**CHAPTER 1**

**Introduction**

A single baby's bootee with the cryptic message 'Get knitting' was posted from London to each set of future grandparents in Adelaide.

'Test positive—champagne at eight' was how one high-powered executive learnt that he had been promoted to the ranks of a prospective grandfather.

These are two examples of how the good news of a confirmed pregnancy was announced. They were both from young couples filled with excitement and happiness at the news of the confirmation of their fondest hope, a much-wanted baby.

Once pregnancy is confirmed, labour is inevitable, but the unknown factors include when, where, and how. If it was unplanned, an early and difficult decision may be whether or not to continue with the pregnancy. After the initial excitement at the realization that she is pregnant, a woman and her partner will find that the next few weeks are taken up with making decisions and planning for the future. The choice of a doctor, the place of birth, arrangements for housing, work commitment, maternity and paternity leave, and holiday schemes all need consideration. Then come thoughts about the baby, for example, wondering whether to breastfeed or bottle-feed and the future desirability of sending the child to a creche, play group, or nursery at an early age.

But after the safe arrival, what then? No woman ever gives a thought to the chance of becoming the one in ten who is later affected by postnatal illness (PNI). This unexpected gloom, which can descend on a new mother and transform her whole personality, leads innumerable husbands to announce that 'She's never been the same since the birth of our baby'. Yet such a possibility is far from the thoughts of the happy young couples.

**Breaking the silence**

This is, of course, as it should be, for needless worrying throughout pregnancy about the one-in-ten chance of developing PNI is obviously not a good thing. There are not many whose suffering is as severe and traumatic as some of the cases recounted here. But there is much that can be done about PNI once it has been spotted, and the earlier it is recognized, the easier it is to treat. This is one reason for writing this book: there is far too much silence about PNI, which is often considered to be just a foible of the weaker sex, a female fancy, or a feminine fantasy. The second reason is that, with our present knowledge, a recurrence of that unpleasant illness is virtually unnecessary.

**The range of postnatal problems**

PNI covers a range of afflictions, from sadness to infanticide, which start after childbirth (see Box). Although the symptoms vary from the mildest blues to the blackest of black depressions, they tend to be lumped together under such euphemisms as 'mental exhaustion', 'nervous debility', or merely a 'breakdown'. PNI does not necessarily occur immediately after childbirth, but within a few weeks or months it can have changed the mother's behaviour, personality, and outlook. It is convenient to divide these manifestations into groups according to severity, but in practice the conditions merge imperceptibly into each other. The groups are the blues, postnatal depression, puerperal psychosis, and infanticide or homicide.

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| **Incidence of problems after childbirth**  Blues 8 in 10  Postnatal depression 1 in 10  Puerperal psychosis 1 in 200  Infanticide 1 in 125 000 |

**The blues**

The blues occur when the new mother cries suddenly for no good reason during the first ten to twelve days after birth. Nowadays it is increasingly thought that, as these are tears of emotion rather than sadness, and as they can occur in up to 80 per cent of new mothers, the blues are physiological rather than pathological. This tiredness is not necessarily unnatural or pathological; rather it is natural or physiological, in much the same way as tiredness after a good day's work is natural. So, while the blues should be recognized, and partners, parents, and friends should be educated about the condition, they are generally not included under the heading of 'PNI' or 'postnatal depression'.

**Postnatal depression**

Postnatal depression (PND) is more rigidly defined as 'the first occurrence of psychiatric symptoms severe enough to require medical help occurring after childbirth and before the return of menstruation'. It does not include the blues, which do not require medical help, and also excludes the condition of those who have previously sought psychiatric help because of other psychiatric illnesses such as schizophrenia, manic depression, depression, or drug abuse. Mothers with PND have symptoms which can occur in a mild form in healthy individuals but which, for them, are present in a severe form. These include complaints of exhaustion, irritability, insomnia, anxiety, and, of course, depression.

PND occurs in about one in every ten mothers. It may start immediately after delivery, carry on from the blues, stopping breastfeeding, or start any time during the first year after childbirth or up to the return of normal menstruation. In some mothers it is self-limiting and all is forgotten in a few weeks or months; in others, however, the changed personality and lifestyle may persist for twenty or more years, with the condition gradually changing into premenstrual syndrome.

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| **Postnatal depression**  is the first occurrence of psychiatric symptoms severe enough to require medical help occurring after childbirth and before the return of menstruation. |

**Postnatal psychosis**

Also included in the definition of PND is psychosis. Some mothers with PND have symptoms which do not normally occur in mentally stable individuals—symptoms such as delusions, confusion, visual or aural hallucinations, and rejection of their baby. These seriously ill mothers are fortunately few, but they have a form of PNI called 'psychosis', previously known as 'puerperal psychosis'. Because of the severity, hospital admission is usually necessary to protect the lives of, and possible harm to the baby, mothers, and others. Admission will preferably be to a mother and baby unit.

**Infanticide**

The most severe form of PNI is when the mother kills her baby. This can occur when the new mother is in such a bizarre mental state that there is a total absence of normal maternal instinct and behaviour. In many cases the hallucinating mother hears voices telling her to harm her baby, but she is able to fight the fears. Occasionally, instead of killing her own baby, she kills herself, other children, her husband, or her parent.

**An unexpected illness**

PND is an apparently inexplicable problem which few people seem to understand. It strikes without warning, bringing guilt, misery, and helplessness just when young parents should be experiencing great happiness. PND is no respecter of persons. It attacks, at random, royalty, nobility, and famous media personalities as well as the typist, the factory worker, and the shop assistant; it can affect the happily married woman, the single mother, the flat dweller, the squatter, and those caught in the poverty trap. The knowledge that Queen Victoria herself suffered is not much consolation. It strikes at those who have a much-wanted child, including women who have endured years of attendance at infertility clinics with relentless early morning temperature-taking, in vitro fertilization, and artificial insemination, and at those for whom the pregnancy was an unwelcome interruption in their well-ordered lives. It affects equally regular attenders at antenatal clinics and relaxation classes, and mothers who have spurned all medical help during their pregnancy. It comes unexpectedly into families who have a clean bill of health and have never before had to cope with a psychiatric illness. It can touch the few who have a stillborn baby but also the many who have a healthy child.

Unfortunately, PND can easily be missed and not recognized as an illness. All too often it is considered as a defect of personality which allows slovenliness, laziness, selfishness, and ingratitude to rise to the top. PND is, however, real, and it can be helped and treated once it is recognized as a hormonal illness which is preventable.

**Gradual recognition of PND**

Until the mid-1960s there was little interest in this subject. Puerperal psychosis was recognized and was allowed a few lines in medical textbooks, but, as the disturbed, confused, or hallucinating new mothers showed the same diverse presentations as other men and women in the psychiatric wards, they tended to be treated in the same way, with the same drug therapy and/or psychotherapy, as other patients. At the other extreme there were the blues, long recognized by midwives, but only brought to the notice of psychiatrists by Dr Brice Pitt when, in 1964, he interviewed a hundred women at random at the Royal London Hospital between the seventh and tenth day after birth and found half had felt tearful or depressed since the birth. In most of the new mothers it was the usual fleeting, trivial blues, but in six women the dejection lasted a month or more. In 1973 Dr Pitt concluded in the British Journal of Psychiatry:

The presence of confusional features and the absence of personality predisposition or special psychological stresses together suggest that the syndrome is organically determined. The lack of any significant association with the infection or other obstetric complications leaves the most likely factor the profound endocrine change which follows parturition. The occurrence of two-thirds of cases within four days of parturition, with a peak incidence on the third day, and the probably significant association with lactation problems among breast feeders, suggest that the relevant change might be the precipitate fall in the progesterone and oestrogen levels postpartum.

**Emotional changes of pregnancy**

'Novelists tell us that women blossom and exude happiness and vitality in pregnancy—do they?' This question was asked by Dr A.G. Mezey, a highly respected psychiatrist, at a medical luncheon at the North Middlesex Hospital in 1965. It provoked a heated discussion: 'Of course they do!' 'Certainly the majority of women have increased vitality at this time', asserted the female general practitioners, who in those days did many home deliveries. 'I never meet them', stated the psychiatrist and his colleagues.

Out of that exchange arose a research project that was for many doctors the introduction to a new interest in PND. I led a group of fourteen general practitioners and the psychiatrist in a study of the emotional changes of pregnant women. Special questionnaires were completed giving the age, occupation, and general health of the patient, previous psychiatric breakdowns in the patient and her family, as well as an assessment of her emotional state—happy, placid, normal, depressed, or anxious. When completed, the questionnaires were posted to a research secretary at the hospital to ensure that the doctor would not refer to them at the next antenatal visit, but the usual antenatal cooperation card giving particulars of blood pressure, weight, and growth of the foetus, was kept by the doctor.

Five hundred women were recruited and their particulars recorded at each antenatal visit, as well as at six days, six weeks, and six months after their baby's birth. The survey found that 7 per cent of the mothers developed PND severe enough to require medical treatment, although none needed hospital admission. What were the characteristics of those developing PND? They were those of the women who 'blossom and exude happiness and vitality in pregnancy'.

My findings of that study were published in the British Journal of Psychiatry in 1971. Psychiatrists and psychologists suddenly appreciated the vast amount of ill health that was suffered by new mothers which was more severe than the blues, and yet without the confusions, delusions, or hallucinations of women with psychosis. They learnt about the new mothers who had sought help from their general practitioners for their miseries and changed personalities. Intense study of PNI followed, aimed at early recognition, methods of diagnosis, treatment, and the effect of the illness on their children. Mother and baby units were developed and, in 1994, 19 per cent of all health districts in England and Wales had dedicated facilities for mother and baby admissions, and in half of these there was a local consultant with a special interest in PNI.

The Marce Society, an international medical society founded in 1980 to further the study of PNI, has held conferences throughout the world. One of its past presidents was Dr Brice Pitt, who did so much to open up the subject in the 1960s. However, since the Marce Society committee consists predominantly of psychiatrists, psychologists, and sociologists, with minimal representation by obstetricians and no gynaecological endocrinologists, it has failed to consider the hormonal aspects of PND or the preceding events of pregnancy. Psychiatrists never see the successes of preventive progesterone treatment; they see the many who have never received preventive progesterone. In this edition I want to emphasize the important hormonal changes of pregnancy and to remind readers that PND is a hormonal disease, and that it can be prevented by progesterone intervention at the completion of the birth process.

**Public awareness**

The problem of mental illness after childbirth was first brought to public attention in a BBC 'Man Alive' television programme entitled 'Baby Blues to Breakdown'. It produced a deluge of letters from sufferers relating their personal experiences. They expressed relief that the subject had at long last been opened up for discussion and the hope that their husbands and relatives might appreciate their personal problems and have more understanding of their altered behaviour.

Anna, who described herself as a long-suffering, overburdened housewife, pleaded:

I am sure there are many of us needing help. I have suffered from these agonizing, unrecognized and untreated symptoms for what seems ages. It's so difficult to explain to others—no one really understands. Please educate everyone.

Brenda, a social worker, asked:

How many women are warned that they might suffer these miseries during the first few weeks of baby's arrival? How many of those who thrive during their pregnancy, and are filled with health and vivacity in spite of their awkward increasing shape, later think they are freaks when instead of sheer happiness at their perfect son they react with silent suffering and helpless depression.

Other letters emphasized the seriousness of the problem:

I tend to have difficult pregnancies and complicated labours, but that wouldn't deter me from having children. However, with the depression experienced after this pregnancy I feel I could never have another one for this reason alone. I just long to get back to my own personality, my old energy and sex drive, and to be able to leave all this behind.

Then there were letters from those who had reached the point of desperation:

I really need help. I can't spend the rest of my life as a psyche cripple. My problem is severe enough to prevent me living a normal life. I'm nearing the end of my rope.

The majority of women suffering from PNI do not even recognize that they are ill. They believe that they are just leading a lower quality of life, bogged down by utter exhaustion and irritability—a sadly changed character. It is all too easy to blame their condition on the extra work that their pain brings into their new life. However, once PND is recognized as a hormonal illness, different from typical depression, the outlook changes, for treatment needs to be specific and individually tailored—it is not enough to prescribe tranquillizers. Once the condition has been recognized and treated the husband will be able to declare: 'She's once again the woman I married.'

**A doctor's personal experience**

A doctor explained how experiencing PND herself changed her 'we- and-they' attitude to medicine. Previously she had thought of 'we' as those with self-control, who did not let themselves go, could control their tempers and tears, and were eternally grateful for their healthy children. Afterwards she felt that women with PND were truly ill, not just ungrateful and lacking moral fibre and self-control, and appreciated that they would not benefit from being told to 'pull themselves together'. It was only when women doctors who had themselves borne children became interested in PND that it began to be considered as a medical entity.

Unfortunately we cannot wait for all doctors to undergo that metamorphosis by personal suffering. This lack of interest by the medical profession is understandable for, with ever greater specialization, there is no room for a disease which falls between several disciplines with no one in overall control. PND belongs to the obstetrician, the psychiatrist, and the general practitioner, while the prevention lies with the community physician.

**Approaching the doctor**

Many letters refer to the difficulty that mothers experience when approaching their doctors. Carol, a mother of two children in Yorkshire, wrote:

I always get the same answer—that it's one of those things—it's something you have to live with—no one dies of it and one doctor even suggested it might be psychosomatic. Well, after having realized what it meant, I was so upset and disgusted to think anyone could think you could imagine such an agonizing sickness. They are not programmed to see a woman as a natural person.

A husband, giving a full description of his wife's sufferings, ended:

To make matters worse, although both of her parents are doctors themselves, Diane has an apparent fear or phobia about visiting doctors or hospitals and has on certain occasions begged me not to let anyone take her away. It's almost as if she believed that she was no longer in control of herself.

Continuous antenatal care is accepted as good medical practice; there are regular monthly examinations in early pregnancy increasing to weekly visits in the later months. Ultrasound scans ensure that the foetus is developing properly, thus ensuring a normal and safe delivery of a healthy baby. By comparison, postnatal care is perfunctory, with little thought or attention being paid to the mental well-being of the mother, apart from a pat on the shoulder and an assurance that everything will settle down soon. This is based on the assumption that all that matters is the delivery of a healthy baby and that once labour is completed all that is needed is a postnatal examination at six weeks.

**Help is available**

The repercussions of the illness fall first on the father, who may already be caring for a family, and is now doing the housekeeping and has also to take care of the new baby, often putting his own job and earning capacity in peril. It is now legally possible for new fathers to take some paternity leave at this time, regrettably at present this is usually unpaid. It is interesting to note that Tony Blair, as Prime Minister, felt unable to do this and only placed himself on 'holiday mode', giving a few extra hours to the family each day.

In the earlier and milder cases of PND the general practitioner, with the help of the midwife and health visitor, will treat the mother. Only in the severest of cases will the psychiatrist be called in. On many occasions the Inst visit by the psychiatrist will be at home, to meet both the patient and her partner and possibly other members of the family. The psychiatrist will then be able to decide whether, in the special circumstances, the best progress will be made at home or by admission to a specialized mother and baby unit. The psychiatrist may arrange for regular visits and supervision by the community psychiatric nurse, who may have had special training in PNI.

Even if doctors and the public have been slow to recognize PNI, it is recognized by English law. The Infanticide Act of 1938 states that a mother cannot be found guilty of murder of her own child within twelve months of childbirth as 'the balance of her mind is disturbed by reason of her not having fully recovered from the effects of giving birth'. She can, however, be prosecuted for the lesser offence of manslaughter of her child, known as 'infanticide', for which a custodial sentence is not mandatory. Actually infanticide is quite rare; there were eleven reported cases in England and Wales during the four years 1995-8.

**Historical reasons for neglect**

For hundreds of years childbirth has been associated with a high death rate, especially due to puerperal pyrexia or septicaemia after the birth. The open area in the womb to which the placenta was attached provides an inviting entrance for infecting bacteria. There is little resistance to infection in the womb following delivery, so bacteria can quickly reach the abdominal cavity, causing the dreaded peritonitis and death. One of the early warning signs of puerperal pyrexia is confusion, delusions, and hallucinations, with a rising temperature, and in the absence of effective treatment death used to be expected to follow within two days. It was Dr Ignaz Semmelweiss (1818-56) who first stressed the importance of doctors washing their hands after visiting the mortuary and before delivering a baby. That was in the days when medical students learnt the art of delivering babies by practising in the mortuary on the bodies of women who had died in childbirth. His warning to wash hands went unheeded in Budapest and later in Vienna, until Professor Joseph Lister at the Royal Infirmary, Glasgow, showed the vital importance of avoiding sepsis in surgical operations by the use of crude antiseptics such as carbolic acid. The death rate has been further reduced, first of all dramatically by the discovery of penicillin by Professors Fleming and Florey, and since then by the discovery of many other antibiotics.

Today puerperal pyrexia no longer spells death, although it is still a notifiable disease, which in England and Wales must be reported to the Department of Health and Social Services if the mother develops a temperature of 38°C (100.4°F) or over during the first fourteen days after the birth of a child. It has been the removal of puerperal pyrexia from the hazards of childbirth which has uncovered the problems of PND.

**Media exposure**

The media regularly expose horrifying tragedies in which the verdicts in the coroner's courts state that PND was the cause. Examples of headlines over the years include:

Mother hanged herself

Mother of twins freed after stabbing

Mother drowns baby girl

Tragic dancer freezes to death

Train death of woman with PND

Mercy for mother who tried to drown her own daughters

Mum threw baby out of the window

Mum's frozen body found

Baby blues sparks bloody hammer rage

Mother of four takes overdose

Mother kills her three children

Wife stabs her husband

Death of burning Mum

In all these examples, severe PND went unrecognized by those close to the new mother.

When a well-known actress committed suicide shortly after her baby's birth, her husband stated that he had never heard of PND and certainly had not appreciated that it could have had such severe consequences. But there had been an early warning, as in all cases: the young mother had not been herself, she had been unusually irritable, no longer laughing, and had lost her bubbling vitality. Such symptoms are too easily blamed on loss of sleep with a crying newborn.

We must never forget the possibility that such symptoms could indicate PND. We all have a responsibility to be aware of the unexpected torment that can occur in a new mother's mind, leading her to act in the most unexpected manner when she is at the end of her tether. Husbands need to be warned during antenatal classes of the possibility of this horrible disease occurring and to appreciate that help is at hand, to know how to recognize it, and the need to summon assistance. More education of the public is required before there can be an end to these tragedies, which is the very reason for writing this book.

**CHAPTER 21**

**And fathers too**

So far in this book we have discussed PND—its effects, treatment, and prevention. We have persistently emphasized the importance of the partner in helping the new mother and in understanding the tremendous hormonal changes she has experienced over the past year or so. We have discussed the need for the father to be supportive and considerate.

Yet there are men who experience a change in mood, some might even describe it as depression, which can follow the arrival of the baby. It takes two to make a baby, and assuming he has stayed around thus far, both mother and father have achieved a major change in their lives. The fathers too may need help and understanding at this difficult time, and they should not be overlooked in our aim to treat the new mother's depression.

**The differences**

There are however great differences between maternal and paternal PND. The mother's PND is generally of hormonal origin, and as has been shown it can be prevented by hormonal treatment begun at delivery. The male type of PND is more often brought about by the change in circumstances within his life, and the deprivation of sleep which invariably follows the arrival of a baby into the family unit. Rarely do men with male PND experience a full-blown depression of psychological origin which requires antidepressant medication and psychotherapy/talking therapies. This depression is extremely unusual in comparison to PND which occurs in one of every ten new mothers.

During the nine months of pregnancy and labour the mother has undergone major physical changes, with tremendous increases in her hormonal levels as well as changes in her cardiac, respiratory, and kidney output, to name but a few. In comparison the male has had it easy—or has he? He has had to watch the many physical and psychological changes occurring to his loved one. The financial implications of living on one income are frightening, even if it's only going to be for a short while because she plans to return to work soon. Then there is the cost of all that baby paraphernalia; how it all mounts up and it takes up so much space! There is the overwhelming responsibility, which is only just dawning on him. There may also be issues relating to his relationship with his own mother and father which need dealing with. His 'men's nights' may now be his only refuge.

**Supportive partner**

The new father has watched his darling change shape into someone with an awkward lump who can't sit still for long, is constantly uncomfortable, and continually wearing the same old clothes. He probably didn't grumble about having to go to the 'open all hours' store in the middle of the night to satisfy her strange food craving.

Although it was a planned decision to have a baby, perhaps this was prompted more by the female. Then when she was pregnant there was the nausea to deal with—her not wanting to eat, or feeling sick, or sometimes actually being sick and in the most inconvenient of places.

Once that stage was over things got on to a more even keel; her shape changed and her waist became thicker. Everything seemed more real. Although seeing the scans was interesting it was difficult to make out exactly what you could see in the fuzzy picture, and what it all meant. Remember the excitement when the bump started to show and the father could actually feel the baby kick—a future footballer perhaps!

During the final weeks of pregnancy she was often tired and found it difficult to move around, her usual excitement and energy somewhat dissipated. She had become more careful and cautious, and much of her time and attention was spent in getting all those last-minute baby things just right. Her sleep was disrupted as she plodded off to the bathroom, and no matter what position she lay in, she was uncomfortable after a while. Regardless of how careful she was, his own sleep was also being disturbed. There had been times when he knew he should rouse himself and be comforting and considerate towards her, but all he wanted to do was sleep.

After several false alarms the time had finally arrived and carefully she was placed in the car for the journey to the hospital. There the staff welcomed them and for a while all was hustle and bustle as they examined her and they all got settled into the delivery suite.

This was it. It really was happening. Could he remember all the little jokes he had collected ready for this time? Where was the sponge to wipe her face? What were those breathing exercises they had practised so care-fully? The labour may have seemed long to her; to him it lasted a lifetime. Suddenly things quickened and there was this tiny being, all red and crying. Here was their offspring. It was a most amazing moment. It would live with him forever. His partner was glowing as the baby was given to her to hold, and he was bursting with pride and wonder as he gazed at them both. Everyone was congratulating them and smiling. The nurses soon got things tidied up and off they all went to the ward. Later, much later, he left to ring around family and friends and broadcast this amazing moment to everyone. In the silence of home he realized that life would never be the same again.

**Home as a family**

When he proudly brought mother and child home, there were moments of complete panic as the responsibility of the care and nurturing of this tiny being dawned. The baby was so fragile and tiny. How will he know what its cries mean and how to satisfy its needs?

Together they will manage far better than they realized. But they both need to work together and share the care of the baby from the earliest stages; even if she is fully breastfeeding there are still a multitude of things he can do.

Often in those first few weeks one of the proud grandmothers, or some other relative, will come to stay and help. This can leave the new father feeling somewhat left out. He must ensure that he is involved in the care. It is sometimes wisest to take time off work when relatives have left, or best of all arrange for them to come to help once father is back at work. Typically the new mother needs the support and company of female relatives when the baby is a few weeks old, rather than in those first few days of the new family's life.

After a full day's work it is hard for the father to come home and find the home a mess, no food ready, and mother and baby both wanting his attention. He may have to prepare supper, sort washing to put in the washing machine, and tidy up. He longs for the old days when there was just the two of them and they could impetuously go out for a meal or to see friends. Now it is a major excursion to go anywhere. A quick visit to the pub is frowned upon; she too may long for the opportunity to socialize again, but who can take a baby into that smoky atmosphere?

So many changes have happened in a relatively short while. He will be wondering what sort of father he will be. Will he be like his own father? Will he be strong and determined? Will his child feel he was overly strict to him? Will he be able to answer all the child's many questions as he grows up? Will they enjoy the same sports together? He knows that he wants to be a 'hands-on' father, to play his part in the caring role, but when he picks up this tiny, fragile little bundle, suddenly it all becomes a bit scary.

**What about me?**

These are all normal thoughts and fears experienced by almost all new fathers, particularly with the arrival of the first child. With subsequent children the worries may not be quite so fearsome, although the financial problems can increase. It is important to share these worries and concerns, particularly with your partner, so that together you can overcome them. This is not to give you carte blanche to moan about your own problems, but you should both sit down quietly and discuss them together. Sharing is important, and it is too easy for a man to put on a brave front so that everybody thinks he is coping well, when in truth he is crying out for someone to ask 'and how are you doing?'

**Sleep**

Tim sat slumped at his desk. Phew, he was exhausted and felt awful. He had lost another contract that morning and his boss had read him the riot act. Whilst usually he would be charged up and determined, now he just couldn't care less. He almost told his boss what to do with the job, but couldn't summon up the effort. He felt so tired all he wanted to do was to go home and sleep, but even that was now impossible.

One of the major changes in the life of the new father is the lack of sleep and the continually interrupted sleep. This probably started during the last weeks of pregnancy and has continued. It seems that he is always wanting to sleep, and could do it anywhere. It needs to be appreciated that sleep deprivation is a form of torture, and it is important to ensure that

whenever the opportunity arises you all do get a good sleep. When the baby sleeps in the day or early evening, this is a chance when both parents should try and sleep, or at least lie down to rest.

If there are elder siblings perhaps you could all watch a quiet video, or spend some time reading and resting whilst the baby sleeps. This is not the time to try and rush around doing all the many jobs that need to be done.

Ensure that you each get a chance to sleep in at weekends. It is often sensible for one partner to get up and take the baby out for a walk or drive on Saturday morning whilst the other sleeps; then on Sunday, swap over.

If you find that you wake in the night worrying, your mind active, this is a sign that your blood sugar has dropped, and you would benefit from eating some starchy food such as biscuits or cake etc.

**How to seek help**

If you feel you are experiencing more than the usual concerns of being a new father, that you are actually feeling rather depressed, then seek help as soon as possible. If you meet the health visitor when she arrives to do the usual checks, seek an opportunity to discuss your feelings and fears with her. Alternatively see your GP and explain how difficult you are finding things.

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| People to talk to => the health visitor  => your GP  => your friends  => your boss/line manager  => a counsellor |

It is likely that you are not the only father among your group of friends. Talk with another father who has been through those early days with babies; they will often have had the same sort of worries and can help you talk about them. They may have suggestions of how they overcame them.

It may be that you should discuss the matter with your boss or line manager. This is particularly important if you find that the lack of sleep and worries are affecting your work. Perhaps you can take some extra time off, or work part-time for a couple of weeks. The law allows every new parent to take up to thirteen weeks' unpaid leave from work within the child's first five years. Whilst not suggesting you should necessarily take all that in one go, a couple of weeks off when needed will possibly give you a chance to establish a routine and get life back on the tracks. Many companies now understand the upheaval a new arrival causes and will do all they can to help the new parents. Talk with your line manager or boss and explain why you are not working to your usual standards, before they start nagging you to pull up your socks. By being the first to raise the subject you will feel more positive and assertive, rather than pressured.

Some find that the best help can be had from counselling, when you get an opportunity to talk about your apprehensions, concerns from the baby, your feelings towards your own father, perhaps changed feelings towards the new mother, and so on. To talk with someone who is non-judgemental and understanding, who will listen without telling you what you should do, can be very helpful to the new father. This need not involve a long-term commitment, just a few sessions will often be sufficient for you to get things in perspective and enable you to enjoy all those new experiences of fatherhood in a positive nature.

It may be that your GP will feel that you would benefit from a short course of antidepressant therapy; these can often make a great deal of difference. However the number of men who need medication is very small indeed.

**A healthy life**

The importance of good general health is exactly the same as for the new mother. You need your healthy diet with three portions of protein and five servings of fresh fruit or vegetables. It may be an easy option to collect a pizza on the way home, but ensure that you get your daily allowance of fruit and vegetables. Perhaps you could bring in some fresh fruit as well. Whilst all new fathers want to 'wet the baby's head' with their friends, alcohol should be taken in moderation.

Again exercise is important and strongly recommended. Choose the types of exercise you personally enjoy. This may be a chance for you to leave the baby with a babysitter so that both you and your partner can partake in sport together, perhaps enjoying a game of squash or tennis. Or perhaps a good run, a workout at the gym, or the local football team are more in your line. If you feel your life is too busy to fit in a special 'exercise session', then ensure you walk to the next bus stop or the station; perhaps park the car a distance from the door at work so that you get the opportunity for a brisk walk. Forgoing the lift and walking up and down the stairs instead will make a tremendous difference to your fitness.

**Enjoy fatherhood**

Most important of all is to enjoy the new baby, who is constantly changing and within a few months quite different from the tiny, fragile baby you first brought home. Share the many tasks between mother and father, delight in the first smile and early sounds, play and talk to the baby, and watch his reactions. This time is most precious and goes so quickly.

Take pleasure in your new family, for there is no greater source of enjoyment and satisfaction, although we all make many mistakes along the way. To see your own flesh and blood learn to sit, walk, and talk and grow into a person in his own right is fantastic. You will find the companionship of a young toddler following you around and 'assisting' in little jobs is most fulfilling, and all those sleepless nights will recede in your mind. Your life has changed—but the benefits far outweigh the losses.

**CHAPTER 22**

**We all can help**

Help for those suffering from depression after childbirth needs to be based on an understanding of the psychological changes in the mother, and the fundamentally different problems facing the father. These factors are dealt with in the first part of this chapter, before some suggested do's and don't's for family members and friends anxious to help the suffering couple.

**Understanding the new mother**

We all need to be aware of the important and tremendous changes a new mother experiences at the end of pregnancy and with the arrival of the new baby. This is regardless of the normality or otherwise of the pregnancy, whether it had been planned or not, how well she had been during the nine months, or if she had undergone many months of fertility treatment to become pregnant. Each person's experience of childbirth is different; for some unfortunate mothers the horrors of their delivery will haunt them long after. We should remember that she is likely to be tired, and also apprehensive of her new role. She may want our advice, but she is also likely to be frightened by her new responsibilities and wary of any presumed criticism or comment from others.

We need to appreciate these changes, but if a mother's reaction to them is more than would be expected, we do have a responsibility to consider that perhaps this is the onset of PND and to ensure that her partner, family, midwife, health visitor, or family doctor is alert to any differences in her personality.

It must also be appreciated that there are psychological factors which occur after birth. It is a daunting time for a mother when she becomes aware that she is responsible for this small bundle of humanity, who is totally dependent upon her for warmth, food, cleanliness, and psychological well-being, as well as learning slowly how to become an independent individual.

It may be helpful to remind the new mother of all the changes which took place in her body during pregnancy and how the return to her non-pregnant state will be gradual. Having become more aware over the months of the baby inside her and his kicks, the mother must now accept that he is a totally separate entity—one that she must get to know, appreciating his uniqueness. It is frightening to realize how dependent the baby is upon her, yet his own individuality is already making itself known. How do you start a relationship with this tiny human being? One moment he is perhaps sleeping soundly, and the next he is demanding— yes, not asking but demanding—food and attention. Suddenly she feels clumsy beside the nurses who pick up her baby so confidently and hand him to her for another feed. The baby struggles and screams whilst she tries to feed him; yet when the nurses hold him and place a bottle to his lips silence ensues and contentedness replaces that scowl. Is the scowl really meant for his mother?

It can be an awesome thought. The enormity of being the main provider ot emotional and physical needs can suddenly get too much. With single mothers, particularly teenage mothers, there is the added apprehension of whether they will be able to provide sufficiently, both physically and financially, on their own. The mother may have doubts about her own ability to cope with the demands of motherhood; an overwhelming sense of the responsibility; fears of harming the baby; feelings of emptiness and resentment at baby being the centre of attention.

It is a natural and normal response to the new responsibilities of parenthood. Sometimes the arrival of the new infant unlocks unconscious fears or memories of a mother's own childhood. We all have many different remembrances of our childhood, both good and bad. The holding of one's own child will often be the trigger-factor for the recollection of these memories and can sometimes be a disturbing and frightening occurrence.

There are also some people who find that holding their own baby in their arms suddenly brings back hidden feelings about their own parenting. A new mother may recall the mothering or fathering she had—perhaps the need to please one or both parents—and compare them with her present feelings of inadequacy. Sometimes new parents feel they will be judged by others on how 'good a job' they make of parenting. Or a mother may find that the freedom she previously had has suddenly gone; she is tied to this child for many years to come, and the consequences and responsibilities of parenthood can seem insurmountable.

Some women have a negative reaction towards their femininity which they cannot ignore. They may adopt a quite different, more masculine hairstyle, spurn make-up, and try to become 'one of the boys'.

When friends and relatives—especially the new grandmother—give advice on what the mother should do or how she should feed the baby, they should remember that every child is a unique individual and what worked or was needed for one baby is not necessarily right for this one. It is essential to work out what suits both mother and child. Remember that babies do not do everything according to the book. The new mother must not become despondent because at a certain age her child is not doing exactly what he should do—each child is unique, so she must relish and consider that individuality.

If she is breastfeeding she must remember that the baby is taking energy and nutrients from her, so she needs to allow her body both the time and the ingredients to do this. It is easy for the new mother to forget to feed herself whilst concentrating on the small infant, but without the correct food intake the breast milk will not satisfy the baby, and thus a vicious circle of hungry baby and irritable mother is set up.