# Perinatal Wellbeing for New and Expectant Parents: Practitioner Guide

THE TALKING THERAPIES UK PRACTITIONER GUIDES



# Perinatal Wellbeing for New and Expectant Parents: Practitioner Guide

## Delivering the programme as guided self-help

A practitioner guide · 8 contacts · to accompany the workbook

**TALKING THERAPIES UK**

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First edition, 2026.

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

Revised and expanded edition, November 2026: the approach and its evidence, written practitioner notes and a worked example for every contact, the module's own teaching set out for the practitioner, and the answers to every sorting task and quiz.

Revision 10. This printing was set on 8 November 2026 from the programme as it stood that day.

A note on clinical responsibility. This guide supports qualified practitioners delivering guided self-help within their competence, their supervision and their organisation's policies. It does not replace clinical judgement, and its thresholds are guidance: where your service's policy differs, follow your service's policy.

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

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# How to use this guide

This guide is for qualified practitioners who support clients through the Perinatal Wellbeing for New and Expectant Parents programme as guided self-help: a short supported contact after each of its 8 modules, with the client working through the programme or its workbook in between.

Part 1 sets out the model the programme is built on, what the research shows, and who the programme is for. Part 2 covers what every contact needs: your part in guided self-help, how to structure a contact, how to review each kind of worksheet, what to do when the work is not being done, how to adapt the programme, the check-ins and when to step up, and risk. Read Parts 1 and 2 before you begin with a client.

Part 3 has a chapter for each contact, to read before that contact: what the client has read in the module, why the skill matters, the messages to reinforce, a plan, the questions to ask, a worked example with dialogue, how to review the week's worksheets with their answers, and what to do when the skill is hard, how to adapt it and its cautions. Part 4 covers ending the work, supervision, and the checklist.

The guide follows the programme as it stands on the platform, so its plans name the programme's own modules, teaching and worksheets, and it is set again whenever the programme changes.

### What this guide covers

- The model the programme is built on, and what the research shows
- Who the programme suits, how to assess for it, and when it is not enough on its own
- Your part in guided self-help, and how to structure each contact
- For each of the 8 contacts: what the client has read, why it matters, a worked example with dialogue, a plan, and the worksheets with their answers
- What to do when a skill is hard to learn or use, how to adapt it, and its cautions
- Keeping the work going, adapting the programme, the check-ins and stepping up, and risk at every contact
- Ending well, supervision, and a checklist for delivering the programme as designed

PART 1

# The approach and the evidence

*The model the programme is built on, what the research shows, and who the programme is for.*

**In this part**


- Chapter 1, The model behind the programme: the perinatal period as a developmental transition, the spectrum from ordinary adjustment to emergency, the strands the programme draws on, how the eight modules are built, fathers and non-birthing partners, and the practitioner's part
- Chapter 2, What the research shows: how common perinatal anxiety and depression are in mothers and fathers, what predicts them, their effects on children, intrusive thoughts and postnatal OCD, birth trauma, postnatal psychosis and the risk of suicide, the evidence for psychological treatments, sleep, hormones and relationships, and the national guidance


CHAPTER 1

## The model behind the programme

### A programme for the perinatal year

Perinatal Wellbeing is written for women in pregnancy and the year after birth, and for fathers and non-birthing partners in the same period, whose difficulties sit at the level NHS Talking Therapies would call step 2: anxiety, low mood, difficulty adjusting, or intrusive thoughts that are interfering with the perinatal experience while the person can still engage with structured material. Its description is careful about what it is not. It is not a substitute for specialist perinatal mental health services, and it is not appropriate for postnatal psychosis, severe depression with thoughts of harming oneself or the baby, or severe birth trauma. It describes itself as self-directed, sitting alongside any other care the person receives, and in its guided form the practitioner's contacts add the assessment, monitoring and judgement that the written material cannot.

That framing matters more here than in most of the practice's programmes, because the perinatal period has emergencies of its own. The practitioner must know them, and must know that some of them cannot wait for the next contact. The rest of this guide returns to them often, without, it is hoped, losing sight of the programme's main message, which is that most of what parents experience in this period is the system responding to an extraordinary demand and is responsive to good information, skilled self-help and the right support.

## Why the period is demanding

Module 1 lists six systems under simultaneous strain: hormonal, sleep, physical recovery, identity, relational and contextual. It stresses that the strain is cumulative, and its call-out states the module's central position: the difficulty is the system responding to the demand, not a sign of personal failure. The research supports treating the transition to parenthood as a period of heightened vulnerability for adult health more broadly, with changes in sleep, stress, relationships and behaviour that can have lasting effects (Saxbe, Rossin-Slater and Goldenberg, 2018).

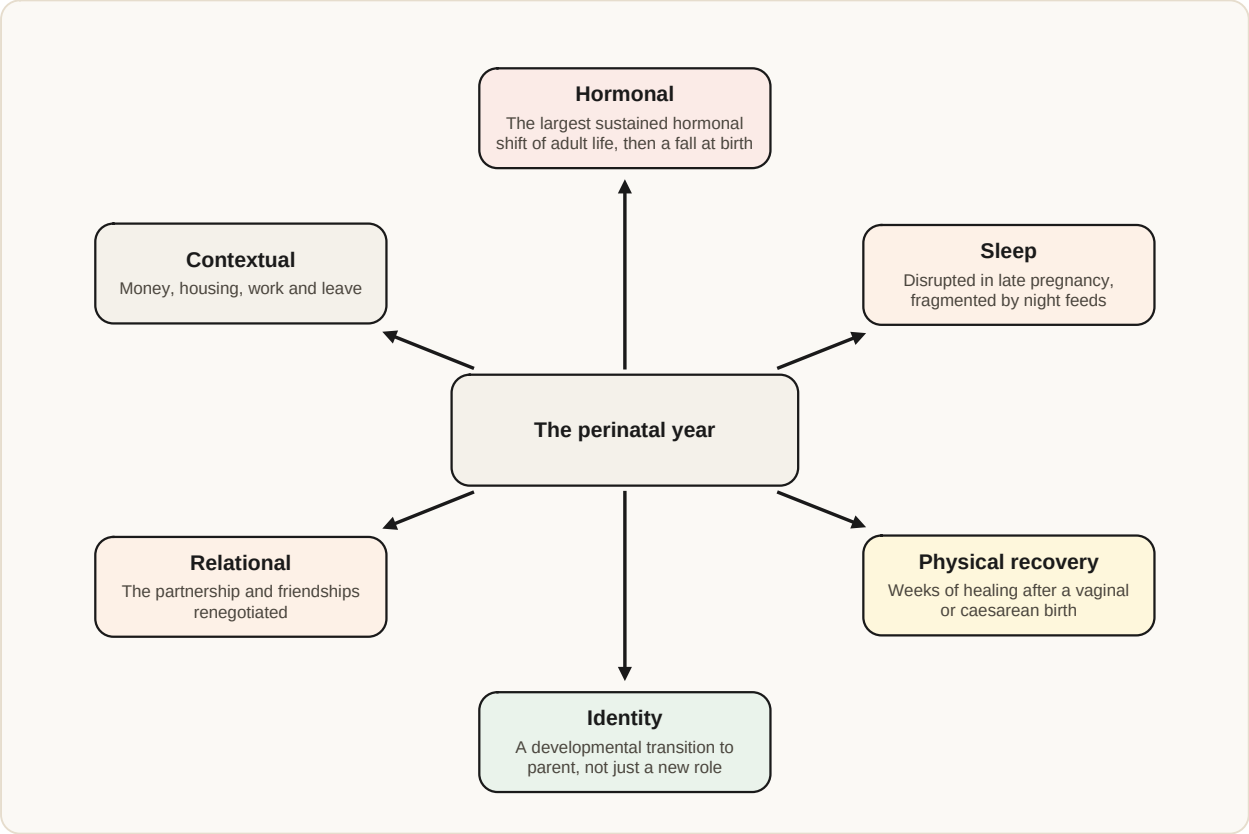



**FIGURE 1.1 Six systems under strain at once**
*Module 1 lists six systems that are strained together in pregnancy and the first postnatal year, and stresses that the strain is cumulative. The point is not to frighten the client but to locate the difficulty in the demand on the system rather than in personal failure.*

Module 3 frames the same transition in developmental terms, as matrescence for mothers and patrescence for fathers and non-birthing partners: a reorganisation as far-reaching as adolescence, taking place under conditions of sleep loss and with little social acknowledgement. A review in Trends in Cognitive Sciences describes matrescence as a period of profound change in the brain and cognition, with effects that may last across the lifespan (Orchard et al., 2023). The framework's value in practice is the one the module gives: it changes what a difficulty means. A new parent who does not yet feel like themselves is, in the module's words, on schedule.

## The spectrum

Module 1 asks the client to read where on a spectrum their experience sits, and the practitioner will return to the spectrum at every contact. Normal adjustment (tiredness, occasional weepiness, doubts about competence, frustration) comes and goes, eases with rest and support, and does

not interfere with the basic functioning of the family. The baby blues affect most women in the first ten days after birth: the mood is markedly changeable, and it resolves within about two weeks; if it does not, or if it intensifies, the module asks the client to consider whether something more has begun. Mild to moderate anxiety or depression means symptoms that have lasted at least two weeks and interfere noticeably with daily functioning, and this is the band the programme is designed for. Severe anxiety or depression, particularly with thoughts of self-harm, of not wanting to be alive, or of the baby being better off without the parent, is beyond self-help and needs a specialist perinatal team alongside the GP, starting with a same-day GP appointment. Postnatal OCD and birth trauma need specialist input when they cause significant distress or affect the care of the baby. Postnatal psychosis is a psychiatric emergency.

The module's own sorting exercise reflects this structure, placing frequent, distressing intrusive thoughts of harm with checking and avoidance among the presentations that need specialist input. The practitioner should hold that boundary too, while remembering what module 6 teaches: that intrusive thoughts of harm in milder form are a common experience of new parenthood, not a sign of risk.

### The strands the programme draws on

The programme's description names its sources: the NICE guideline on antenatal and postnatal mental health, the cognitive model adapted for the perinatal period, behavioural activation scaled to the realities of early parenthood, the matrescence and patrescence frameworks, and acceptance and commitment therapy for the identity shift. The guideline (National Institute for Health and Care Excellence, 2014) recommends facilitated self-help for persistent subthreshold depressive symptoms and for mild to moderate depression in pregnancy and the postnatal period, and for persistent subthreshold anxiety, alongside high-intensity psychological intervention for moderate and severe depression and for anxiety disorders. The programme's modules on thinking and on activation draw on the evidence for CBT and behavioural activation in this period, which the next chapter summarises. Its module on intrusive thoughts draws on the research showing how common such thoughts are after birth (Fairbrother and Woody, 2008) and on the cognitive account of postnatal OCD.

### How the programme works

Module 1 gives the frame, the spectrum and three goals. Module 2 covers the body: the hormonal environment, sleep as the largest amplifier, and a perinatal-realistic version of self-care. Module 3 names the identity shift and the losses that accompany it. Module 4 teaches Beck's cognitive model, eight thinking traps common in the perinatal period, a five-step thought record and when-then plans for catching thoughts in real time. Module 5 applies behavioural activation at the scale of ten or fifteen minutes. Module 6 opens the subject of intrusive thoughts of harm, the difference between thoughts and intentions, and when specialist help is needed. Module 7 covers the partnership, the wider circle and how to ask for help that actually helps. Module 8 builds a maintenance plan and sets out the step-up criteria.

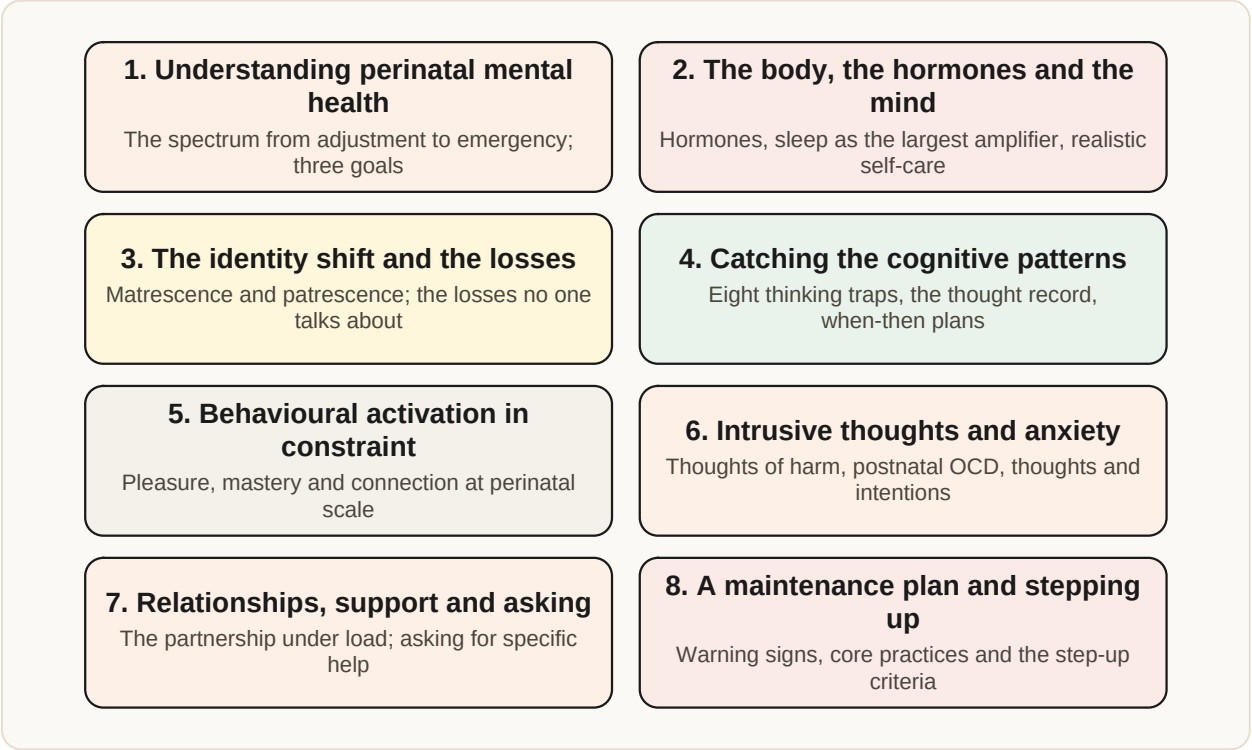



**FIGURE 1.2 The eight modules and what each works on**
*The programme moves from a frame for the perinatal year, through the body and the identity shift, to the cognitive and behavioural skills, the intrusive thoughts module, the relationships around the family, and finally a maintenance plan with clear criteria for stepping up.*

## How the modules are built

Each module has an introduction, two or three teaching sections, a worked example, a sorting exercise, a practical worksheet, a closing summary and the reflection “Taking this forward”; module 4 has two worksheets. The sorting exercises carry much of the teaching, and their answers and reasons print in this guide. The examples follow three women met in module 1, Hannah, Sarah and Maya, who are in three different places on the spectrum at four months after birth, and return to them later: Sarah’s losses and her activation plan, Hannah at the weighing clinic and asking specifically for help, Maya’s intrusive thoughts slowed down.

The check-ins come in modules 1, 4 and 8: the PHQ-9 and the Work and Social Adjustment Scale in module 1, and the PHQ-9, GAD-7 and WSAS in modules 4 and 8. Take the GAD-7 at assessment too. Read the PHQ-9 with care in this population: its items on sleep, tiredness and appetite can be raised by the care of a baby, so look first at the items about mood, interest and self-worth, and at the ninth item, which needs acting on the same day if it is scored above zero (Chapter 9). Many clients will have completed the Edinburgh Postnatal Depression Scale with their midwife or health visitor (Cox, Holden and Sagovsky, 1987); NICE suggests the EPDS or the PHQ-9 as part of a full assessment, and the EPDS’s tenth item asks about thoughts of self-harm. The worked examples in this guide follow one composite client, Nadia, through all eight contacts.

## Fathers and non-birthing partners

The programme is written for fathers and non-birthing partners as well as for mothers, and its description notes that their experience is often invisible in perinatal services. A meta-analysis

found paternal depression in about one in ten men between the first trimester and the first postnatal year, with higher rates three to six months after birth and a moderate correlation with maternal depression (Paulson and Bazemore, 2010); an updated meta-analysis put the figure at 8.4 per cent (Cameron, Sedov and Tomfohr-Madsen, 2016). Anxiety disorders in men across the perinatal period are less well studied, with wide ranges across studies (Leach et al., 2016). Module 2 notes that hormonal changes affect fathers too, and a longitudinal study in the Philippines found that men's testosterone fell after they became fathers, particularly among those most involved in childcare (Gettler et al., 2011). When the client is a mother, the practitioner should still ask how her partner is; when the client is a father or partner, the modules' examples, written mostly about mothers, can be adapted as Chapter 8 describes.

### What the practitioner adds

The programme carries the teaching. The practitioner's part has three demands that are particular to this period.

The first is to know the emergencies and the thresholds, and to act on them without delay. The step-up criteria in module 8 are set out in detail, and the practitioner should know them by heart: thoughts of suicide or self-harm, thoughts of harming the baby that feel like intent, and any sign of psychosis call for the same day; symptoms beyond two weeks that are not improving, distressing intrusive thoughts that affect the care of the baby, and active post-traumatic symptoms after a birth call for an appointment within the week. NICE asks professionals to be alert for possible symptoms of postpartum psychosis in the first two weeks after childbirth in women with a past or present severe mental illness or a family history of severe perinatal mental illness, and to refer sudden-onset symptoms for assessment within four hours.

The second is to hold more than one person in mind. The client is the parent, but the baby's welfare, the partner's wellbeing and the family's support all bear on the work. The practitioner works with the client's consent alongside the GP, midwife or health visitor where that helps, and follows their service's safeguarding procedures where there is a genuine concern about a child, as they would for any client (Chapter 10). Equally, they must not mistake common perinatal experiences, such as intrusive thoughts of harm, for safeguarding concerns.

The third is to scale everything to the realities of infant care. Contacts may be interrupted by a feed, plans must survive a night of four hours' sleep, and worksheets will be completed in fragments. The programme's own language (perinatal-realistic, tiny is enough) sets the tone. The practitioner's job is to help the client choose changes small enough to happen, and to answer the perfectionism that is so common in this period with accuracy and warmth rather than reassurance. Chapter 5 shows how a thirty-minute contact can hold all three demands.

CHAPTER 2

# What the research shows

## How common perinatal anxiety and depression are

Mental disorders are among the commonest complications of pregnancy and the year after birth. A Lancet series paper summarised the evidence for non-psychotic disorders in the perinatal period, noting that their phenomenology and risk factors are largely similar to those at other times of life while treatment considerations differ during pregnancy and breastfeeding (Howard et al., 2014). A systematic review and meta-regression of 96 studies found a pooled prevalence of depression of 11.9 per cent of women in the perinatal period, with higher figures from symptom scales than from diagnostic interviews and in low- and middle-income countries (Woody et al., 2017). Anxiety is at least as common. A meta-analysis of 102 studies found self-reported anxiety symptoms in between 18 and 25 per cent of women across the three trimesters, a clinical anxiety disorder in 15.2 per cent in pregnancy, and anxiety symptoms in 15.0 per cent and an anxiety disorder in 9.9 per cent in the first six months after birth (Dennis, Falah-Hassani and Shiri, 2017). The programme's figure of roughly one in five women experiencing clinically meaningful anxiety or depression is consistent with these figures taken together.

## What predicts perinatal depression

A synthesis of research on antenatal risk factors found the strongest predictors of postnatal depression to be depression in pregnancy, anxiety in pregnancy, stressful life events in pregnancy or soon after birth, low social support and a previous history of depression (Robertson et al., 2004). Module 7 opens with this finding: the quality of a parent's support is one of the strongest predictors of postnatal depression. It is also one of the few that the programme can help to change; the practitioner should hold the others in mind at assessment, particularly a history of depression or anxiety in pregnancy.

## Effects on children, and what moderates them

Parental mental disorders in the perinatal period are associated with a greater risk of difficulties in the child, from fetal development to adolescence, but these disturbances are not inevitable; their transmission depends on modifiable factors such as the quality of parenting, social and partner support, material support and how long the parent's disorder lasts (Stein et al., 2014). That is a reason for prompt treatment, not for alarm, and the practitioner should present it that way if the client raises it: treating the parent's anxiety or depression is one of the best things that can be done for the child.

## Intrusive thoughts and postnatal OCD

Intrusive thoughts of harm to the baby are a normal experience of early parenthood. In a study of a hundred women followed from pregnancy to twelve weeks after birth, unwanted intrusive thoughts of accidental harm to the infant were universal, and close to half of the women reported unwanted thoughts of intentionally harming their baby; these were more common with high parenting stress

and low social support, and there was little evidence of any association with aggressive parenting (Fairbrother and Woody, 2008). A review of obsessive-compulsive symptoms in pregnancy and the puerperium described the characteristic presentation: intrusive thoughts of harm to the baby, with checking, avoidance and reassurance seeking (Abramowitz et al., 2003). Postnatal OCD itself is more common than once thought. A meta-analysis found OCD in about 2.1 per cent of pregnant and 2.4 per cent of postpartum women, against about 1.1 per cent in the general population (Russell, Fawcett and Mazmanian, 2013), and a Canadian cohort study using repeated interviews found higher figures, with a point prevalence peaking close to 9 per cent at about eight weeks after birth (Fairbrother et al., 2021). Specialist CBT works: in a pilot randomised controlled trial, time-intensive CBT for postpartum OCD produced large reductions in maternal symptoms, although mother-infant interaction did not change during the trial, and attachment was secure in most infants in every group (Challacombe et al., 2017).

### Birth trauma

A meta-analysis found post-traumatic stress disorder related to childbirth in about 4.0 per cent of women in community samples and about 18.5 per cent in high-risk groups (Yildiz, Ayers and Phillips, 2017). A meta-analysis of risk factors found that the most strongly associated factors during birth were a negative subjective experience of the birth, an operative birth, lack of support and dissociation, and before birth depression in pregnancy and fear of childbirth; after birth, PTSD was highly comorbid with depression (Ayers et al., 2016). NICE recommends a high-intensity psychological intervention (trauma-focused CBT or EMDR) for women with PTSD after a traumatic birth, miscarriage, stillbirth or neonatal death, and advises against single-session interventions with an explicit focus on reliving the trauma.

### Postnatal psychosis and severe mental illness

Postnatal psychosis is rare: a systematic review found incidence figures ranging from about 0.9 to 2.6 per thousand women (VanderKruik et al., 2017), and the programme gives one or two in every thousand births, in module 1 and in module 8. It usually begins abruptly in the first weeks after birth and is a psychiatric emergency. Women with bipolar disorder or a previous postpartum psychosis are at much higher risk (Jones et al., 2014): a meta-analysis of 37 studies found an overall postpartum relapse risk of 35 per cent, with severe episodes in 17 per cent of women with bipolar disorder and 29 per cent of those with a history of postpartum psychosis (Wesseloo et al., 2016). These are reasons to ask about personal and family history at assessment, and to know the route to same-day assessment.

### The risk of suicide

Suicide is a leading cause of maternal death in the United Kingdom. The latest findings of MBRRACE-UK, the confidential enquiry into maternal deaths, show maternal suicide as the leading cause of death between six weeks and a year after the end of pregnancy, with mental health-related causes accounting for a third of maternal deaths in that period (National Perinatal Epidemiology Unit, 2026). The review of November 2026 added this finding to module 8, and the practitioner should take it as the module does: not as a reason for fear, but as a reason to ask every client, at every contact, and to act the same day on any thoughts of suicide.

### The evidence for psychological treatment

Psychological treatments work in this period. A meta-analysis of seventeen controlled studies found a mean effect size of 0.61 for psychological treatments of postpartum depression compared with control conditions (Cuijpers, Brännmark and van Straten, 2008). A systematic review of CBT found significant reductions in depressive symptoms in both treatment and prevention trials, with interventions begun after birth more effective than those begun in pregnancy (Sockol, 2015). In a pragmatic randomised trial with depressed pregnant women, behavioural activation led to lower depressive symptoms and higher remission (56.3 against 30.3 per cent) than usual care, with early increases in activation mediating the improvement (Dimidjian et al., 2017). A review of postpartum depression summarises the wider literature on its course and treatment (O'Hara and McCabe, 2013).

### Sleep, hormones and relationships

Disturbed sleep in pregnancy and after birth is associated with increases in depressive symptoms and with the development of postpartum depression (Okun, 2016), which supports module 2's emphasis on sleep. The role of hormones is real but specific. In an experiment simulating the fall in oestrogen and progesterone after birth, five of eight women with a history of postpartum depression, and none of eight without, developed significant mood symptoms during the withdrawal, suggesting that some women are especially sensitive to the change rather than that the change affects everyone equally (Bloch et al., 2000). Relationship quality declines on average after the birth of a first child: in an eight-year prospective study of couples, both mothers and fathers showed a sudden, small to medium deterioration in relationship functioning after the birth that tended to persist, varying with the characteristics of the couple and the pregnancy (Doss et al., 2009). Module 7's emphasis on repair rather than the avoidance of conflict fits that finding.

### The national guidance

The guidance the programme is grounded in is the National Institute for Health and Care Excellence (2014) guideline on antenatal and postnatal mental health, last updated in 2020. Beyond the treatment recommendations above, three of its recommendations bear directly on the practitioner's work. It suggests two depression identification questions and the two-item GAD scale at a woman's first contact and in the early postnatal period, with the EPDS or PHQ-9 for further assessment. It asks that a woman with a known or suspected mental health problem referred in pregnancy or the postnatal period be assessed within two weeks and offered psychological interventions within one month of that assessment. And it asks that a woman with sudden onset of symptoms suggesting postpartum psychosis be referred to secondary mental health services, preferably a specialist perinatal service, for assessment within four hours.