be useful; the GP appointment is also important because a discussion of whether to consider an antidepressant alongside the psychological work would be appropriate.

Maya, thirty-four, is in postnatal OCD territory. Her overall mood is reasonable; she is not depressed in the broad sense. What is overwhelming her is a specific pattern of intrusive thoughts about harm coming to the baby: images of dropping her on the stairs, thoughts of accidentally smothering her in the night, fears about car accidents on every car journey. She is appalled by these thoughts. She has begun avoiding stairs while carrying the baby. She has stopped driving with the baby in the car if she can avoid it. She is checking the baby's breathing perhaps thirty times a night. The thoughts and the checking are taking three to four hours of her day in total. She has not told her partner the content of the thoughts because she is afraid he will think she is dangerous. She is, of course, not dangerous; the thoughts are the classic ego-dystonic intrusive-thoughts pattern of postnatal OCD, which affects a noticeable minority of new mothers. Maya needs more than this programme alone can offer. The programme will be useful as one piece, but the primary intervention should be a perinatal mental health team via her GP, which can offer specific CBT or ERP for the OCD presentation. The relief of speaking to someone competent about the content of the thoughts, who will not be alarmed and who will recognise the pattern, is often the first significant shift.

The discrimination matters. The same broad surface (a new mother struggling) sits in three different clinical pictures. Hannah needs ordinary support and time. Sarah needs the programme plus GP. Maya needs specialist services as the primary route, with the programme as a supplement. Choosing the wrong level either under-treats a clinical presentation that needs more, or over-medicalises a normal adjustment. The honest self-assessment in the categorise exercise that follows is what helps you place yourself accurately so that the right level of support is in place.

WORKSHEET

Sort each presentation along the perinatal spectrum

Before setting your personal goals for the programme, sort twelve presentations along the perinatal mental-health spectrum. The three-category sort builds the where-am-I-on-the-spectrum skill that the programme uses to calibrate the appropriate level of intervention. Recognising which level a given presentation represents in other people's examples builds the recognition skill you will need when looking at your own experience, and the discrimination matters because the same set of feelings can be normal adjustment in one context, the programme's target zone in another,

and beyond what self-help can address in a third.

Normal adjustment or baby blues are the predictable experiences of the perinatal period: tiredness, occasional weepiness, ordinary doubts about competence, moments of overwhelm, the markedly changeable mood of the first ten days postnatally. These come and go, are responsive to rest and support, do not persist beyond two weeks, and do not interfere with basic functioning. Mild-to-moderate perinatal anxiety or depression is the sustained pattern that the programme is designed for: low mood, persistent worry, sleep difficulty beyond what the baby explains, irritability that exceeds the situation, feeling disconnected, lasting at least two weeks and interfering with daily functioning to a noticeable degree. Severe or specialist presentation is beyond the scope of self-help and warrants perinatal mental health team involvement alongside the GP: severe depression with thoughts of self-harm or of the baby being better off without you, postnatal OCD with significant intrusive thoughts affecting care of the baby, postnatal psychosis (medical emergency), active birth trauma symptoms.

The groups: A Normal adjustment or baby blues B Mild-to-moderate perinatal anxiety or depression C Severe or specialist presentation

Write the letter of the group each item belongs to in its box.

☐ 1. Three weeks in, weepy in the morning, fine by lunch, suddenly tearful at a piece of music in the afternoon, mood markedly more changeable than usual but responsive to rest, the brain still settling after the hormonal cliff after birth

☐ 2. Three months in, persistent low mood across most days, loss of interest in things that used to give pleasure, persistent worry about the baby that exceeds the situation, sleep difficulty beyond what the baby's pattern explains, lasting clearly more than the two-week threshold

☐ 3. Two weeks postnatally, experiencing visual hallucinations, the felt-conviction that the baby is not my baby, severe confusion, mood swinging rapidly within hours; the partner has been alarmed by the changes across the past three days

☐ 4. A week in, tired in a way that exceeds anything I have known before, occasional doubts about whether I am doing this right, moments of overwhelm at the volume of feeding, but the picture is responsive to a good rest and a supportive conversation

☐ 5. Frequent and distressing intrusive thoughts about harm coming to the baby, sometimes including thoughts that I myself might harm her, accompanied by avoidance of being alone with the baby and compulsive checking that is now consuming several hours a day

☐ 6. Five weeks in, irritability that exceeds the situation, feeling disconnected from the baby in a way that has not eased, going through the motions rather than being present in my own life, daily functioning noticeably but not catastrophically affected

☐ 7. Six months in, persistent thoughts that the baby would be better off without me, sustained sense that life is not worth continuing, accompanied by significant changes in sleep, appetite, and self-care that have not improved across the past several months

☐ 8. Eight days in, the partner is exhausted, the baby has been more unsettled than expected, occasional thoughts that everything was easier before, a few moments of frustration that pass within the hour and that I would call ordinary perinatal adjustment

☐ 9. Active post-traumatic symptoms in the weeks after a traumatic birth: intrusive memories of the delivery room, nightmares, hypervigilance around medical settings, avoidance of healthcare

appointments, emotional numbness that has not lifted

- [ ] 10. Two months in, anxiety that has been persistent and is not responding to ordinary rest, with worry about the baby's wellbeing that occupies several hours a day, sleep affected beyond what the baby's pattern explains, the picture matching what the programme is designed to support
- [ ] 11. Ten days in, tiredness, occasional weepiness, ordinary doubts about competence, moments of overwhelm, all of it within the predictable shape of early adjustment and easing as the days pass and the partner shares the night load more deliberately
- [ ] 12. Four months in, persistent low mood, anhedonia, the symptoms have lasted clearly beyond two weeks and are interfering with daily functioning at a noticeable level, but no thoughts of self-harm, no thoughts of the baby being better off without me; this is the programme's target zone

The answers are at the back of the book.

WORKSHEET

Set three goals for the programme

Take fifteen minutes to set three concrete goals for what you want this programme to change. Goals work better when they are specific to your life right now, achievable within an eight-module timeframe, and within your influence. Vague goals ("feel more like myself") are harder to measure than specific ones ("go for a fifteen-minute walk three times a week", "have one honest conversation with my partner about how I am actually doing", "go through one full thought record for a recent worry about the baby").

Set three goals. The good ones are specific, observable, time-bounded, and within your influence. They do not have to be ambitious; small concrete goals that you actually achieve build momentum better than large abstract ones that drift, particularly when the daily context is as constrained as the perinatal one.

Goal 1

How I will know I am making progress on Goal 1

Goal 2

How I will know I am making progress on Goal 2

Goal 3

How I will know I am making progress on Goal 3

CHAPTER 4

Closing Module 1

You have a working frame for the perinatal period as a developmentally distinct phase rather than a randomly difficult time, a sense of where on the spectrum your own experience is presently sitting, and three concrete goals for what this programme should change. You also have the criteria for when self-help alone is not enough and specialist input is the right next step.

Looking ahead

Module 2 covers the body. Sleep, hormones, physical recovery, and what self-care actually means in a context where the standard advice (yoga classes, long baths, time alone) is not available in the way it would be in a non-perinatal context. The work in Module 2 is foundational because the threshold for everything else in the rest of the programme is partly determined by how the body is being supported through the period.

Practice for the week ahead

Between now and Module 2, notice without judgement what your day looks like in terms of sleep, eating, and physical recovery. The aim is observation, not problem-solving. The data you collect will inform the work in the next module.

CHECK-IN

Mood check-in (PHQ-9)

Before you begin, take a few minutes to complete this short questionnaire. It is the same one used in NHS Talking Therapies and gives us a baseline against which to measure your progress over the programme.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3

8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Total: _____ Date: _____

Add up the numbers you have circled. A total of 0 to 4 suggests minimal symptoms of depression, 5 to 9 mild, 10 to 14 moderate, 15 to 19 moderately severe and 20 to 27 severe. Note your total and the date, so you can compare the next check-in with this one.

If you circled anything other than 0 for the last question, please talk to your GP or call NHS 111 today. If you are in danger now, call 999.

The PHQ-9 and GAD-7 were developed by Drs Robert L. Spitzer, Janet B. W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission is required to reproduce, translate, display or distribute them.

CHECK-IN

Everyday life check-in (WSAS)

And one more short questionnaire about how things are affecting everyday life: work, home, social life, relationships and leisure. Functioning often recovers on a different timetable to symptoms, and it matters just as much.

This check-in uses the WSAS (Work and Social Adjustment Scale). If you are using the online programme, complete it there, where your scores are kept and compared for you. If you are working from this book alone, your GP or therapist can give you a copy.

WORKSHEET

Taking this forward

Before you move on, take two minutes to make this module harder to lose. Skills fade fastest in exactly the moments they are needed most, so the work here is to decide now, while things are steady, what you will reach for when they are not.

If things ever feel much worse rather than better, that is a signal to reach out rather than push on alone: use the messaging button to contact the practice, speak to your GP, or if you feel unsafe right now contact 999 or the Samaritans on 116 123.

Three short answers, in your own words. First: what single idea or skill from this module do you most want to keep? Second: when, realistically, will it be hardest to use, name the actual situation. Third: what exactly will you do in that moment? Write it as a sentence you could follow when stressed.

PART 2

The Body, the Hormones, and the Mind

How the physiology of pregnancy and early parenthood shapes mood, and what realistic self-care actually looks like in this period

CHAPTER 5

Why the body comes first

Most self-help advice assumes a body that is reasonably rested, reasonably fed, and reasonably stable hormonally. The advice is good advice within those assumptions. The advice does not always travel well into the perinatal context, where none of the assumptions hold. Trying to apply standard cognitive-behavioural skills to a body that is running on four hours of broken sleep, that is twelve weeks post-caesarean, and that is in the middle of a hormonal recalibration is like trying to drive a car with three flat tyres: the steering still works, but the steering is not the limiting factor.

The body comes first in this programme because the body is the limiting factor in the perinatal period. The cognitive and emotional work in later modules will land much better when the body has the resources to receive it. Pretending the body is not in the picture, or treating self-care as a luxury that can be postponed until the baby is older, makes the rest of the work harder than it needs to be.

This module covers three things. First, what the perinatal hormonal environment is doing to mood, so that fluctuations that would otherwise feel personal can be located in the physiology where they belong. Second, the specific role of sleep deprivation, which is the single largest amplifier of perinatal mental-health symptoms and which is also the area where small realistic improvements have the largest effect. Third, what self-care actually looks like in this context: not the standard list (yoga, baths, hours of alone time) but the perinatal-realistic version, which is much more modest and much more achievable.

CHAPTER 6

Hormones and mood, in plain terms

The hormonal context of the perinatal period is genuinely large. The detail is more than you need; the headline is that the brain is operating in an environment that is changing, and the changes affect mood, energy, sleep, and emotional reactivity in ways that are not always obvious from the outside.

During pregnancy. Oestrogen and progesterone rise steadily, reaching levels many times higher than their pre-pregnancy values. Both hormones affect mood in complex ways; for some people the effect is mood-stabilising and feels like a relatively well period mentally, while for others the effect is the opposite. Antenatal depression and anxiety are real and affect roughly one in seven women during pregnancy. The persistent narrative that pregnancy is a mentally protected period is not supported by the actual research, and the experience of struggling during pregnancy is not a failure to enjoy what you should be enjoying; it is a recognised clinical pattern that is responsive to good support.

At birth and the first ten days postnatally. Oestrogen and progesterone fall by more than 90 per cent within 72 hours of birth. The hormonal cliff is the largest single physiological event of the perinatal period and is the reason for baby blues: the weepiness, mood swings, and emotional sensitivity that affect roughly four out of five women in the first ten days. This is not depression and it is not a problem to be solved; it is the brain's response to the hormonal recalibration. It typically resolves within two weeks. If it does not, the picture may have shifted into postnatal depression or anxiety, which is a different category and is what the rest of this programme addresses.

Through the first postnatal year. Prolactin (high if breastfeeding) supports milk production and has a sedating effect that is part of what allows night-time feeds to happen at all. Oxytocin, the hormone associated with bonding, is released during feeding, contact, and care, and its release is part of what supports the relationship that develops between parent and baby. Cortisol, the stress hormone, runs higher than baseline and stays elevated longer than would be ideal, partly because of fragmented sleep and partly because of the sustained low-level vigilance the parental role requires. Thyroid function shifts in some women, sometimes producing symptoms (low energy, low mood, weight changes, hair changes) that look psychological but are actually thyroid-driven and are easily picked up by a blood test, which is one of the reasons the GP postnatal check is worth attending and worth asking specifically about thyroid function during.

For non-birthing partners. Hormonal changes affect non-birthing partners too. Testosterone tends to drop in expectant fathers in the months around birth, and the drop is part of the biological adaptation to fatherhood. Cortisol, prolactin, and oxytocin shift in non-birthing partners as well as in birthing parents. Postnatal depression in fathers and non-birthing partners has been a recognised clinical entity for some time and affects roughly one in ten in the year following birth, with the highest risk window between three and six months postnatally.

A NOTE

The hormonal context is real and is doing real work. Mood fluctuations that feel inexplicable in the perinatal period often have a physiological cause that you cannot see directly. Locating the fluctuation in the physiology, when it is there, takes some of the personal weight off it: the experience is the system responding to the conditions, not a personal failure to feel the way you think you should feel.

The end of the sample

This is a free sample of “Perinatal Wellbeing for New and Expectant Parents”, and it ends here.

Everything you have read here is from the opening of the book, set exactly as it is printed in it. The rest follows in the same way, chapter by chapter, with its worksheets, its examples and its reference list.

The full book is on sale in the Talking Therapies UK shop. A copy is yours to keep, as a PDF and an ebook, licensed to you by name: a short line saying so is printed at the foot of each page of the PDF and on the title page of the ebook.