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FOR DUMMIES®

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- **Be a supportive partner during (and after) pregnancy**
- **Know what to expect during labor and delivery**

Matthew M. F. Miller
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Breastfeeding For Dummies

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Dad's Guide to Pregnancy FOR DUMMIES®

by Matthew M. F. Miller
and Sharon Perkins

Wiley Publishing, Inc.

Dad's Guide to Pregnancy For Dummies®

Published by
Wiley Publishing, Inc.
111 River St.
Hoboken, NJ 07030-5774
www.wiley.com

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Published simultaneously in Canada

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Library of Congress Control Number: 2010939503

ISBN: 978-0-470-76790-0

Manufactured in the United States of America

10 9 8 7 6 5 4 3 2 1

About the Authors

Matthew M. F. Miller is a dad to one, an uncle to ten, and a "father" to anyone who will listen to his countless nuggets of unsolicited advice. Author of the book *Maybe Baby: An Infertile Love Story,* Matthew is a graduate of the University of Southern California's Master of Professional Writing program.

Matthew lives in Chicago where he is a full-time work-at-home dad, providing childcare for his daughter while working as the health-and-wellness editor for a national newspaper syndicate. In his spare time (because there's just so much of that!), Matthew is a musician, runner, tennis enthusiast, and baker.

Sharon Perkins has never been a dad, but she's had lots of experience on the mom side of parenting, with five children and three grandchildren. Almost 25 years as a registered nurse in fertility, labor and delivery, and neonatal intensive care have also taught her a thing or two about pregnancy and babies.

Sharon lives in New Jersey with her husband but would live in Disney World if it were legal. The opportunity to write about what she does for a living has been a dream come true.

Dedications

From Matt: Whether writing this book, watching tennis, or taking a nap, I am inspired, awed, and grateful for the love and support of my wife, Constance, and our beautiful daughter, Nola. Thank you for a charmed life.

From Sharon: This book is dedicated to my three grandchildren, Matthew, Emma, and Jessica, who keep me current on what's going on in the world of kids.

Authors' Acknowledgments

From Matt: Writing about family takes a deep, rich understanding of what it means to be a good person, and I am grateful to my mom, dad, sisters, nieces, and nephews for teaching me how to be one. Also, a very special thanks to my favorite doula, Holly Barhamand, for teaching and empowering me to explore and educate myself about what childbirth means to me.

As this is my first *For Dummies* tome, I am particularly grateful to the folks at Wiley, but also to Sharon herself. She took me under her wing and made this one of the most rewarding, fun experiences of my writing career. To my agent, Grace Freedson, you are a joy to work with and I look forward to the next amazing opportunity you bring my way.

Finally, thank you to my wife and, most importantly, to our daughter, an IVF baby born after nearly three years of waiting. And although we waited a long time for you, every day since your birth has been counted among the best of my life.

From Sharon: Wiley took a chance on me with my first book, *Fertility For Dummies,* almost ten years ago, and I've been extremely grateful ever since. In particular, Lindsay Lefevere, Erin Mooney, Chrissy Guthrie, and Caitie Copple have been the usual pleasure to work with throughout this book's creation.

Matt Miller has been the easiest coauthor ever! From day one, our writing styles meshed, and this book just flowed. Thanks, Matt, for making this a piece of cake.

And, last but not least, I thank my family for giving me so much raw material to work with over the years!

Publisher's Acknowledgments

We're proud of this book; please send us your comments at http://dummies.custhelp.com. For other comments, please contact our Customer Care Department within the U.S. at 877-762-2974, outside the U.S. at 317-572-3993, or fax 317-572-4002.

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Contents at a Glance

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Introduction

Welcome to impending fatherhood! Being a dad is better than you can ever imagine and far less scary than you're probably believing it to be. One of the main reasons we wrote this book was to empower men to get actively involved in every aspect of the childbirth process, as well as the care, feeding, and loving of newborns. Most dads-to-be have only a dim idea of what parenthood is going to be like, and their excitement mixes liberally with sheer terror and trepidation. We hope this book will spare you some of that fear and trepidation by giving you the knowledge you need to feel confident.

Traditionally, men have been removed from the processes of pregnancy, labor and delivery, and raising children. On TV, fathers have long been portrayed as emotionally distant, bumbling fools incapable of changing diapers, getting kids to go to bed, or handling any of the routine tasks that mothers seem to do with ease. In reality, today's dad is confident, capable, and totally in love with his children — and not afraid to let it show. Not that it all comes easily and naturally. Learning how to support your pregnant partner and, subsequently, to care for a newborn, takes time, effort, and education.

Most men in the world will become fathers at some point, and most will enter the experience without much knowledge of how babies develop, how to be a supportive partner, or what their role should be in the process. But not you. The savvy readers of this book will be prepared for just about anything — and will know exactly what it takes to be an equal partner on the pregnancy (and parenting) journey.

About This Book

This book answers all the burning questions you have about the impact your partner's pregnancy will have on your life. We tell you how your sex life will change, because we know that's at the top of your list. But we also explain everything you ever wanted to know about how a fetus develops, what it's like to live with a pregnant woman, and how your pocketbook will be hit by adding a new member (or members) to your family.

We also delve a little into what to expect the first six months or so after the baby arrives. We walk you through the ins and outs of feeding, changing diapers, dealing with common illnesses and emergencies, and how to stay sane and true to yourself through it all.

In short, you will close this book feeling completely prepared for fatherhood. You won't be, because no one ever is, but you'll at least feel like you are until the baby comes.

Conventions Used in This Book

Following are a few conventions we used when writing this book:

- We don't know if your baby is a boy or girl — you may not even know that yourself. So we use *he* and *she* interchangeably throughout.
- Because we also don't know if your medical practitioner is a doctor or midwife, or a pediatrician or nurse practitioner, we use the term *medical practitioner* when we talk about anyone medical.
- We call your partner your partner, because that's what she is, in every sense.
- We use *italic* font to highlight new terms, and we follow them up with a clear definition.
- **Boldfaced** font indicates keywords or the action in numbered steps.
- `Monofont` is used for Web addresses.

What You're Not to Read

If you decide this book is too long, you may decide to skip some of it, so you want to know what's not very important. Naturally, we think every word we've written is not only essential but brilliant, so we're the wrong people to ask. However, info marked with the Technical Stuff icon may be more than you want to have to think about. Information marked with this icon is certainly interesting and helpful, but skipping it won't impede your understanding of the topic in the slightest.

Also, we've included sidebars throughout the book (look for gray-shaded boxes) that often contain interesting but nonessential information and personal stories, and we give you permission to skip them if you really have to.

If your partner is already pregnant, congratulations! That means you can skip Chapter 2, which discusses conception. And we hope everyone will be able to skip reading Chapter 12, which discusses problems that can come up after delivery. However, you may still want to skim this one so you'll know where to turn in the unfortunate event of complications.

Foolish Assumptions

If you picked up this book, we assume you fall into at least one of the following categories:

- You don't know much about pregnancy.
- You're an expectant dad.
- You're hoping to become an expectant dad.
- You are already a father but are looking to learn new tricks for the next go-round.
- You know an expectant dad and would like to get into his head and understand why he's behaving the way he is.

Expectant dads are often the forgotten partner in the new family-to-be, and they need all the understanding they can get.

How This Book Is Organized

This book starts with the process of getting pregnant and ends with practical information on day-to-day dad stuff. However, we know you may not be interested in reading about the journey straight through from beginning to end. So feel free to start wherever you want. If tomorrow is your first ultrasound appointment, jump right into that section so you know what to expect. If your partner isn't pregnant yet but you want to read about labor, go right ahead. Every chapter of this book is modular, which means you can understand it without reading other chapters first.

Part 1: So You Want to Be a Dad . . .

Becoming a dad is one of the most exciting times of a man's life, but that doesn't mean you don't also have concerns and questions. This part dives into the normal fears and frustrations associated with deciding to start a family and the actual process of getting pregnant — and no, you don't already know it all!

Part II: Great Expectations: Nine Months and Counting

Your partner may be the one who's pregnant, but you're in it for the ride, too. From morning sickness to labor, we tell you exactly what happens during pregnancy, from your perspective as well as hers and the baby's. We also talk about the fun stuff, like baby showers (okay, maybe not so fun for you) and naming, and the not fun stuff, like potential health issues for mom and baby. We also give you an overview of birthing options so you can talk knowledgably with your partner about what she wants to do.

Part III: Game Time! Labor, Delivery, and Baby's Homecoming

No one ever said labor and delivery are fun, but they are interesting, and you have a lot to learn if you want to win the supportive partner of the year award. This part covers everything about actually having the baby, from the first contraction to the first all-night crying session — which just may come from an exhausted parent, not the baby!

Part IV: A Dad's Guide to Worrying

This part touches on all the things that keep you up at night worrying after the baby's born. We discuss possible postdelivery issues such as congenital defects and postpartum depression as well as baby's inevitable illnesses. If your worries are more monetary, we also advise you on handling your money with an expensive new baby and planning for your family's financial security. We also help you stay sane and happy with suggestions for managing your time so that you don't let the new baby take over your life.

Part V: The Part of Tens

The Part of Tens is just fun. We touch on how to be both a super dad and a super partner. We also talk about what it's like to be a stay-at-home dad.

Icons Used in This Book

Icons are another handy tool you can use as you work your way through this book. If you find the tips really helpful, for instance,

you can skim through and search for that icon. Conversely, when you see a Technical Stuff icon, you can know that information is completely skippable (though certainly worth the extra time, if you have it).

Following is a rundown of the icons we use in this book:

The Remember icon sits next to information we hope stays in your head for more than two minutes.

TechnicalStuff goes into more detail than you really need to understand the facts, but you may find it interesting if you're an especially curious type.

The Tip icon gives helpful insider info that you may take years to learn on your own.

Whenever we use a Warning icon, you'd better sit up and take notice, because not heeding our warning could be disastrous for you or your loved ones.

Where to Go from Here

This is where we tell you to go read the book, already!

Although you can start absolutely any place and get the benefit of our expertise, if your partner isn't yet pregnant or is newly pregnant, we suggest starting at the beginning and reading right on through. It will calm your nerves, we promise.

If you're the last-minute type of guy and you're reading this book just a few months (or weeks!) before the impending birth, you can certainly skip the first trimester stuff (at least this time around) and start wherever makes the most sense for you.

And if you got this book at the beginning of the pregnancy but never got around to opening it until now, when baby has his first case of sniffles, that's okay too — we still have plenty of valuable information for you. Pregnancy is the start of the adventure, but the fun continues long after.

Part I

So You Want to Be a Dad . . .

"I'm bonding with the baby. We're sharing an intimate moment with the Cleveland Browns on their 37 yard line."

In this part...

Chances are, the road to fatherhood wasn't something you dwelled on much in your earlier years. When you decide to begin a family, though, exciting thoughts about conception alternate with fears of not being a good dad and concerns about money, time, and a brand-new way of life. In this part we look at the doubts and worries that consume every new dad-to-be and explain the mechanics of getting pregnant. You may think this is one area where you need no help, but many couples find getting pregnant a frustrating struggle, and even those who don't can benefit from a refresher course on Conception 101.

Chapter 1

Fatherhood: A Glorious, Scary, Mind-Boggling, and Amazing Experience

In This Chapter

- Exploring what it means to be a father today
- Understanding what will change in your life
- Facing the decision of whether to have a baby
- Looking down the long road ahead

Apparently congratulations are in order: Either you're going to be a father sometime within the next nine months or you're in the planning stages of becoming a dad. Either way, you've come to the right place. You'll face no bigger life decision than choosing to become a parent (and no bigger jolt than being told baby is coming if you didn't expect it!), and the best gift you can give to your soon-to-be child is confidence. And the only way to feel confident before you've ever been a parent is to get yourself prepared for the unknown journey that lies ahead.

Perhaps you've already been floored by equal doses of joy and fear, which is a good sign that you recognize the magnitude of the change but you're up for the challenge of fatherhood. Emotions run deep when confronted with the prospect of raising a child, mainly because it's a huge commitment and responsibility that, unlike a job, never has off-hours. Babies are expensive, confusing, time consuming and, for many fathers, they represent the end of a carefree "youth" that extends well into adulthood.

Experiencing a jumble of feelings is normal, and the more you take those emotions to heart and explore what fatherhood means to you — and what kind of father you want to be — the easier the transition will be when baby arrives.

Looking at the Concept of Fatherhood

What exactly does it mean to be a father? The answer depends on the kind of father you want to be for your child. In recent years, movies, TV, and even commercials have begun to transition from the bumbling, know-nothing father of yore to the modern dad who is just as comfortable changing a diaper as he is fixing a car. Fathers today range from traditional to equal partners in every aspect of parenting.

The majority of parents today don't adhere to the traditional masculine and feminine roles that our parents and grandparents grew up with. Women work, men work, and caring for the home — inside and out — is both partners' responsibility. Today, fatherhood is a flexible word that's defined by how involved you want to be in the rearing of your child, but the more involved you are in your child's upbringing, the more likely he is to be a well-adjusted, loving, and confident person.

A father? Who, me?

Yes, you. As strange as it sounds, you are going to be a father. A great one at that, because just through the mere act of reading this book, you're taking the proverbial bull by the horns and doing your homework to learn what it takes to be a good dad from day one. As they say, anyone can be a father, but it takes someone special to be a dad.

Even if you've never held a baby before, don't let self-doubt rule the day. Being a good father isn't about knowing everything about everything; it's about loving and caring for a baby to the best of your abilities. So don't be afraid. Yes, that's easier said than done, but being fearful of what lies ahead doesn't change the fact that you've got a baby on the way, however far off.

You may feel silly, but start by saying the words "I'm going to be a father" out loud a few times. Maybe even look into a mirror while you say it. If the thought of fatherhood scares you, you need to get used to the label, and the more you say and internalize it, the more it will become you.

Reacting to a life-changing event

Devolving into a tearful, slobbering mess upon finding out that you are going to be a father isn't unusual. Neither is throwing up, passing

out, laughing, swearing, or any of the normal, healthy reactions people have upon receiving life-altering information.

If your reaction isn't 100 percent positive, that's okay, too. Just remember that your partner likely won't be particularly thrilled if you get upset, defensive, or angry when she tells you she's expecting. As best as you can, react to the news with all the positivity you can muster. You'll have plenty of time to revisit any concerns or frustrations after you've given the situation some time to sink in.

Some dads-to-be go into fix-it mode upon hearing the news, ready and eager to crunch budget numbers, baby-proof the entire home in a single night, begin make college plans 18 years in advance, and so on. Feeling like you need to get everything in order before baby arrives is normal, but remember that you can't do it all in a day, and take some time to celebrate before you dive into the practical side of life with baby. (Turn to Chapter 3 for more on handling the news.)

Dealing with fears of fatherhood

Even men who have been lucky enough to be surrounded by positive male role models for their entire lives still find themselves doubting whether or not they have what it takes to be a dad. It's like the fear of starting a new job amplified by 100. Part of being a good father is taking the time to confront these fears so that when baby comes, you won't be parenting with fear.

Following are some of the common fear-based questions men ask themselves in regard to fatherhood:

- Am I ready to give up my present life (free time, flexibility, freedom) to be a dad?
- Will I have time for my pastimes and friends?
- Will I ever sleep again?
- Is this the end of my marriage and sex life as I know it?
- Do we have enough money to raise a child?
- Do I know enough about kids to be a good dad?
- Am I mature enough to be a good role model for my child?
- What if the baby comes and I don't love him?

Your head may be spinning with all of the questions you ask yourself, and although you can't answer them all right away, you need to address them at some point. However, plenty of men have felt unprepared and unwilling and turned out to be great dads, so don't despair if your initial answers to the questions above are mostly negative.

Parenthood involves a lot of sacrifice, but it doesn't have to sound the death knell for your identity or happiness. Talk with your partner, a trusted friend, or a therapist — anyone who will listen to you and support your concerns without getting defensive — about the questions you have. Some of your fears, as you will find, have no basis in reality. Others, such as the fear of losing yourself and your free time, will require you to prioritize your time and energy.

Regardless of what your fears may be, don't let them fester. No man is an island, and you can't effectively deal with all those emotions by yourself. Starting an open dialogue with your partner will keep you both on the same page, which is a good start toward making you an effective parenting duo.

Debunking a few myths of fatherhood

Many of the concerns or fears you likely have originate from the many long-standing myths of what a father's role should be in the life of a child. Not all that long ago, men stood in the waiting room at the hospital during delivery and returned to work the next day. The landscape of fatherhood has changed quickly, leaving the modern dad wondering where he fits in the parenting scheme.

Following are some of the most common misconceptions about fatherhood. We debunk those myths to help you understand how to be a more-involved father.

Myth #1: Only the mom-to-be should have input about labor and delivery

While the focus is on your partner — she is, after all, the one carrying your child — you also matter, and you have the right to voice your opinions along the way. Throughout the pregnancy, share what you're experiencing and let her know what you're afraid of. She has a lot to think about and worry about, too, but the more you deal with those issues together, the stronger your relationship will become.

If you have thoughts and opinions about what kind of delivery option you're most comfortable with, share those with her as well. Although ultimately you need to let your partner pick the childbirth option that's best for her, she deserves to know your feelings on the matter. Getting involved in the decision-making process isn't just your right; it's the right thing to do. You can turn to Chapter 8 to start getting informed on the options and many decisions to be made.

Myth #2: Men aren't ideal caretakers for newborns

Boobs are generally the issue at the forefront of this myth. No, you won't be able to breast-feed your child or know what it's like to

give birth. Because they don't have that initial connection, a lot of fathers wonder what exactly they're supposed to do.

Mother and baby are attached to each other for nine months, but after baby arrives, it's open season on bonding and caretaking. When your partner isn't breastfeeding, hold, rock, and engage in skin-to-skin contact with your baby. Changing diapers, bathing, and changing clothes are just a few of the activities that you can do to get involved. And the more involved you get, the less likely you are to feel left out of the equation. Chapter 10 provides tips for caring for your new baby so you can feel confident in your abilities.

Myth #3: You will never have sex or sleep ever again

Good things come to those who wait, and you will have to wait. Sex won't happen for at least six weeks following delivery, and even then you have a long road back to normalcy. For many couples, a normal sex life following childbirth isn't as active as it once was, but you can work with your partner to make sure both of your needs are being met.

One need that will deter your sex life — and override the sex need — is sleep. Babies don't sleep through the night. They wake up hungry and demand an awake parent to feed them, burp them, and soothe them back to sleep. Some babies begin sleeping through the night at six months while other kids won't until the age of 3. The good news is that they all do it eventually, and when you begin to understand your baby's patterns, you'll be able to figure out a routine that allows you to maximize the shut-eye you get every day.

Myth #4: Active fathers can't succeed in the business world

Unless work is the only obligation you've ever had in your adult life, you're probably used to juggling more than one thing. Fathers who are active in the community or fill their schedules with copious hours of hobbies will have to reevaluate their priorities. Family comes first, work comes second, and with the support of a loving partner and a few good baby sitters, you'll be able to continue on your career trajectory as planned.

In fact, being a dad may just make you a more effective worker. Having so many demands on your time will make you better at time management and maximizing your workday. Focus on work at work and home at home, and you'll succeed in both arenas.

Myth #5: You're destined to become your father

Destiny is really just a code word for the tendency many men have to mimic the patterns and behaviors that are familiar because they grew up experiencing them. However, if you didn't like an aspect of your father's parenting or don't want to repeat a major mistake or

flaw that he perpetrated, talk about it with your partner. The more you talk about it, the less likely you are to repeat that mistake because you'll engage your partner as a support system working with you to help you avoid it.

But don't forget to replicate and celebrate the things your father may have done right. You'll be chilled to the bone the first time you say something that your father used to say, but remember that repeating the good actions isn't a bad thing. Don't try to be different from your father "just because." Identify what he did that was right, what was wrong, and use that as a blueprint for your parenting style.

Myth #6: You will fall in love with your baby at first sight

Babies aren't always so beautiful right after being born, but that's to be expected, given what they've just gone through to enter the world. Don't feel guilty if you look at your baby and aren't immediately enamored with him. Emotions are difficult to control, and for some fathers — and even mothers — falling head-over-heels for your baby may take some time.

Childbirth is a long, intense experience (as we describe in Chapter 9), so allow yourself adequate time to rest and get to know the new addition to your family. If you suffer from feelings of regret, extreme sadness, or experience thoughts of harming yourself or the baby, seek immediate medical assistance.

Becoming a Modern Dad

Dads today are involved in every aspect of a child's life. They're no longer relegated to teaching sports, roughhousing, and serving as disciplinarians. Modern fatherhood is all about using your strengths, talents, and interests to shape your relationship and interactions with your child.

Modern dads change diapers, feed the baby, wake up in the middle of the night to care for a crying child, and take baby for a run. They do not "baby-sit" their children; they're capable parents, and no job falls outside of the realm of a modern father's capabilities. Though all that involvement does mean you're going to put in far more effort and time than previous generations, it also means that you're bridging the gap of emotional distance that used to be so prevalent in the father-child experience.

In addition to reading the sections below, you can flip to the chapters in Part IV for information and advice on making changes and stepping into the practical role of daddy.

Changes in your personal life

If what you fear most is losing the freedom to spend as much time as you want engaging in leisure activities, then you are in for some mammoth sacrifices. Babies require you to say no to a lot of commitments that the prebaby you would have agreed to partake in. Don't make a lot of outside-the-home plans that you consider optional, at least at first.

For the first six months, going out at night will be challenging, especially if your partner is breast-feeding, and even more so if you don't live near family. However, as your baby ages, leaving him with a baby sitter becomes more feasible and less stressful.

Perhaps what you fear the most is the impact baby will have on your relationship with your partner. This fear is valid, given that you will scarcely find time for the two of you to be alone. But that doesn't mean you won't have time to connect.

Just because going out as a couple is tough to manage doesn't mean you can't have ample one-on-one time. Plan stay-in dates that start at baby's bedtime. Order food or make a fancy dinner, queue up a movie, or bring out your favorite board game. Try not to talk about baby. Rather, focus on each other and talk about topics that interest you both.

Changes in your professional life

Depending on the requirements of your job, your daily routine may go completely unchanged aside from the uptick in yawns due to late-night feedings and fussiness. Thoughts of your new family may make focusing difficult, especially when you first return to work following any paternity leave or vacation you take. In time, you'll settle back into a normal routine, and work just may become the one arena of your life that provides a respite from parenting duties.

Workaholics, however, will find themselves at a crossroads. Some will choose to cut back on hours spent at the office while others, hopefully with the full support of their partners, will proceed with business as usual. There is no right or wrong way to balance a demanding job with a new baby as long as you and your partner both are comfortable with the arrangement and you spend enough quality time with your child.

What is quality time? It's time you spend with your child, focusing *on* your child. Some people say quality time has nothing to do with the quantity of time you spend with your child, but we feel it is affected by the amount of time you devote to your child. Give as much as you can, because the old adage is true — they grow up so fast.

Some dads even leave the workforce altogether or take work-at-home positions in order to provide full-time childcare for their newborn. If you choose this route, make sure to check out Chapter 14, where we discuss some important considerations of being a stay-at-home dad.

Lifestyle changes to consider

Bad habits are hard to break, but when you have the added stress of a child, those bad habits can be even harder to conquer. That said, you're about to have a child — a sponge that will soak up your every word and action — so it's time to clean up your act.

Following are a few lifestyle alterations to consider making so you can lead by example without reservation:

- **Quit smoking/drinking too much/taking recreational drugs.** Second-hand smoke increases the risk of illness for your child, as well as the likelihood that she will become a smoker as an adult. Frequent overconsumption of alcohol makes you less likely to be a responsible parent capable of making good, safe decisions for baby. In fact, alcohol and drugs often lead to harmful and neglectful decisions that can land you in legal trouble and your child in the foster care system.
- **Start an exercise regimen.** Physically active, healthy parents get less run down and are less susceptible to illness. Plus, you'll want to live a long life with your children.
- **Lose weight.** If you're heavily overweight, you're more susceptible to illness and a shortened lifespan, and furthermore, children of obese parents are more likely to be obese. Kids learn nutrition and lifestyle habits from their parents, so set a good example and give your child a fair shot at a long, healthy life.
- **Eat healthier.** Your partner needs to be extremely diligent about eating pregnancy-positive foods, so use this time as an opportunity to get your diet in order. Soon enough, you'll be cooking for three, and if you're already in the habit of preparing healthy foods, you'll have no trouble providing proper nutrition to your child.
- **Control your anger/censor your potty mouth.** Kids learn how to treat and interact with others at a very young age. Start revising your behavior now and get used to swearing less, before your kid picks up some nasty communication habits.
- **Spend less money on nonessential items.** Teaching kids fiscal responsibility is just as important as teaching them social responsibility. Plus, kids aren't cheap, so stop spending $50

per week on beer and start banking your savings to provide a sound, secure future for your family.

- **Organize and de-clutter your home.** Create a safe, livable place for your new addition, which also helps decrease the amount of stress in your life.
- **Develop routines.** Be it running errands, cooking, phone calls, or paying the bills, get systems in place to ensure that everything gets done with the least amount of hair pulling. Knowing who does what when keeps you on track when baby throws a wrench into everything.

Deciding to Take the Plunge (Or Not)

For some of you, the question of whether or not you're ready for fatherhood comes too late. Others may be reading this book as a first step in planning for the future. Deciding the right time in life to have a baby isn't an easy task, especially because circumstances change on a seemingly daily basis.

However, family planning is an essential step that can minimize what ifs, frustrations, and regrets. Once you have a baby, you can't take it back. Knowing when you're ready to be parents and then trying to conceive means that when you actually do get pregnant, the time will indeed be right. Or at least as right as any time can be, as you have such little control over life's variables.

Determining whether you're ready

How does it feel when you know you want to be a father? And how can you know when you're actually ready to start trying for a baby? Those questions have no simple answers, because the feeling is different for everyone, but suffice it to say, you'll know when you know.

One sign to look for is a prolonged interest and fascination with the babies of friends and family members. Women call the growing desire for a baby a *biological clock,* and many men experience similar feelings. The desire to procreate, to have your genes carried on in the species, can be powerful.

Just make sure it's a desire that lasts more than a day. Also, make sure that you take the time to analyze the impact baby is going to have on your life. If you're in the final two years of a college program, it may be in your best interest to wait. If you're unemployed,

perhaps you want to put off trying until you find a job you like that can support a family.

Just because you're ready doesn't make now the right time. Don't decide to have a baby on an impulse. Think about the impact a child will have on your time, money, and home, and if you don't see any major obstacles, then by all means, proceed. Obviously you can choose to proceed even if having a baby now doesn't make sense on every level, but please make sure first that you can provide a loving, safe home and can pay for all the things baby needs to thrive.

Telling your partner you're ready

You can tell your partner anytime and anyplace that you're ready to take the plunge into parenthood, but however you broach the subject, remember that she may not be as ready as you. A good way to introduce the subject is by asking her questions about her feelings on when the right time is to have a baby.

Let her know how excited you are, but also let her know that you've thought about the finances and logistics of having a baby, too. Fatherhood involves a lot more than choosing a name and a nursery theme. A big part of feeling ready is knowing that the person you're going to have a baby with isn't just enamored with the idea of a baby but is also prepared for the practicalities of responsibly starting a family.

You don't have to outline every aspect of how and why you're ready, but treat the idea with respect and let your partner know you're sincere by proving that you've actually thought it through.

Telling your partner you're not ready

If your partner is already pregnant, do not under any circumstances tell her you're not ready. If, however, the two of you simply are exploring the idea of having a child, now is the perfect time to speak your piece and let her know that you're just not prepared for fatherhood.

Reasons for not being ready vary from practical (not enough money or time) to logistical (still in school, caring for a sick parent) to selfish (not ready to share the Xbox). No reason to not be ready is wrong, but if your partner is ready for a baby, don't expect her to be fully supportive.

Regardless, don't agree to have a child before you're up for the challenge just so your partner doesn't get angry with you. Be honest,

because when she's pregnant, you can't do anything to change the situation. If you're uncertain now, be honest and speak up!

Being patient when one of you is ready (and the other isn't)

Being on different pages can be an uncomfortable position for any couple, especially when it comes to the kid issue. Men have long been saddled with the Peter Pan label whenever they announce they aren't ready to "grow up" and have kids. Women are unfairly chastised for choosing career over family if they aren't ready to have a child.

Everyone has his reasons for wanting or not wanting to have a baby, and every one of them is valid — at least to the person who isn't ready. Attempting to persuade your partner, or vice versa, to have a baby is not recommended. Having a child with someone who isn't ready is setting up your relationship — and your relationship with the child — for failure.

If one of you isn't ready, try to work out a timeline as to when the wary party will be ready. If you can't set a definitive date, choose a time when you will revisit the topic. Check in with each other on the topic at least every six months. Nagging the other person isn't a good idea, but if it's something one of you wants, then you should continue to work toward a solution.

Seek counseling at any point if you and your partner are fighting about the issue frequently, or if one of you makes the decision that you never want children. Couples who find themselves at an impasse about whether or not they will have children often need the guidance of a trained professional.

Dealing with an unexpected pregnancy

Unplanned pregnancies aren't uncommon, and, for the majority of people in a committed relationship, adjusting to the surprising news is often no more than a minor bump in the road. If you unexpectedly find out that you're going to be dad, do not get angry with your partner. Blaming the other person is easy when emotions run high, but don't forget how you got into this situation in the first place. It does, indeed, take two.

Birth control and family planning are the responsibility of both the man and the woman, and accidents sometimes happen. The best

thing you can do in this instance is to talk with your partner about your options and start making a plan about how to give that child the best life you possibly can. Having a child unexpectedly is not the end of the world, and you don't have to feel ready to have a baby to be a good father.

Welcoming long-awaited pregnancies

Getting pregnant isn't always as easy as they make it look in the movies, as the millions of infertile couples know all too well. (And if you and your partner are dealing with infertility, turn to Chapter 2 for help.) Finding out that you're pregnant after a long wait brings a mixed bag of emotions, most of which are joyful.

If you and your partner have been struggling to get pregnant, you likely feel relieved that you're about to get the gift you've been working so hard to find, but don't be surprised if you have difficulty adjusting to life outside of the infertility world. After months and years of scheduled sex, countless doctor visits, and suffering month after month of disappointment, not everyone transitions into the pregnancy phase with ease.

You also may struggle with a hypersense of fear due to previous miscarriages, close calls, and years of disappointment. Make sure to allow yourselves the opportunity to gripe, complain, worry, and grieve for a process that took a lot of patience and energy. Frustrations that were bottled up for the sake of optimism may finally surface, which is absolutely healthy.

Just because you've finally achieved your goal doesn't make all the feelings of sadness and frustration suddenly disappear. If you and/or your partner are having trouble letting go of the feelings that gripped you during your fertility struggle, you can find countless support groups, online communities, and blogs that provide both of you a place to talk about what you've been through. You can also learn transition tips from others who have been through the same thing. Moving forward will get easier, but it can take time — and a heaping helping of support.

Glimpsing into the Pregnancy Process Ahead

When you get used to the idea of being a father (which you hopefully will), you may wonder what comes next. For the uninitiated, first-time dad, the nine months of pregnancy are a whirlwind of planning, worrying, parties, nesting, name searching, doctor visits,

and information gathering as you move toward baby's birth. In the following sections we lay out what you can expect in each trimester (period of three months).

First trimester

In the first trimester, which encompasses the first three months of pregnancy, your partner suffers from the majority of pregnancy symptoms, such as nausea, intense sleepiness, unexplained tears, and the all-important cravings.

By the end of the first trimester, your baby grows to be about 3 or 4 inches in length and weighs approximately 1 ounce. At that time your baby's arms, legs, hands, and feet are fully formed, and your baby is able to open and close her fists. The circulatory and urinary systems are fully functional. Secondary body parts, such as fingernails, teeth, and reproductive organs, begin developing. Turn to Chapter 3 for more information on what happens during the first trimester.

Second trimester

During the second trimester, most of your partner's early pregnancy symptoms disappear, but her body undergoes visible changes. She begins to look and feel pregnant, and may begin struggling with the not-so-fun aspects of carrying a child, such as weight gain and forgetfulness.

This is also the time when the fun stuff begins. Around week 20, your partner has the ultrasound that can determine the sex of the baby — if you choose to find out and if the baby allows the ultrasound technician a clear view. It's also the time when you register for your baby shower, prepare the nursery, weed through countless baby names, attend birthing classes, and baby-proof your house.

By the end of the second trimester, your baby is roughly 14 inches long and weighs approximately 2 pounds. Her skin is still be translucent, but her eyes begin to open and close, and your partner likely starts feeling movements and even baby's tiny hiccups. Check out Chapter 4 to find out more about the second trimester.

Third trimester

Assuming all goes according to plan and your baby goes full-term (isn't premature) or somewhere close to it, the third trimester is one of the longest three-month periods of your life. Your partner begins to feel uncomfortable as her body makes it difficult to

move and sleep in a normal way, and you both get antsy about the impending arrival.

To make the most of the time, you and your partner need to take care of business, mainly picking a pediatrician who you're comfortable with and has a similar parenting philosophy as you and your partner, crafting your birth plan, hiring a doula if you want one, getting your maternity and paternity leave squared away, ensuring that you understand your insurance benefits, creating a phone tree to announce baby's arrival, and finishing up any odd projects around the house that need to be done prior to baby's arrival.

During the third trimester, your baby is fully developed and focused on growing larger and stronger for life on the outside. This is also the last time for many, many years that you and your partner exist solely as a couple, so be sure to take the time to indulge yourselves in the things you love to do together. Life may feel like it's on pause for at least the first six months of baby's existence, so get out now and enjoy the freedom of childlessness. Soon enough, your life will be a lot more complicated and busy — and happy, too. Very, very happy. Chapter 7 gives you more information on what to expect and do in the third trimester.

While You Were Gestating

Because the first few weeks of pregnancy will probably be rather uneventful, now is a good time to start a time capsule for the year your baby will be born. Many years down the road, when your child is an adult, it will be a touching, informative look back at the time when he entered the world. For you and your partner, it will be a fun, celebratory action to kick off the pregnancy festivities.

Keep movie tickets stubs, take-out menus, a newspaper from the day you found out your partner was pregnant (as well as clippings of the most important headlines of the year), favorite ads, magazine clippings, and so on. Make a mix CD of the most popular songs, as well as one of your favorite music.

As you choose names, add the list of all potential names into the time capsule. When you choose a paint color for the nursery, put in the paint color card. Any decision you and your partner make for the baby is a good candidate for inclusion. It may seem silly now, but in 20 years it will be the best gift you can give your child.

Chapter 2

Beyond the Bed: Conception Smarts

In This Chapter

- Finding out why getting pregnant is harder than it looks sometimes
- Improving your health and lifestyle to help your chances
- Determining the right time for fertilization (and making it a good time)
- Understanding and dealing with infertility issues
- Talking to your family about your baby plans

You may have spent years trying not to get pregnant, so the change from not trying to trying can be mind boggling. Something even the most clueless people manage to do effortlessly can cause you to lose sleep at night and turn sex into a job. Getting pregnant is hard work sometimes.

In this chapter we tell you how to make the getting pregnant process not just painless, but fun, even if it takes longer than you expected.

Understanding Conception

You can't get pregnant any old time you want; your partner has to be ovulating and releasing an egg, and you have to be sending some good swimmers her way. The whole baby-making process can be so complex that it seems like a miracle people are on earth at all. This section tells you about the mechanics of how eggs and sperm actually get together and what they need from the two of you.

Baby making 101

Getting pregnant requires that several players be on the scene at the right time: namely, good sperm and a mature egg. If the two meet in the fallopian tube, which is the conduit from the ovary

down to the uterus, join together to form a fertilized egg, and then float down to a uterus with a lining that's exactly the right thickness to facilitate implantation, pregnancy occurs. If any of those factors are amiss, well, that's when things get complicated.

Producing a mature egg

Before she's even born, a woman has all the eggs she'll ever have. Unlike sperm, no new eggs are being produced; the original eggs are just matured, usually one at a time. Mature eggs are produced from immature ones (called oocytes), located in the ovaries, through a complex interaction of three hormones during the menstrual cycle. Those hormones — estradiol (a form of estrogen), follicle stimulating hormone (FSH), and luteinizing hormone (LH) — work like this:

1. FSH stimulates the ovaries, which produce estrogen.
2. Estradiol production starts to mature a number of egg-containing follicles, small cystlike structures that contain the immature eggs.
3. One follicle, called a lead follicle, continues to develop while the rest atrophy.
4. Around day 14 of the menstrual cycle, LH kicks in to mature the egg and move it to the center of the follicle so it can release.
5. The egg releases from the follicle and begins to float down the fallopian tube. This is where you come in.

Figure 2-1 shows the events of a menstrual cycle when pregnancy does not occur.

Sending in some good sperm

Sperm can only fertilize an egg that's mature, so you need to either have sperm waiting in the tube when the egg is released or get some there within 12 to 24 hours after ovulation, because that's how long the egg can live. Sperm (shown in Figure 2-2) live for at least a few days, so having sex the day before ovulation, or even two days before, is usually adequate. If your partner is monitoring her ovulation, give it one more shot the day of ovulation.

Making the journey and attaching to the uterus

After fertilization, the new potential life has to make it down the tube to the uterus, where it implants. The journey from fallopian tube to uterus takes between five to seven days, on average, and implantation normally occurs seven to ten days after conception. The fallopian tube is normally a fairly straight tube, but if it's been damaged by infection so that it's twisted or dilated, the embryo may wander around in the crevasses and never get to the uterus.

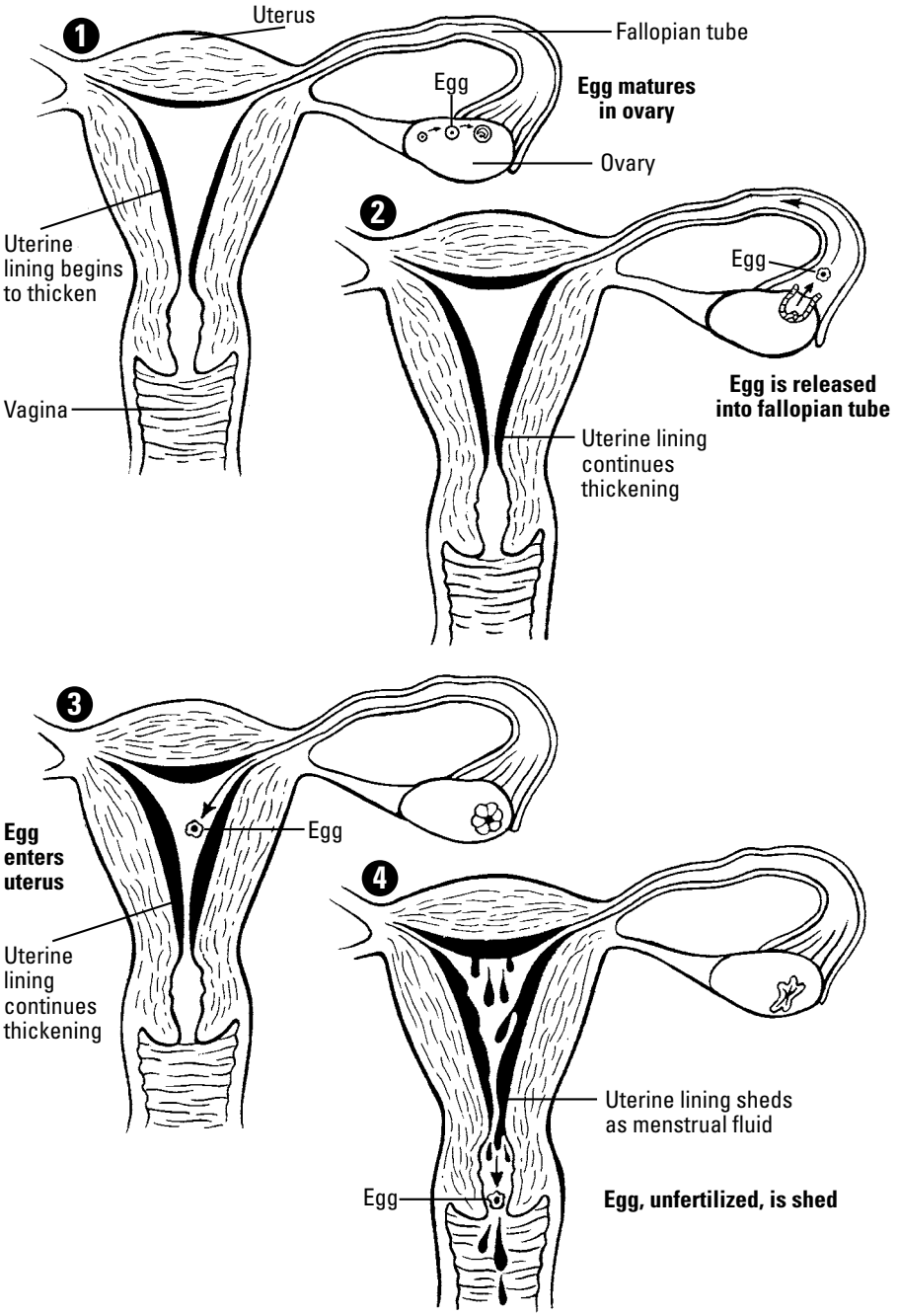


Figure 2-1: Every event in the menstrual cycle has a purpose.

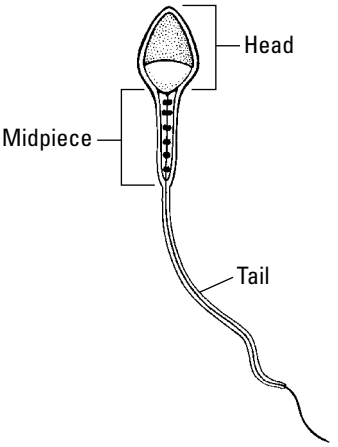


Figure 2-2: Sperm are compact swimming machines.

Even worse, it may implant in the tube, which is an *ectopic pregnancy.* The tube has no room for a developing fetus, so an ectopic pregnancy is doomed from the start and can cause serious, life-threatening bleeding if the tube ruptures.

Even after the embryo reaches the uterus, it's not always clear sailing. The uterine lining has to be just right for implantation. Estrogen thickens the lining before ovulation, and progesterone released from the corpus luteum, the leftover shell of the follicle that contained the egg, prepares the lining after ovulation.

Why so many sperm?

Women produce one egg a month, most of the time, and men produce millions of sperm. You may wonder, why the huge disparity? Because of the inability of one sperm to do the honors. Only one sperm makes it into the egg, but it takes many sperm to break down the coating that surrounds the egg. And while eggs get to drift downward from the ovary to the fallopian tube, sperm have to swim upstream. Needless to say, some fall by the wayside.

Sperm also are produced in large quantities because many are abnormal, having two tails, no tails, round tails, small heads, large heads, or abnormally shaped heads. Abnormal tails make navigation difficult, and abnormal heads often indicate chromosomal abnormalities.

Only 50 to 60 percent of sperm need good motility, or movement, for a sperm sample to be considered normal, so lots of sperm don't make the grade, creating a need for more numbers.

If either of these hormone levels are low, the lining may not be able to support a pregnancy. Your partner's doctor can assess the uterine lining by ultrasound and prescribe extra progesterone if needed to achieve pregnancy.

After the embryo reaches the uterus and implants, the implanting embryo begins to produce human chorionic gonadotropin, or hCG, the hormone that pregnancy tests measure. hCG levels aren't detectable until the embryo implants, or around the time of the first missed period.

Conception statistics

If you don't get pregnant the first month you try, the wheels in your head may start turning as you obsess about why this is taking so long. Pregnancy is by no means a sure thing, even when you do everything right and have no major fertility issues. In any given month, statistics say that:

- Out of 100 couples under age 35 trying to get pregnant in a given month, 20 will achieve their goal, but 3 will miscarry.
- If your partner is in her late 30s, you have a 10 percent chance of pregnancy each month, but a 34 percent chance of miscarriage.
- If she's older than 40, you have only a 5 percent chance of pregnancy each month, and more than a 50 percent chance of miscarriage.

The good news is that 75 out of 100 30-year-olds trying to get pregnant will become pregnant within a year of trying, and 66 percent of 35-year-olds will get pregnant in a year. Around 44 percent of 40-year-olds become pregnant within a year. Over age 40, variables such as hormone levels affect pregnancy rates, and generalizations are hard to make.

Answering commonly asked questions about getting pregnant

Getting pregnant may seem straightforward, but what exactly does it take? Here are some answers to the most common concerns:

- **How long does it take?**

  On average, more than half of couples get pregnant within the first six months of trying and four out of five are pregnant within one year.

- **Does having more sex increase the chances of pregnancy?**

  No. In fact, due to the amount of time it takes for semen volume to build back up to normal levels following ejaculation, overdoing it around ovulation time by having sex several times a day can deplete your sperm count, which probably won't be a problem if you have a normal sperm count, but can be if your count is low.

- **Should we only have sex with my partner on her back and me on top?**

  It's a myth that this standard position is the best way to get pregnant. While it may help the semen stay in better, there is no scientific proof that the sexual position you choose has any effect on conception rates.

- **Does my partner's past use of the birth control pill mean it will take longer?**

  It varies from person to person. One woman can miss a single pill and end up pregnant while others may take a little longer. Just remember, the chances of getting pregnant the first month are small, but the average couple is pregnant within a year regardless of past birth-control usage.

- **Is it okay to drink and smoke when trying to conceive?**

  If you're ready to be pregnant, you should give up smoking immediately. Occasionally having a drink or two when you're trying to become a mom or dad won't likely produce a negative outcome, but the general rule of thumb is to live as though your partner is pregnant from the moment you begin trying to conceive. Check out the next section for more tips on getting healthy to improve the odds of conception.

Evaluating Health to Get Ready for Parenthood

Some health issues and bad habits can make it harder to get pregnant. A few months before trying to get pregnant, take inventory of behaviors and health issues and get yourselves into the best shape possible, not only so that you can get pregnant without difficulty but also so you'll be healthy new parents.

Checking out your physical health before trying to get pregnant isn't difficult. See your doctor, let him know you're trying to get pregnant, change any medications that may impact fertility, and run some blood tests.

Uncovering female health issues that impact conception

Many female health problems can cause fertility difficulties. Some affect egg production and the menstrual cycle; others affect egg transport and implantation, like fibroids and fallopian tube damage. Many can be improved after you identify them.

Sexually transmitted diseases

One of the biggest fertility busters in the age of sexual freedom is sexually transmitted diseases, or STDs. The following STDs can affect female fertility in these ways:

- Chlamydia, if not treated promptly, increases by 40 percent the risk of pelvic inflammatory disease, which damages the fallopian tubes. Women with PID are seven to ten times more likely to have an ectopic pregnancy. Eighty percent of women who have had chlamydia three or more times are infertile.
- Gonorrhea also increases the risk of PID and ectopic pregnancy.
- Syphilis can cause miscarriage, stillbirth, and developmental delays and blindness in your unborn child.

STDs need to be treated early with antibiotics before damage is done to the tubes. Having a hysterosalpingogram (HSG), a dye test to assess the patency of the tubes, is a good idea if your partner has any concerns about whether her tubes have been damaged in the past.

Endometriosis

Endometriosis, implantation of the tissue that lines the inside of the uterus in places it doesn't belong, is common; 5.5 million women in the United States suffer from it, and 40 percent of women with endometriosis have fertility issues.

Endometriosis tissue bleeds at the time of the menstrual period and leads to scarring and pain. Endometrial implants can be removed in some cases, but they tend to recur. Most endometriosis is found in the pelvis, near the uterus, but it can turn up in some odd places, like the lungs. In vitro fertilization (IVF) can increase the chances of pregnancy in women with endometriosis.

Polycystic ovary syndrome

Polycystic ovary syndrome, PCOS, affects between 5 to 10 percent of women of childbearing age, and can cause *anovulation,* or failure to produce a mature egg. PCOS is associated with an abnormal rise in male hormones, called androgens; all women have some

male hormones, but women with PCOS have more than normal. They're often overweight and have excess body and facial hair, thinning head hair (just like some men), and acne. Women with PCOS also have a higher rate of type 2 diabetes, heart disease, high cholesterol, and high blood pressure. Fertility medications may be needed for women with PCOS to get pregnant.

Thyroid problems

Thyroid problems are common in women of childbearing age and can cause anovulation (failure to recruit and develop eggs). A simple blood test checks for thyroid function. Low thyroid levels can raise prolactin levels, which can also interfere with ovulation.

Fibroids

Fibroids are common uterine growths (rarely cancerous) that occur in up to 75 percent of women and often cause no problems with conception. However, fibroids can grow big enough to interfere with embryo implantation or to cause preterm labor in some women. See Figure 2-3.

Fibroids are easily seen with pelvic ultrasound, and can be removed surgically if they appear to be interfering with pregnancy.

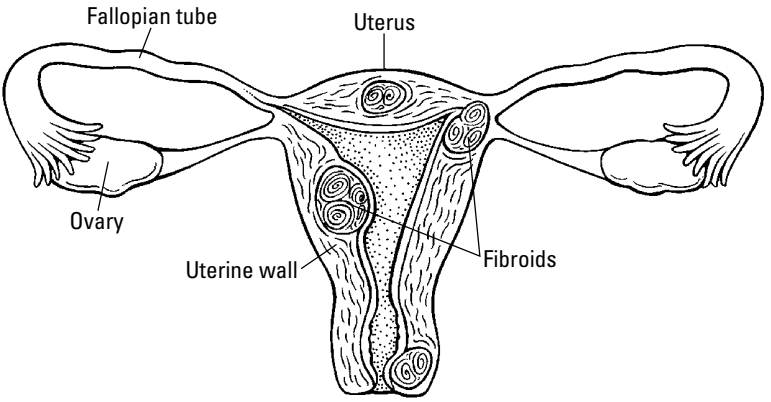


Figure 2-3: Fibroids grow into the uterine lining and occasionally interfere with pregnancy.

Recognizing issues that cause fertility problems in men

Sperm take a long time to make. Sperm you ejaculate today have been three months in the making, so if you're working on health problems or making lifestyle changes, give them enough time to take effect.

While male health issues may seem less important to a quick conception, your health problems can interfere with conception. Here are a few examples of potentially problematic issues:

- Diabetic men often have problems with erection and ejaculation. Presumably if you have a problem with erection, you're already well aware of it, but ejaculatory issues may not be quite as obvious. Retrograde ejaculation, where sperm get pushed into the bladder rather than out through the urethra, can affect diabetic men.
- Men who take high-blood-pressure medications called calcium channel blockers may have sperm that don't penetrate eggs well; other blood pressure medications may cause retrograde ejaculation.
- Toxins common to the workplace, such as lead, X-rays, inhaled anesthetics in the operating room, and a host of other environmentally damaging substances can also be damaging your internal plumbing if you work with them frequently.
- STDs can also take their toll on the male reproductive system. Chlamydia and gonorrhea can cause an infection and inflammation in the epididymis, part of the testes where sperm develop. Syphilis can cause low sperm count and poor motility.

Assessing lifestyle choices that affect eggs and sperm

You can impact your chances of pregnancy every month with your lifestyle choices. Yes, giving up bad habits is painful, but not getting pregnant month after month is pretty painful, too. Take the step of cutting the following bad habits out of your life before you start trying to get pregnant.

Smoking

Smoking can affect sperm and eggs and increase miscarriage rates. Nearly one in four adults smoke in America. If either of you is a smoker, quit for at least a few months before trying to get pregnant. It may help you avoid these pitfalls:

- Smokers have sperm that are less motile (capable of moving spontaneously). They have a long way to go to reach the egg, so they need all the motility they can get.
- Smokers have lower sperm counts and more abnormally shaped sperm, which are chromosomally abnormal.
- Female smokers have more eggs that are chromosomally abnormal.

- Female smokers have a 50 percent higher rate of miscarriage.
- Smokers are two to four times more likely to have ectopic pregnancy, pregnancy that implants outside the uterus.

Drinking alcohol

Alcohol has far-reaching issues for the fetus long past the moment of conception, so cutting out alcohol before trying to get pregnant and avoiding it like the plague after getting pregnant are essential for your partner. It won't hurt you, either. Heavy drinking, three or more drinks a day for a guy, can decrease sperm quantity and quality. And a drink doesn't have to be hard liquor; one beer is a drink.

Using drugs

Two commonly used drugs can affect male fertility: marijuana and anabolic steroids. Marijuana lowers testosterone levels in males, and testosterone is the male hormone responsible for male sexual functioning and sperm production. Sperm counts are lower and sperm is less motile in men who use marijuana regularly.

Steroid use is more common than you may think: 6 to 7 percent of all men have used steroids to build muscle mass. Steroids suppress testosterone production and can cause irreversible damage to the sperm production line. Avoid anabolic steroids at all costs.

Maintaining an unhealthy weight

Unfortunately, being overweight is a huge problem, and it's getting bigger all the time. Around 20 percent of women of childbearing age in the United States are obese. Women who are overweight may not ovulate, and if they don't ovulate, they can't get pregnant. One Australian study showed that obese women were only half as likely to get pregnant as normal-weight women.

However, being underweight can also interfere with ovulation. Overall, 12 percent of infertility issues are related to being over- or underweight. Fortunately, either losing or gaining weight in these cases results in pregnancy 70 percent of the time.

Issues that may never have crossed your mind

Sometimes behaviors you may never have considered can negatively impact your chances of pregnancy. Here are a few:

- **Douching:** Although between one-third to one-half of childbearing age women do it, it's not only unnecessary, it's potentially harmful. Women who douche are 73 percent more likely to have pelvic inflammatory disease, which can seriously damage the fallopian tubes and increases the chance of ectopic pregnancy by about the same percentage.

And because you want your partner around for a long time, remind her of this statistic: Women who douche are 80 percent more likely to develop cervical cancer.

- **Not sitting on the couch enough:** No, not really — some exercise is definitely good for you. But some sports, like bicycling, may cause testicular damage from the pressure of the bike seat. Women who exercise too heavily may stop having periods (called *amenorrhea*), and good luck getting pregnant without them.
- **Spending time in hot tubs and other heat sources:** Hot tubs, tight underwear, saunas, steam rooms, and anything else that raises the temperature of the testicles is bad for the boys. Hot tubs may also damage eggs and increase miscarriage rates, so neither of you should be lolling in the hot tub.

Keeping Sex from Becoming a Chore

As unfathomable as it seems, sex while trying to conceive isn't always fun. Couples often begin to feel a sense of duty and pressure when they segue from spontaneity to planning exactly when to have sex to increase chances of conception. Monitoring rises in body temperature, charting mucus, and even lying down afterward to give the semen time to do its job are just a few of the unromantic actions that can take your sex life from crackin' to clinical.

Pleasure may seem to take a back seat to the goal of having a baby, and nothing takes the "sexy" out of sex faster than making it feel like work. In fact, if the sex becomes solely about trying to conceive, you may begin to feel a bit like a sperm-producing machine that's only needed during ovulation, and performance issues can arise (no pun intended).

If for some reason conception takes a while, this feeling will only increase as you both grow impatient. If you begin to suffer these feelings, share them with your partner immediately. Plan "sex dates" that don't revolve around conception time and discuss ways to create a more relaxing, less stressful, romantic environment.

Choosing the best time for conception

We're not talking about the phase of the moon or the alignment of the stars here; we're talking about planning to have sex at certain times to increase the odds that you'll hit the day when an egg is present and ready to be fertilized. Not all women have 28-day menstrual cycles, and ovulation doesn't always occur on day 14 of the cycle. Ovulation does always occur 12 to 14 days before the

next period is due, or, to be more accurate, your partner's period starts 12 to 14 days after ovulation occurs. You can figure out the best timing for your conception efforts in several ways, which we explore in the following sections.

Monitoring ovulation with a kit

Predicting ovulation doesn't take mind-reading abilities. Simple observation and a few ovulation predictor kits from the pharmacy are all you need to pinpoint the big day. Ovulation predictor kits (OPK) pinpoint the rise in luteinizing hormone that occurs just before egg release. Your partner urinates into a cup, and then dips the test stick into the urine and reads the results.

The only drawback to OPKs is that women who have high levels of LH normally, like women in or near menopause and women with PCOS, may not get accurate results.

Watching for physical signs of ovulation

Your partner may also be able to tell when ovulation occurs by these signs:

- Cervical mucus becomes more copious, thinner, and more slippery and stretchy as ovulation approaches.
- She may have *mittelschmerz,* a pain on the left or right side as the egg releases from the ovary.
- Her temperature drops slightly right before ovulation and rises afterward.

Ovulation can be tracked by keeping a monthly temperature chart, but it can be a real pain because she has to take her temperature first thing in the morning, before she gets out of bed, uses the bathroom, or has a cup of coffee.

Catching ovulation with a regular visit

If you don't want to closely monitor ovulation, you can take the easy way and simply have sex on a frequent, regular schedule. Doctors seem to have differing opinions on how much sex is enough when you're trying to get pregnant. Some say every other day helps build up a good supply of sperm; some say every day is okay starting a few days before ovulation and continuing (if you're not dead yet) until the day after ovulation.

The most sensible schedule suggests having sex every other day, all month if you're up for it, starting right after her period ends. Since sperm live for up to 5 days, having sex the day before ovulation or the day of gives you a good shot at fertilization, and if you're aiming for every other day, you're bound to hit one or the other.

Looking at do's and don'ts for scheduling sex

Just because you've written sex down on your calendar doesn't mean it's just another obligation that eats up your time and lacks excitement. After all, this appointment has a far bigger upside than the average visit to the dentist.

Since you have only a few ideal times each month to conceive, you need to make time for sex on those days, which requires planning ahead. Follow these do's and don'ts to make sure your sex life doesn't suffer for the sake of conception.

Do:

- **Put it on your calendar.** While it may seem unsexy, it can be very exciting to look forward to intercourse all week. In fact, verbal foreplay leading up to intercourse will only increase the excitement.
- **Plan a date that night if possible to make it a full-fledged romantic evening.** Making it just about the sex will increase the pressure to perform.
- **Engage in foreplay.** On TV and in movies, you often see the ovulating woman demand sex the minute her body temperature leads her to believe it's the best time. Make sure to keep it romantic and intimate. Some light massage, touching, and kissing should do the trick.
- **Mix it up.** Remember that though some positions are supposed to be better when trying to conceive, that doesn't mean you have to stay in the same one the whole time.
- **Keep it spontaneous.** Knowing the exact date you're going to have sex doesn't mean the setting has to stay the same. Play music, light candles, take a warm bath (not too hot — remember, you don't want to overheat the boys!), or even play out a fantasy if your partner is onboard.
- **Help make the aftermath enjoyable.** Your partner may want to elevate her legs and stay in bed for a while after intercourse to give the semen the best chance to stay put. Help her elevate her legs, and then put on her favorite show or read to her from a book. Don't just get up and leave her alone.
- **Have unscheduled sex.** Letting nature run its course every once and a while is okay, even when your road to conception is more like driving in bumper-to-bumper traffic than the autobahn. After ejaculation, sperm can live in a woman's reproductive tract for up to five days.

Don't:

- **Try too hard.** Sex carries its own set of complex, anxiety-inducing expectations, but now that the expectations include creating a baby, the pressure can become downright overwhelming. If you experience performance issues, either mental or physical, due to the stress of the moment, talk it out with your partner. You won't do anyone a favor by having sex as if you're taking the SAT.
- **Talk about the baby.** Unless talking about getting her pregnant is a turn-on to your partner, keep the baby discussion out of the sex equation. Although trying to have a baby does indeed require sex, talking about getting her pregnant while engaging in intercourse likely won't set your bedroom on fire.
- **Drink before you have sex.** Alcohol can cause performance issues, and the last thing you want to do is let your partner down because you had one too many beers.
- **Assume your partner isn't interested in both pleasure and conception.** In fact, studies show that women who orgasm have a greater chance of conceiving than those who don't.
- **Make her laugh afterward.** Keeping a good sense of humor during sex is always a good thing, but after you ejaculate keep the comedy to a minimum. Laughing tenses muscles that cause the semen to come out, reducing the chance of conception.

Taking a Brief Yet Important Look at Infertility

Infertility is an issue that affects more than 7 million people in the United States, but not getting pregnant within a month or two doesn't necessarily mean you're infertile. Couples under the age of 35 are diagnosed with infertility following 12 months of attempted reproduction that do not yield a pregnancy.

Knowing the facts about infertility

Imagine 100 average couples under the age of 35 trying to get pregnant — the following outcomes are expected:

- 75 couples are pregnant within a year.
- 10 couples are pregnant after two years of trying without medical intervention.
- 10 couples need treatment from an infertility specialist in order to conceive.

Causes of infertility can be complex and often hard to diagnose. Some are related to health and lifestyle issues discussed in the section "Evaluating Health to Get Ready for Parenthood" in this chapter. Despite treatments and diagnostic practices that primarily focus on women, the statistics paint a different picture:

- One-third of infertility is diagnosed as female-factor.
- One-third of infertility is diagnosed as male-factor.
- Between 10 and 15 percent of infertility cases are diagnosed as a combination of male- and female-factor.
- About 20 percent of infertility cases are unexplained following diagnostic testing.

For women, the main causes of infertility are

- **Ovulatory disorders:** No ovulation or ovulation on an irregular schedule
- **Tubal disorders:** Fallopian tubes are blocked or have an infection that interferes with ovulation or sperm travel
- **Uterine issues:** Fibroids (noncancerous tumors in the uterus) and polyps (growths that can cause blockages)

For men, the main causes of infertility are

- **Low sperm count:** Not enough guys to get the job done
- **Decreased sperm motility:** The sperm has trouble moving forward into the fallopian tubes
- **Abnormally shaped sperm:** Abnormal shapes usually indicate chromosomal abnormalities
- **No sperm present in the ejaculate:** A blockage somewhere in the reproductive tract or hormonal disorders can cause an absence of sperm

Checking on potential problems when nothing's happening

For many couples, the first step toward fixing infertility is admitting that you're having a problem. It's not an easy revelation to make, because it means that at some basic level your bodies are failing you. Fertility problems aren't fair, they're not fun, and they can be cause for a wide array of emotions, frustrations, and outright anger.

The good news is that we live in an age in which getting pregnant doesn't have to be a simple matter of the birds and the bees.

Throw in a doctor or two, and you may be well on your way to conceiving in no time flat.

If you're not getting pregnant after a few months, especially if your partner is older than 35, it's time to check things out — for both of you. For her, this may involve the following tests:

- **Blood tests:** These check hormone levels, including follicle stimulating hormone, or FSH. FSH levels are normally below 9 mIU/ml on day two or three of the menstrual cycle; higher levels indicate decreased ovarian reserve and the possible need for medical intervention.
- **Hysterosalpingogram (HSG):** This test injects dye into the uterus through a catheter placed through the cervix. The dye outlines the shape of the uterus and fallopian tubes. HSG can identify blockages in or dilation of the fallopian tubes that interferes with embryo transport, and it also shows fibroids and polyps in the uterus, which may interfere with implantation.
- **Hysteroscopy:** This test uses an endoscope, a sort of mini-telescope, to evaluate the uterus for fibroids or polyps, small growths that can interfere with implantation. Small fibroids and polyps can also be removed at the time of the test.

For you, it's a quick trip to the urologist for a full physical, blood work, and a semen analysis. This is the only way you can find out your sperm count and the quality and motility of your sperm.

Collection of semen is just as uncomfortable as it sounds, but it must be done. Just keep your expectations to a minimum and forget all of those movie scenes showing posh rooms, dirty magazines, and absolute privacy. If you have to produce in the doctor's office or a hospital lab, you may very well find yourself in a bathroom, unable to escape the distractions of screaming children and the witty banter of the nursing staff.

Some offices allow specimens to be collected in the privacy of your home and then delivered to the lab within an hour. Ask your doctor about this alternative, as well as any special instructions for collection and transportation.

Working through it when your partner needs treatment

Some female fertility issues are easily dealt with by simply taking a pill that induces ovulation. But female infertility can also lead to daily injections of fertility medications, uncomfortable vaginal

ultrasounds to assess egg development, painful surgeries to remove fibroids or repair damaged fallopian tubes, and frequent blood tests.

Fixing female fertility issues can be a drawn-out affair that combines inconvenient and uncomfortable procedures with medications that manipulate hormones, a difficult combination if there ever was one. And if she suddenly views childbearing as a woman's most important prerogative, her seeming inability to accomplish it and subsequent emotions can make fertility treatment a tough time for both of you.

Even though you may have your own stresses when dealing with fertility issues, remember that at least you aren't dealing with a barrage of excess hormones, and keep your cool if conversations get complicated.

Exploring solutions when your sperm don't stack up

A count of less than 20 million is considered a low sperm count. Although that may sound like a large number, due to the number of abnormal sperm in the normal sample as well as the distance required to reach the egg, it takes a lot of good sperm to achieve conception.

Sperm is produced on a cycle, so the semen you produce now actually was created three months ago. If your sperm count is low, start by thinking back to what was going on then. An illness, medications, or a hot-tub vacation may be the culprit.

Learning the components

What exactly makes a semen specimen normal? The following guidelines from the World Health Organization (WHO) are deemed the ideal for baby making:

- **Volume:** About 1.5 to 5 milliliters of semen should be present in a single ejaculate, equaling about a teaspoon.
- **Concentration:** Strength in numbers is key. You'll need at least 20 million sperm per milliliter of ejaculate to hit the normal range.
- **Motility:** For every man, an average ejaculate contains dead, slow, and immobile sperm. However, at least 40 percent of your sperm in a single sample should be moving.
- **Morphology:** Shape is also important to reproduction, and the lab technician examining your sample takes a close look at

how many of your swimmers are normally shaped. A normal amount of normally shaped sperm is considered to be anything above 30 percent.

- **Trajectory:** Graded on a four-point scale, this test determines how many of your sperm are moving forward. You're looking for a score of 2+ to be considered normal.
- **White blood cells:** Too many white blood cells can indicate an infection in your groin. A passing grade is no more than 0 to 5 per power field.
- **Hyperviscosity:** Your semen sample should liquefy within 30 minutes after ejaculation. If it takes longer, it reduces the chances for sperm to swim before being expelled from the vagina.
- **pH:** Like a AA battery, your semen needs to be alkaline in order to avoid making the vagina too acidic and, ultimately, killing the sperm.

In addition to the above, a semen analysis evaluates the following:

- **Head quality:** The head of the sperm contains all of the genetic material, so if the head is misshapen, it won't be capable of fertilizing an egg.
- **Midsection malaise:** Believe it or not, this part of your sperm contains fructose, which gives your sperm energy to swim. If the levels are low, it can account for slow swimmers.
- **Tail troubles:** Much like a fish, a good tail is required for the sperm to swim forward. If too many of your sperm have no tail, multiple tails, or tails that are coiled or kinked, they won't reach their destination.

A low sperm count may have you feeling, well, downright low. Feeling embarrassed is completely natural but also completely unnecessary. Infertility has no correlation to a man's masculinity, nor does it have anything to do with the size of his penis. Having a low sperm count is no different than having asthma — it's a medical condition that requires treatment.

Identifying and treating the causes

Because sperm counts are created months out, you'll need to have a follow-up semen analysis to see if the issue is corrected by lifestyle changes. Although you won't be in a rush to do it all again anytime soon, whether your results are good or bad, schedule a follow-up analysis four to six weeks after the first one to get a better, more complete picture.

The most common cause of a low sperm count is a *varicocele,* an abnormality in the vein in your scrotum that drains the testicles. Varicoceles can cause decreased fertility in the following ways:

- Increasing temperature in the testes
- Decreasing blood flow around the testicles
- Slowing sperm production and motility

Varicoceles are treatable in the following ways:

- **Surgery:** An outpatient procedure during which an incision is made just above the groin and the swollen vein is "tied off." Recovery takes seven to ten days and requires minimal activity and no heavy lifting. Risks are minimal and include infection, nerve injury, and the collection of fluid around the testicles.
- **Radiographic embolization:** Also an outpatient procedure, this requires the insertion of a catheter through the femoral vein in the groin. Dye is injected to show where the problem is located and, when isolated, it's blocked so blood flow to that vein stops.

Other less-common male-fertility issues include the following:

- **Hormone imbalances:** Medications to adjust hormone levels may improve sperm quantity.
- **Chromosomal abnormalities:** One such problem is sperm that lack part of the Y chromosome, the male chromosome. *In vitro fertilization* (IVF) and *intracycloplasmic sperm injection* (ICSI), where the best-looking sperm are injected directly into your partner's egg in the lab, can help overcome abnormal sperm issues. (See the following section for more info.)
- **History of cancer:** Having treatment for cancer, including lymphoma and testicular cancer, can kill or damage sperm. Many men freeze sperm before undergoing cancer treatment for this reason.
- **Various diseases:** Diabetes, sickle cell disease, and kidney and liver diseases can cause problems. Treatment depends on your individual issues.

Even if your ejaculate has no sperm at all, a procedure called a *sperm aspiration* in conjunction with an IVF cycle may be able to remove sperm directly from the testicles.

Deciding how far to go to get pregnant

Deciding what steps you're willing to take in order to get pregnant will be easier after you have a better understanding of the infertility issues you and your partner are facing. Most infertility treatments can be quite expensive, so check with your insurance company to see what is covered. Making the decision based on finances seems heartless, but if your insurance doesn't cover a treatment or medicines, you can be looking at bills in the thousands of dollars.

The most common procedures to aid in pregnancy are the following:

- **Intrauterine insemination (IUI):** A lab tech takes your sperm sample, pulls out the best of the best, and adds it to a saline solution, which then is inserted past your partner's cervix. This gives the sperm a far shorter distance to travel and a greater chance for success.
- **In vitro fertilization (IVF):** Sperm meets egg in a lab, and then the fertilized embryo is placed into the womb. Fertilization can take place by either placing a concentrated semen sample in a dish with the egg or via *ICSI*, intracytoplasmic sperm injection. In ICSI, a single sperm is injected directly into a mature egg. Even with ICSI, fertilization may not occur, because the egg or sperm may be chromosomally abnormal, which in some cases isn't evident just by looking at it.

Try not to make too many long-term decisions about how far you're willing to go, because undergoing fertility treatments is like riding a roller coaster, and once you're on, it becomes harder to get off. Especially when it feels like your baby could be just around the next corner. Make decisions month-to-month and procedure-to-procedure to avoid stress and allow for an open, ever-changing dialogue with your partner.

Sharing Your Decision to Have a Baby

Deciding to try to have a baby is a very big, very exciting step for most couples, and increasingly it is something many people choose to share with a select group of friends and family members. News of an expanding family is usually met with joy, cheers, and even a few inappropriate jokes about your sex life. But although

sharing good news is fun, you also need to be prepared for people in the know to ask nosy questions and offer unwanted advice.

Considering the pros and cons of spilling the beans

Sharing the news means that you're turning your quest to have a baby into a mini-reality show that your loved ones are going to closely follow. Having a well of support during this time can be great, but having your mom and dad hinting for info every time you talk on the phone also can feel intrusive.

If getting pregnant takes longer than expected, you're also setting yourself up to have to deal with the inevitable questions about the delay. On the plus side, if you and your partner must deal with infertility, you'll need all the support you can muster.

Just make sure you're both ready to continue sharing information and dealing with questions from the people you tell. Once their curiosity is piqued and their excitement sparked, there's no turning back. (Especially for a first-time grandmother-to-be.)

Handling unsolicited advice about reproduction

You may think you've got a handle on lovemaking, but after you announce to the world that you're trying to have a baby, it may seem like all the folks in your life suddenly morph into Dr. Ruth.

Now that reproduction is fodder for morning news programs and countless blogs and Internet sites, more people have more sound bites and nuggets of wisdom to offer you and your partner than ever before. If your mother tells your partner she shouldn't be eating that grilled hamburger because the *Today* show said so, or telling you that you really should be wearing boxers instead of briefs, you may find yourself at wit's end before you even make it to the bedroom.

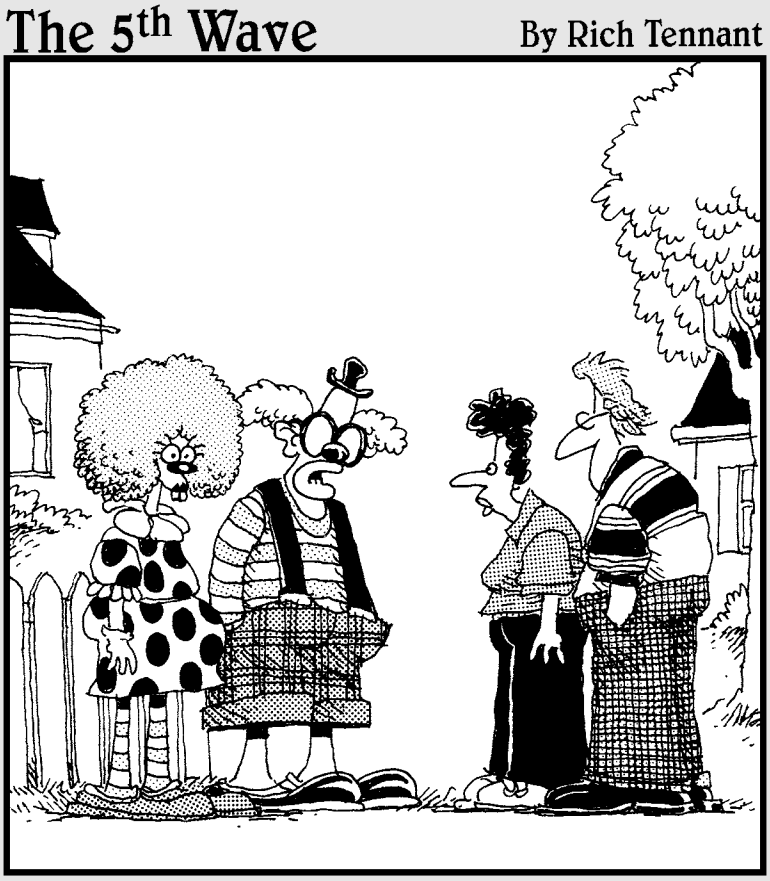
If your loved ones start interfering or offering advice that you don't want, thank them for their excitement and interest, but reassure them that you have the situation under control. Remind them that people have been having babies forever and let them know that being bombarded with all this information, be it from them, the TV, or the newspaper, stresses out you and your partner, and that can decrease your chances of conception.

Not all unsolicited advice is about the act of having sex. Some people may think you're too young or too old to have kids. Your parents may chime in about how expensive kids are, implying that you're not financially ready to have a baby. Perhaps your stressed-out brother (and father of three) tells you to enjoy your freedom while you still can.

Whether somebody thinks you're too immature to be a father because you still play Xbox or that your wife's job is too demanding for her to be a mother, remember that the only voices that matter are yours and your partner's.

Part II

Great Expectations: Nine Months and Counting



"We're going to stick to a more traditional name for the baby–'Chuckles,' 'Zippy,' something like that."

In this part...

After you've gotten past conception, a whole new field of emotions, experiences, and concerns pops up. From the sometimes uncomfortable moments of early and late pregnancy to the thrills of hearing the baby's heartbeat and seeing the first ultrasound pictures, pregnancy is a roller coaster ride like no other. This part takes you from the positive pregnancy test to delivery options, covering every aspect of fetal and maternal growth as well as the all-consuming questions of what kind of stroller and car seat to buy.

Chapter 3

Surviving Sudden Doubts and Morning Sickness: The First Trimester

In This Chapter

- Getting the news that your partner is pregnant
- Finding a doctor and attending important appointments
- Taking a look at fetal growth in early pregnancy
- Understanding the complications that can arise
- Taking on the role of a supportive partner

Few new fathers-to-be actually pass out when they get the big news that there's a baby in their future, despite what you see on old television shows. That's not to say you may not feel a bit blown away by the news, though. Whether you've been trying for ten years or just met your partner last month, hearing that you're about to be a dad is life changing.

Early pregnancy is not without its physical, mental, and emotional challenges, and although your partner bears the brunt of it, you can expect to experience a few symptoms, too. In this chapter we tell you what happens in the first few months and help you adjust to one of the biggest events in your life.

Baby on Board: It's Official!

Nothing is more momentous than hearing from your partner, "It's positive! I'm pregnant!" If you've been trying to get pregnant for a while, these words are your cue to breathe a sigh of relief — your boys can swim! In fact, you may feel more relief than excitement at first. Trying to get pregnant can be quite stressful, as we discuss in Chapter 2, and the news that your worst fears can be put aside is reason for relief.

On the other hand, if this was a big "oops" on your part — and many pregnancies are, even in this day and age — your first reaction may be more like, "Oh . . . heck," or worse. Don't feel guilty if your first reaction is negative; most of the world's babies were an "Oh, heck" at one time. In many cases pregnancy takes time to get used to.

Reacting when your partner breaks the news

When your partner tells you the big news, try to mirror her reaction, at least outwardly. If her reaction is, "Oh . . . heck," you can go along in that vein also, at least for a minute or two. Remember, though, that she is gauging your reaction to the news, and if you act like having a baby is a huge imposition in your life, she's going to be really upset, even if she just said the same things five minutes before.

So try to throw in a few encouraging statements about how you wanted kids eventually, having a baby will be fun in the winter when there's nothing else to do, or whatever encouraging babble you can come up with at a stressful time.

Some women get very creative with their announcements, from filling the living room with balloons to baking a cake with a pair of booties inside. Just try to not choke on one, literally or figuratively. If she's gone all out to break the news, you can safely bet that she's really excited, so make sure she knows you feel the same way.

Even if you've been trying to conceive forever, an initial fear reaction isn't uncommon. Remember that your partner may also be feeling some sudden doubts and fears, and allow her to express them. Under no circumstances is "We spent $20,000 for fertility treatments and now you're not sure this is the right time?!" the right response to her feelings of concern.

Making the announcement to friends and family

Deciding when to tell family and friends is tricky. On one hand, telling on the first day of the missed period makes the pregnancy seem about 15 months long, and telling early means you'll need to go through the grief of telling everyone if a miscarriage occurs, which happens in around 20 percent of pregnancies.

On the other hand, you may have told people you're trying, and they may be obsessively counting the minutes until your partner

can take a pregnancy test, too. If that's the case, saying, "Gee, we don't know yet; we forgot to do the test" is going to come across as a big insult, and "We've decided not to tell anyone" will probably get you thrown out of the will. If you've been going through fertility treatment, you may feel the need to tell your fertility friends right away, because they know exactly when your embryo transfer and pregnancy test took place.

If you've already had to deal with a miscarriage, you may be understandably more reluctant to tell people in the first trimester. Nearly all miscarriages occur in the first 12 weeks of pregnancy, and most of those occur before 8 weeks, so waiting until you're pretty sure the pregnancy is going well may be prudent.

Whenever and whoever you decide to tell, realize that keeping news this big to yourself is hard. Even if you and your partner make a solemn pact not to tell a soul until after the first ultrasound, don't be shocked and disappointed to find out she's already told her best friend, mother, and entire online support group. In fact, she may have told them before she told *you*. Be understanding, and sheepishly admit you secretly told your parents, the guys at the gym, and half your co-workers, too.

Overcoming your fears of being a father

You have a lot of time to get used to the idea of being a dad, so don't worry if you have a lot of fears at first. Even if you aren't sure you're ready to become a father, you'll be surprised how quickly you come around to the idea. Besides, the baby will be here before you know it, ready or not.

When to tell work

For you, letting your work know that you're a father-to-be may not be such a big deal, because many workplaces still don't have any sort of daddy maternity plan. If yours does, though, let your boss know after the first three months, when you're reasonably sure things will go well with the pregnancy.

If your partner is working and dealing with a lot of nausea or other pregnancy issues, the secret may be out earlier. The boss may not figure it out, but her co-workers may.

It's important, however, to use this time to confront any fears about parenting that you may have. Spend time with the male role models from your past (and present!) and use them as learning tools. Ask them what they did right, what they would change, and what advice they have for you when raising your own child. It may feel like you're the first father ever, but you don't need to reinvent the wheel when it comes to parenting. If you admire someone else's skills, monitor and mimic their behaviors.

Working on overcoming your fatherhood fears is doubly important if the father in your life wasn't the best role model for the type of dad you want to be to your son or daughter. To attempt to come to terms with any wrongdoings your father may have committed, talk with a counselor or therapist, or even a trusted friend, about your relationship with your father and try to identify the mistakes you don't want to repeat. Talking about your experience with your own father can also help heal some of the emotional wounds. Being a father is hard work, and you don't want to wait until after the baby arrives to start overcoming your fears or past traumas.

Finding a Practitioner Who Thinks Like You

When we talk about finding the right medical practitioner, we're not talking personality, although that's important, too. Finding the right pregnancy "partner" primarily means finding someone whose basic philosophies on pregnancy and birth are similar to yours, so that you don't find yourself debating every single pregnancy and birthing decision with your partner's practitioner.

Medical practitioners' views can vary tremendously on every facet of pregnancy, from medication in labor to the vitamins your partner should take, so make sure you're all in agreement on the biggies before signing up for nine months of visits.

Finding a doctor who works for both of you

Finding a medical practitioner who both of you like and trust isn't as easy as looking in the phone book for the first obstetrician listed under *A*. For one thing, many women already see a gynecologist for routine care. However, not all gynecologists deliver babies; as they age, they often choose to stop doing the middle-of–the-night phone calls and races in to the hospital and just do gynecology.

The situation can get sticky if your partner's gynecologist doesn't do OB (obstetrics) but her partners do, and your partner can't stand the gynecologist's partners. Or you're thinking about a hospital birth, but you find out her gynecologist has the highest cesarean section rate in the city. Or, in some cases, you and your partner may opt for a low-tech birth and want to use a midwife for the pregnancy and delivery. If your partner has been seeing her current gynecologist since she was 13, she may be concerned about hurting his feelings by seeing someone else during her pregnancy.

Your partner and you, if you go to the appointments, will be seeing a lot of the person who's going to deliver your baby over the next eight months, so being comfortable with each other is essential. Chapter 8 contains a list of interrogations — err, questions you want to ask your prospective medical partner before planning on spending the most important occasion of your life with her. In addition, keep the following tips in mind:

- **Doctor shopping is not a sin.** Your insurance company may refuse to pay for visits to several doctors, but if you can afford it, you may want to see a few to decide who works best for you. The office mood, the length of time you wait, and the answers you get to your pointed questions can give you a much better idea of who to choose than just going with a friend's recommendation or the information you find on the Internet.
- **Find out where your practitioner delivers.** Next to how much you like your practitioner, how much you like the birthing facility is the most important thing.
- **Ask who covers when your practitioner is off.** Even the best doctors and midwives take vacation and get sick, and getting the partner you really dislike for your delivery can make the birth a bit stressful (although in the end you'll have the same baby you were going to end up with anyway, no matter who delivers him).
- **Discuss birthing options right upfront.** While this conversation may seem premature, the day your partner's water breaks is no time to find out that bed rest–labor induction–epidural and a 50 percent rate of cesarean sections is your practitioner's standard labor plan. Asking about a doctor's rate of cesarean, for example, can give you insight into his practices. Throwing out a few questions about water birth or unmedicated delivery can also allow you to gauge his feelings by his response.

If you want a midwife delivery, you may be extremely limited in choices if you don't live near a large city. Some hospitals have

midwives who run clinics but don't do private practice, which may not be what you want. If you can't find a midwife, look for an obstetrician who treats childbirth more like a natural event than a pathology.

While you want to be involved, this is not your show. Let your partner ask the questions and remember that she makes the final decision on who she feels most comfortable spending the next nine months with.

Attending the first of many prenatal visits

Many dads now attend prenatal visits, in stark contrast to the dark ages before 1970 when fathers never went near the obstetricians — or the labor room, either.

This is what you can expect during the first prenatal appointment:

- **A vaginal exam:** Many guys are not comfortable watching their partner undergo a vaginal exam. Discuss this with your partner before you go, because it will definitely happen.
- **A pregnancy test:** Blood may be drawn for specific pregnancy levels, or a simple urine test may be done, even if she's already had a positive home test.
- **Blood tests:** Your partner's blood will be drawn to determine the blood type and check for certain diseases, such as HIV and syphilis, which can impact the baby. A complete blood count, or CBC, to check for anemia will also be done.
- **Time to talk:** Your practitioner or the ancillary staff will go over the prenatal schedule, prescribe vitamins, and discuss your specific concerns. Because obstetricians, like other doctors, often seem to have one foot out the door even in the middle of important discussions, make sure you pipe up and ask about what's important to you.

The first prenatal appointment is the longest one and is probably the most important one for you to attend, so if you're going to have trouble getting to a lot of appointments, make sure you're at this one if at all possible. The later appointments are often so short you may wonder why she has to go at all, but rest assured that doing a few simple tests can prevent big-time problems.

Going to the first ultrasound

Your partner's practitioner may decide to do an ultrasound in the first few weeks, often as part of the first OB appointment,

especially if she has any vaginal bleeding, the time of conception hasn't been determined, or if your partner did fertility treatments. Ultrasounds are done at the doctor's office, hospital, or radiology office. Even though you won't see much, seeing that "something" is in there is still a thrill! If you can get to this appointment, go. You may even get to see the tiny heartbeat flicker if your partner is six-plus weeks pregnant.

Baby's Development during the First Trimester

When the embryo first implants in the uterus, about a week before a menstrual period is missed, it's too small to be seen without a microscope. Within a week, though, the first signs of pregnancy can be seen via vaginal ultrasound. While the embryo still isn't discernable, the gestational sac that surrounds him shows up as a small black dot. From this point on, fetal growth is an astounding miracle.

He may not look like much now, but . . .

In six weeks your baby embryo grows from a ball of cells to a recognizable creature, although the exact species is difficult to define. Following are the changes that occur in the first six weeks of pregnancy, which include the first four weeks, the time from the last menstrual period to the first missed period.

- **Week 2:** Egg and sperm meet, usually in the middle of the fallopian tube. The zygote formed by the union of egg and sperm drifts down to the uterus over several days.
- **Week 3:** Implantation occurs 7 to 12 days after fertilization. There may be a small amount of *implantation bleeding* as the embryo burrows into the uterine lining.
- **Week 4:** The menstrual period is missed. A pregnancy test, which detects minute amounts of *human chorionic gonadoptropin,* or hCG, may be positive as early as week 4. On ultrasound, a small dark spot, the gestational sac, may be seen. The embryonic cells divide into two sections during this week, one that will become the embryo and one that will become the placenta.
- **Week 5:** The yolk sac, which nourishes the embryo before the placenta forms, may be visible next to the gestational sac on ultrasound. The embryo now consists of three layers that will develop into different areas of the body.

- **Week 6:** During this week, the embryo looks like a bent-over bean with a slight curve at the end. The heart is still a primitive tube, but a flickering heartbeat can be seen on ultrasound as blood begins to circulate. Arm and leg buds are sprouting, and the eyes, ears, and mouth begin to form, although they're still a long way from a finished product at this point.

Amazing changes in weeks 7 to 12

Although few people would says, "Yes, sir, that's my baby" by week 6, between weeks 7 and 12 the embryo really starts to look human (take a look at Figure 3-1).

- **Week 7:** In week 7, the baby is huge — around the size of a blueberry! At least he's something you could see with your own two eyes, and it's a 10,000-times increase over his original size. The brain and the internal organs are all growing, and the arms and legs have primitive hands and feet.

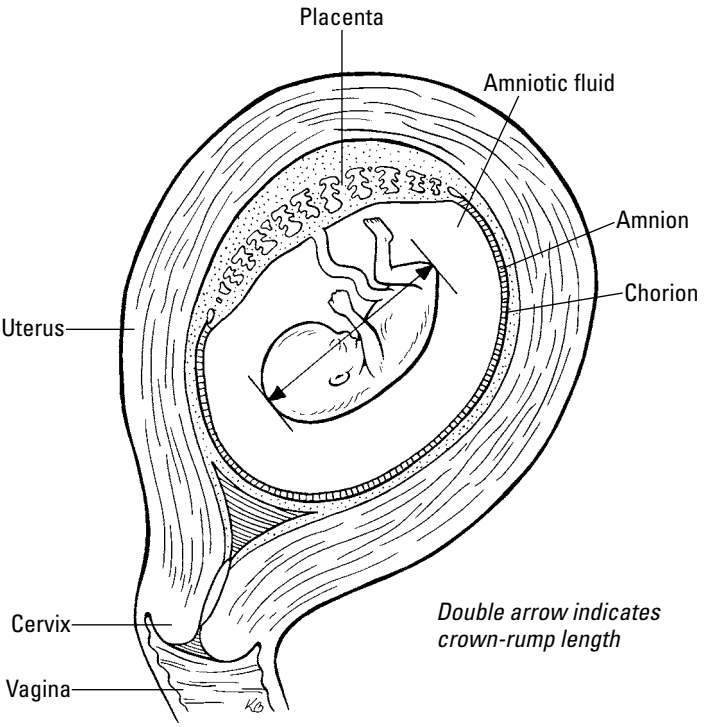


Figure 3-1: By the end of 12 weeks, the fetus actually looks like someone who just may be related to you.

- **Week 8:** Fingers and toes start to form, and the nervous system is starting to branch out. Those new limbs are moving, although it will be weeks before your partner can feel movement, even if she swears she's feeling it already.
- **Week 9:** The baby's heartbeat may be audible using a Doppler, which amplifies sound. You'll never forget the first time you hear that rapid beat and realize there's a real human attached to it.
- **Week 10:** The kid doesn't even have knees yet, and he's already forming teeth in his gums! He does have elbows, though, and knees aren't far behind.
- **Week 11:** Your 2-inch bundle of joy is beginning to look like a real miniature person, one who has brand-new fingernails and an admittedly large head.
- **Week 12:** The internal organs are growing so much that they protrude into the umbilical cord (they'll start moving back into the abdominal cavity shortly), and the baby is making urine.

Dealing with Possible Complications in the First Trimester

Although the majority of pregnancies really do go like clockwork, things can and do go wrong. In early pregnancy, the biggest threat is that of miscarriage. One in four women has a miscarriage at some point in her reproductive life. Another less common threat is an ectopic pregnancy. We discuss both miscarriages and ectopic pregnancies in this section and provide some tips for coping if you experience either of these complications.

Miscarrying in early pregnancy

Miscarriage is more common as women age, and though you may not consider your partner "old" if she's older than 40, Mother Nature does, at least for childbearing purposes. In fact, doctors used to refer to pregnant women older than 35 as "elderly." The reason that miscarriage increases with age is that her eggs, which have been hanging around since before she was born, have aged, and you can't put face cream on eggs and have them look younger. The good eggs get used up first, so the ones left are more likely to be chromosomally abnormal. Miscarriage rates by age break down like this:

- **Under age 35:** 15 percent
- **36 to 40:** 17 percent
- **41 to 45:** 34 percent
- **Older than 45:** 53 percent

Keep in mind that these are averages and that a woman's actual risk depends on many other health factors. These numbers describe the potential risk *after* a pregnancy is diagnosed. Before the first missed period, many pregnancies are lost when they start to implant but then stop growing, usually because they're chromosomally abnormal.

The symptoms of miscarriage are bleeding that becomes heavier over time, passing clots, and abdominal cramping. If your partner is newly pregnant, she may just have what seems like an unusually heavy period around the time of her period or shortly afterward. Pregnancies that end this early are often called *chemical pregnancies.*

Some women have spotty bleeding that isn't continuous, sometimes called a *threatened abortion.* (Abortion is the medical term for a miscarriage.) Some medical personnel still prescribe bed rest for women with spotting, although studies show it really doesn't change the risk of miscarriage.

The overwhelming number of miscarriages are caused by chromosomally abnormal embryos. You and your partner didn't cause the miscarriage, and you couldn't have prevented it. But although miscarriage is a natural event, it's still an emotional loss (to varying degrees for different people) and talking about how you feel is an important part of coping. Allow yourself and your partner to mourn the loss of the baby, no matter how early in the pregnancy it occurs.

Having one or two miscarriages doesn't increase the risk of it happening again, but women with three or more miscarriages should see a fertility specialist to determine the cause, if possible. Following are some of the possible causes of recurrent miscarriage (three or more losses):

- **Uterine abnormalities:** Fibroids, polyps, scar tissue, or congenital uterine malformations can prevent the pregnancy from implanting properly in 15 to 20 percent of recurrent miscarriage cases. Surgical correction of the abnormality may help.
- **Incompetent cervix:** An incompetent cervix dilates prematurely because it's been weakened by trauma or congenital deformities. Women whose moms took DES to help prevent miscarriage may have incompetent cervices. Miscarriage

usually occurs after 12 weeks. Incompetent cervices cause around 5 percent of recurrent miscarriages and can be treated by placing a stitch in the cervix to hold it closed.

- **Chromosomal abnormalities:** You or your partner may carry genes that are causing recurrent miscarriage. Genetic testing can help determine the cause.
- **Immune system problems:** Women who have autoimmune disease can have recurrent miscarriages. Treatment with medication may reduce pregnancy loss.
- **Low progesterone levels:** Sometimes progesterone levels are too low to sustain a pregnancy, and supplementation helps.

After a miscarriage, many women pass all the tissue and need no further medical care. Others need tissue surgically removed so it doesn't cause infection or continued bleeding. This procedure, called a *dilatation and curettage,* or D&C for short, is done as an outpatient procedure.

If your partner passes tissue, be sure to save it and take it to your medical practitioner so she can see that everything's been passed and possibly test to figure out what happened. When cramping intensifies, keep a clean container with a lid in the bathroom so you can collect any tissue as it passes. Take the tissue to your practitioner's office as soon as possible; keep the container in the refrigerator or follow your practitioner's instructions on where to take it if a miscarriage occurs during the weekend.

The miscarriage may be diagnosed afterwards as a *blighted ovum,* a pregnancy where the embryo stops developing and only the placenta grows. Blighted ovum is the most common type of chromosomally abnormal pregnancy. It can't be predicted or prevented; a certain percentage of embryos are chromosomally abnormal, and one blighted ovum doesn't mean problem will recur in the next pregnancy.

Understanding ectopic pregnancy

Sometimes a pregnancy implants in the fallopian tube, or rarely, in another location, such as the ovary, abdominal cavity, or cervix. A pregnancy that implants outside the uterus is called an *ectopic pregnancy.* Ectopic pregnancies are more common in women who have damaged fallopian tubes and occur in 1 in 100 pregnancies.

An ectopic pregnancy usually seems to be developing normally up until around seven weeks. An early pregnancy test is positive, but if an ultrasound is done, nothing shows up in the uterus. If the embryo is in the fallopian tube, the tube may appear distended.

If an ectopic is diagnosed early enough, medication to stop the pregnancy from growing can be given, which saves the tube or other implantation sites from being removed. The products of conception are absorbed naturally and don't need to be surgically removed if the drugs are given early enough and are effective.

Rarely, abdominal pregnancies have continued to the point where the baby reaches viability and can survive after delivery, but such cases are very rare.

When the ectopic pregnancy gets too far along, bleeding starts, and the tube is in danger of rupture. At this point, removal of the fallopian tube is the only way to prevent serious blood loss that may threaten the mother's life. An ectopic pregnancy cannot be removed and replanted elsewhere, so the embryo will be lost.

Signs of ectopic pregnancy in danger of rupture include slight bleeding, abdominal pain on one side, lightheadedness, shoulder pain, or passing out. Ectopic pregnancy is a life-threatening emergency. Get to the hospital immediately!

Coping with pregnancy loss

Losing any pregnancy can be devastating. Many people you tell won't make coping with the loss any easier with comments suggesting it was "for the best" or that "you'll have another one," either. Many people don't really see early pregnancy loss as something to grieve over and may not understand it's hitting you or your partner so hard.

In fact, one of you may not understand why the other is taking it so hard. Whether you're on the same page or not, be respectful of each other's feelings and give yourselves time to grieve. It can be gut-wrenching to attend christenings, family gatherings with lots of kids running around, or children's birthday parties during this time.

Don't try to handle what you're really not up for. If your partner doesn't want to go see your sister's new baby right now, run interference for her. Hopefully your sister will understand that this is a temporary situation, not a permanent rejection of her and your new niece or nephew.

Common First Trimester Discomforts — Yours and Hers

Early pregnancy can be uncomfortable — for both of you. Though your partner bears the brunt of it, the first three months of pregnancy

may bring some unwelcome changes into your life as well. Hang in there, though — it'll all be worth it in the end!

Helping your partner cope with the symptoms of early pregnancy

Early pregnancy brings extreme fatigue and the overwhelming desire to take a nap, food cravings, food aversions, nausea, vomiting, and a constant need to urinate. Not to mention hormonal changes that cause pendulum-like mood swings, from crying to euphoria almost before you can ask what's wrong.

Knowing the symptoms ahead of time helps you keep your cool when all around you seems to be falling to pieces. Following are more things you can do to help your partner through these first topsy-turvy months of pregnancy:

- **Let her rest.** Although sitting at home all weekend watching her take two naps a day may not seem like a whole lot of fun, use this time to get projects done around the house or catch up on your parenthood reading.
- **Help her.** Shoulder some of her chores for now, especially the ones that make her nauseated, such as cooking, garbage patrol, dishing out the dog food, and cleaning toilets. Remember that handling cat litter is strictly verboten for pregnant women, so that's your job, too.
- **Accept her limitations.** Maybe you went out to eat several times a week and now the sight of restaurants makes her sick. Hang in there. By the middle trimester she'll be eating everything in sight, and the Szechuan restaurant will still be there.
- **Don't take emotional outbursts seriously.** Not letting her outbursts get to you is hard when they're pointed at you and all your shortcomings, but listen to what she says, accept what may actually be true, and disregard the rest. Don't forget to fix any shortcomings you can, though.
- **Satisfy her cravings.** Not that many pregnant women really want pickles and ice cream, but if your partner does, get some for her. Try not to gag as you watch her eat them; you may have to leave the room yourself.
- **Plan pit stops.** If you're the type of driver who doesn't stop the car unless the road abruptly ends before you reach your destination, realize that pregnant women really do have to pee every five minutes; she's not making up an excuse to go in to the gas station shop for a frozen custard. Also, because blood volume increases during pregnancy, blood clots can

develop if she doesn't move her legs regularly. Let the woman get out of the car every few hours!

Getting used to strange new maternal habits

At times, you may look at your partner and wonder who this woman actually is. The sweet-tempered woman you once knew may have been replaced by someone whose head appears to be rotating at times, and the woman who used to party all night long barely makes it into the living room to collapse on the couch after work. You knew having a baby was going to change your life, but you probably didn't expect things to change this much so early in the game.

Take heart: These are temporary changes. After her body adjusts to the new hormone levels, many of the symptoms will decrease, and your original partner will start to emerge again.

In the meantime, some of her new habits may be impacting you in a big way, and you may need to find ways to cope with them. The following sections help you deal with a few of your least favorite early pregnancy things.

Vomiting

Although she's the one vomiting, sometimes you may not be far behind. Many people have a hard time dealing with vomit, whether it's their own or someone else's. If you have a sensitive stomach, hearing her heave may inspire the same reflex in you. Staying supportive while holding on to your own cookies can be difficult. You may want to try the following tips if the sight, sounds, and smell of vomiting are getting to you:

- **Dab something under your nose that smells good to you.** This really helps. Peppermint oil can get you through some tough moments. Nose plugs may also work, if your partner doesn't take offense at them. She probably doesn't want you to start vomiting too, so she may be okay with them.
- **Stay cool.** People are less likely to vomit when cool air is blowing on them, so turn the fan all the way up and get a small fan that can blow right on you. This may help keep your partner from vomiting, too.
- **Avoid trigger foods.** If certain things really get to her, make sure they don't enter your house, no matter how much you crave them.

Gaining weight

While weight gain isn't such a problem during the vomiting weeks, when the nausea ends, your partner may start eating like food is going to be taken off the market next week. This can be bad for her waistline, sure, but it can also be not so good for yours, since you may find yourself overeating just to keep up with her and matching her weight gain pound for pound. The woman who never let a chocolate-covered donut in the house may now be eating them by the cartload.

For both of your sakes, try to put a stop to the madness. You don't have to remind her how hard this weight is going to be to lose later; just talk about your own weight gain and how you're afraid you're not going to play frisbee on the beach with the kid if you keep eating like this. Don't turn into the food police; no one responds well to being told what they should and shouldn't eat.

Even if your pleas for healthier food choices don't get her out of the junk food aisle and back into the vegetable section, force yourself to cut back on the unhealthy foods. She's eating for two, but you aren't, although you may look like you are about halfway through the pregnancy. And, all kidding aside, that extra weight will interfere with your ball-playing and horsey-back-ride abilities down the road.

Coping with your cravings

If an active sex life was part of your semiweekly (or more) agenda, you may be in for a rough few weeks. Sex may be the last thing on her mind in the first trimester. And some types of sex may trigger her gag reflex, which is the last thing you want to associate with a previously enjoyable activity! While turning into a monk may not be on your list of fun things, you can cope with the words "Not tonight, honey" by

- **Experimenting with touching.** Depending on how open your partner is to experimentation, you can do a lot to pleasure each other that doesn't involve intercourse. In fact, this may be a great time to start understanding your partner sexually more than ever before. Find out what she's up for by taking it slow, working together to find comfortable positions and techniques, and by being supportive if at any moment she needs to stop.
- **Practicing self-release.** Masturbation isn't something most adults like to talk about, but if you have a voracious sexual appetite and both you and your partner are okay with the idea, there's no shame in taking the matter into your own hands, so to speak.

- **Watching her patterns.** If morning sex used to be your thing but her new thing is promptly vomiting every time she wakes up, shake things up. Try to engage in sexual activity at times of day when she's generally not tired, nauseated, or weepy.
- **Being flexible — this too shall pass.** Some women are ready for sex sooner than others, and for some, when the sex drive returns, it's strong. It may come and go throughout the day. Be ready to perform when your partner is ready, because the window of opportunity can be slammed shut before you've had a chance to look outside.

A desire to have sex is normal, and becoming frustrated during the time she isn't up for it doesn't make you a pig. Don't push the issue or make your partner feel bad about the lack of sex, but do let her know that you miss being with her and look forward to when she's up for having sex again. In the meantime, work off that extra steam with a nice run or a game of tennis.

Taking on your emerging support role

Don't think of yourself either as your partner's personal assistant or as the pregnancy police. She may become a diva in her pregnancy, but it's not your responsibility to do it all. And try to avoid becoming overprotective of your partner's physical capabilities, especially early in the pregnancy. If everything goes well with the pregnancy, she won't have many restrictions on her activities. But that doesn't mean she's going to be up for taking care of everything she's always managed.

For the first several months — and for the last few — your partner may be too tired/nauseated/hot/and so on to make dinner, walk the dog, or perform many of the household chores you used to split. Pick up the slack until she feels good enough to contribute again. When she's back in the swing of things, she can move around and help again. Physical activity is beneficial for both mom and baby.

One of your main roles is ensuring that she eats healthfully and exercises if and when possible, but the way to do this is by example, not with a whip and chain in hand and bathroom scales placed in front of the refrigerator. Ask her to take walks with you and help by preparing meals that will settle her stomach and feed baby's growing systems.

Pregnancy does not turn your partner into a child, even though she's carrying one around with her. She still gets to make her own choices about what she eats and when, or if, she exercises, and you may have to bite your lip if she starts exceeding the weight limit for your delicate Queen Anne chairs.

In addition to supporting your partner physically, you need to support her emotionally. She will likely be weepier and more sensitive than normal. If you're not the kind of guy who likes to talk about feelings, I suggest you become that guy for a month or so.

As hormones surge and wane, roll with the punches. Let the little things go without a struggle, because your partner won't always be able to control her reactions the way she used to. Let her dictate what's for dinner, and if her stomach turns when you plate the exact dinner she asked for, don't take it personally.

Being a rubber wall isn't easy, but the more you can let things bounce off you, the easier this time is for everyone. Supporting your partner throughout pregnancy is a constant game of choosing your battles and helping her make healthy decisions for her and the baby. Don't tell her what she should do — lead by example. It's good practice for when you have a kid in the house.

Chapter 4

Growing Into the Second Trimester

In This Chapter

- Watching baby's growth in the second trimester
- Helping your partner through physical and emotional changes
- Understanding prenatal ultrasounds and blood tests
- Finding a childbirth class that suits your style

Welcome to the best three months of pregnancy, for both you and your partner. The second trimester is universally regarded as the "golden era" of pregnancy — she's big enough to look pregnant and not just pudgy, morning sickness is left in the dust, and the aches and pains of late pregnancy are still in the distant future. Enjoy these three months, because the next three will bring much more upheaval into your partner's life — and consequently into yours!

In this chapter we walk you through the garden of the second trimester, with your first exciting look at your baby, finding out the sex (if you want to), and few emotional upheavals.

Tracking Baby's Development during the Second Trimester

By the end of the first trimester, your baby's vital parts are all in place and beginning to perform the functions they'll carry out for the next 80 or so years. By the end of the second trimester, the baby's lungs, one of the slowest organs to mature, are almost capable of supporting life with assistance if he's born very prematurely (23 to 24 weeks is considered the earliest that a fetus can survive if born early). But the lungs aren't the only area experiencing change; every body system is becoming more refined with each passing day.

Growing and changing in months four and five

Even though the basic structures are in place, they undergo further refinement in months four and five:

- **Week 14:** The baby's eyes close for several months while they develop on the inside.
- **Week 15:** Some women may start to feel flutters when the baby moves; many women, especially those in their first pregnancy, don't feel movement for several more weeks.
- **Week 16:** By week 16, hair (including eyebrows) begins to grow.
- **Weeks 17–18:** Air sacs start to form in the lungs, but the lungs won't be able to support life for another six weeks or so.
- **Week 19:** The permanent teeth form in the gums. The baby can swallow.
- **Week 20:** By this week, the midpoint of pregnancy, the fetus is around 6.5 inches long and weighs around 10 ounces.
- **Weeks 21–22:** The fetus now has a functioning tongue! A baby girl's ovaries contain all the eggs she'll ever have in life, around 6 million.
- **Week 23:** The baby can now hear, but more importantly, if born now, she has around a 15 percent chance of survival.

Figure 4-1 gives you an idea of what these changes look like.

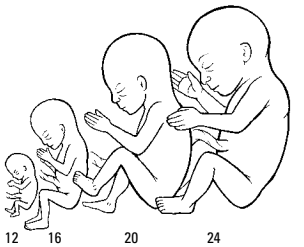


Figure 4-1: Months four and five of pregnancy.

Refining touches in the sixth month

The sixth month continues the refining process; all the major components are in place, and all the baby has to do is grow and mature.

- **Week 24:** Your baby has around a 50 percent chance of survival if born at this point. She now weighs around 1.3 pounds.
- **Weeks 25–26:** The spinal cord and lungs are forming more completely, and the eyes reopen at last!
- **Week 27:** At the end of the second trimester, your baby approaches 2 pounds and 14.4 inches. The lungs, spine, and eyes continue their refinement process. Every week increases the odds of survival if born early.

Check out Figure 4-2 to see how much baby has developed by the end of the sixth month.

Figure 4-2: By the end of month six of pregnancy, the fetus is likely to survive if born early.

Checking Out Mom's Development in the Second Trimester

The middle trimester of pregnancy may be the best time of your partner's life: She feels good, looks "cutely" pregnant, and usually enjoys these three months, which means that you get to enjoy them, too! It's also the time when her sex drive may return and the urge to begin getting the home ready for baby kicks in.

During this time, make the most out of your waning days as a twosome. Later in the pregnancy, your partner may not be up for doing as much, and after baby arrives all bets are off. So get out now! Go on dates, take a vacation, or just indulge in all the things that you and your partner enjoy doing one-on-one.

Now also is the time when your partner's body goes through a lot of changes, which means that your support is more important than ever. Giving up her body for a baby isn't easy, and the more you help her deal with the ups and downs of pregnancy, the easier it will be for everyone.

Gaining weight healthfully

One of the most overwhelming concerns for many pregnant women is weight gain: They're afraid they're gaining too much, aren't sure how much they should gain each month, and are desperately afraid that extra weight will be with them for a lifetime.

It's not unusual for dads-to-be to begin packing on the pounds, too. Perhaps you also indulged in your partner's first-trimester cravings. Maybe she wasn't feeling up for those long walks you used to take after dinner so you skipped it, too. If you're gaining right along with her, you may have some concerns in this area, too! The following info may help you help her (and yourself) with weight gain issues:

- After the first trimester, a weight gain of around a pound a week is considered normal.
- Total weight gain, on average, should be between 25 to 35 pounds, with underweight women gaining a little more (28 to 40 pounds), and overweight women less (15 to 25 pounds).
- Pregnant women need only an extra 100 to 300 calories a day.
- The baby contributes around 8 pounds to the total weight; amniotic fluid, placenta, breast tissue, an increase in uterine muscle each add another 2 to 3 pounds. The rest is stored fat and increased blood, each adding around 4 pounds.

Keeping the emphasis on eating well during pregnancy helps you and your partner ensure that the baby grows well — and that your partner won't end up with 40 extra pounds after the pregnancy. Focus on eating plenty of fresh fruits, vegetables, and healthy protein sources and limiting junk food, rather than focusing on the daily weigh-in numbers. Pregnancy is not the time to keep an obsessive weight chart; even if you fear that she'll never get back to her normal weight, rest assured that she most likely will.

Foods to avoid during pregnancy

In the second trimester, a pregnant woman's first-trimester distaste for food and often decreased appetite seem to vanish in the wind. Your partner may now seem to be chowing down on anything and everything with gusto. Although a healthy appetite is good for her and the baby, pregnant women must avoid certain foods that can be harmful to the growing fetus or to their own health. Some of the listed no-nos aren't good for you, either, so you can stop eating them together.

Mercury can affect fetal brain, nervous system, and visual development. Most fish contain some mercury, but some have very high levels of mercury and should be completely avoided by pregnant women, including the following:

- Grouper
- Mackerel
- Marlin
- Orange roughy
- Shark
- Swordfish
- Tilefish

The following fish also have high amounts of mercury, but fish from this group can be eaten up to three times a month:

- Bluefish
- Halibut
- Lobster (Maine)
- Tuna

Following are some other foods to avoid, or at least limit, during pregnancy:

- **Deli meats:** Deli meats may contain listeria, bacteria that can cross the placenta and cause pregnancy loss.
- **Soft-serve ice cream/frozen yogurt:** Listeria is also the concern here as the machines used to make the equipment can be magnets for bacteria.
- **Imported soft cheeses:** Soft cheeses can also contain listeria if made from unpasteurized milk. Brie, Camembert, feta, Roquefort, and Mexican-style soft cheeses should be avoided unless made from pasteurized milk.
- **Raw eggs:** Raw eggs can contain salmonella, a bacterial infection that can cause severe vomiting and diarrhea.
- **Raw meat:** Raw meat can contain a number of harmful pathogens, including coloform bacteria, salmonella, and toxoplasmosis, which can cause severe fetal complications.
- **Unwashed vegetables:** Unwashed vegetables can also transmit toxoplasmosis as well as salmonella.

Pregnancy is also not a time to lose weight or avoid gaining it, unless she's very overweight and is working with a medical practitioner. If she's really cutting down on food intake, she may need

some help dealing with her fear of weight gain. Talk to her medical practitioner about how to handle the issue, because it's a pretty sure bet she'll take her practitioner's advice over yours when talking about weight gain.

And remember, leading by example is always the best option. The healthier you both are during this time, the more likely you are to continue those healthy eating habits after baby comes. Don't wait to start living healthy until baby arrives, because it won't happen. Soon enough, it will be your responsibility to teach your child how to eat as well as you.

Looking pregnant at last!

One annoying aspect of early pregnancy is looking not quite pregnant enough and worrying that you look pudgy instead of pregnant. Thankfully, by the end of the second trimester, most women definitely look pregnant, although if your partner is overweight, it may still be difficult to tell, something that may frustrate her to no end.

The days of voluminous maternity wear are, for the most part, long gone, although most women will invest in a few pairs of maternity pants with an elastic tummy and a few shirts either in a larger size than they normally wear or made of a stretchy fabric. Women who have to dress well for work will probably break down and buy actual maternity clothes so they don't look sloppy if their clothes are just overall too big for them or to avoid the skin-tight "hey, I'm pregnant, look at my belly!" look that may be considered out of place in an office.

Many pregnant women today do accentuate their bellies with tight T-shirts, hip-hugger pants, and two-piece bikinis (not on the streets of Manhattan, hopefully, although stranger things have happened). If you're extremely conservative, the "let-it-all-hang-out" look may bother you.

Approach your partner carefully with any suggestions as to how she should dress in pregnancy. Pregnancy hormones may be under control in this trimester, but they make an immediate reappearance under duress. There's really no nice way to say "I hate the way you're dressed," so you may just need to keep your opinions to yourself.

You can try buying her a few articles of clothing that fit your image of what a well-dressed pregnant woman should wear. She may just wear them, if for no other reason than that she doesn't want to hurt your feelings!

Figure 4-3 shows where the uterus is during the fourth, fifth, and sixth months of pregnancy, as well as where you can expect it to

go throughout the rest of the pregnancy. You can see why pregnancy gets really uncomfortable in the third trimester.

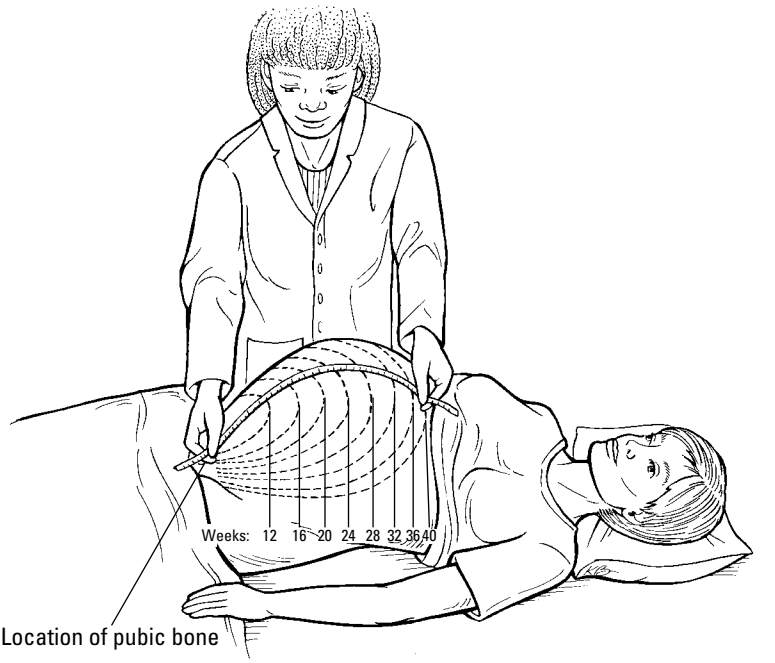


Figure 4-3: Uterine height changes during pregnancy.

Testing in the Second Trimester

The second trimester is often the time for blood tests and ultrasounds that show the baby's development is on target and no major problems exist. Blood tests to assess the risk of genetic defects are usually done between weeks 11 to 13 or 15 to 20, depending on the tests being done, and screening ultrasounds, which look at the baby's major organs for anomalies and often can determine the baby's sex, are done around week 20.

Some babies are extremely reluctant to show their private parts on ultrasound, so not all parents learn their baby's sex at the first ultrasound, and insurance may not pay for a second without good medical cause. If you can't find out the sex of your child, don't stress about it. Buying gender-neutral clothing and nursery décor is easier than ever. Greens and yellows work for boys and girls, and you'll always have time to add touches of gendered colors after baby comes home.

Preparing for the risks of tests and ultrasounds

Having screening blood work and an ultrasound done bring risks of a kind, as well as benefits. Neither procedure carries any significant physical risk to either mom or baby, but the procedures do carry a risk of finding out that something is wrong with the baby. This is knowledge some parents would rather not have.

Most parents prefer to know if the baby has problems so they can consider their options and prepare for potential difficulties, but others would not consider terminating the pregnancy under any conditions and prefer not to know. This is a personal issue that every parent has to consider for him or herself.

If you are opting not to undergo testing, make sure that your partner's OB/GYN is supportive of that decision. Be upfront about your preferences so that you don't feel pressured by your medical provider down the road. Most midwives will allow you to make special considerations so long as those decisions pose no risk to the baby or mother.

Understanding blood test results

Although some prenatal screening tests are for your partner's overall well-being and check for potentially harmful medical conditions, second-trimester triple- and quadruple-screen blood tests are aimed at determining the risk of genetic anomalies in the fetus.

Also used in conjunction with second-trimester ultrasound, quadruple screens help predict the risk that the fetus has Down syndrome, trisomy 18, or neural tube defects such as spina bifida or anencephaly, where part of the brain is missing.

Quadruple screens test the blood for four things:

- **Alpha feto-protein, produced by the fetus:** High levels of AFP may indicate neural tube defects, abdominal wall defects, or multiple pregnancy.
- **hCG, produced by the placenta:** hCG levels may be higher than normal in Down syndrome pregnancies.
- **Estriol, a form of estrogen made by the placenta and liver of the fetus:** Estriol levels are low in Down syndrome pregnancies.
- **Inhibin A, produced by the placenta:** Inhibin A levels are elevated in cases of Down syndrome.

Following up on the test results

Remember that first and second-trimester blood tests are screening tests only. They do not diagnose congenital defects; they only indicate the odds that a congenital defect exists. The risk also varies with maternal age: The older your partner is, the more likely you are to have a child with a genetic defect, although the risk is still low.

If your partner's screening test comes back abnormal, the most important thing to do is stay calm. An abnormal result only indicates a need for further testing. Try hard to keep both of you thinking positive until you have a clear answer on what, if anything, is wrong.

The March of Dimes reports that 5 percent of screening tests are abnormal, but only 4 to 5 percent of fetuses with abnormal test results actually have Down syndrome. This is a very small percentage, so stay optimistic; the odds are highly in your favor for a good outcome.

In the second trimester, amniocentesis may be done between weeks 15 and 20, when amniotic fluid is easily accessible. A thin needle is inserted into the fluid through the abdominal wall, and the fetal cells in the fluid are analyzed. Amniocentesis comes with a slightly increased risk of miscarriage afterward, so most medical practitioners don't recommend doing an amniocentesis routinely.

Women older than age 35, who have a higher risk of having a child with chromosomal abnormalities, and those with a family history of genetic problems may consider doing amniocentesis, which can determine if chromosomal defects such as Down syndrome, hemophilia, cystic fibrosis, and other genetic disorders are present.

Scrutinizing ultrasounds

As excited as you both are for the first prenatal ultrasound, the actual event can sometimes be a bit of a letdown. Reading ultrasounds is an art, and unless the ultrasonographer is really patient about pointing things out, you may be unsure of whether you're viewing the baby's head or its tush.

Much depends on the direction the baby's facing. You may get a somewhat frightening straight-on face shot, which looks far more like the creature from *Alien* than any relative of yours, or you may get a front-on foot view that looks like nothing more than five round balls. You may be happy to know the baby has five toes on each foot, but that's usually not the main information parents-to-be want. The next section describes what the ultrasonographer is trained to look for.

Measuring growth

First and foremost, your medical practitioner wants to know that the baby is growing as he should. Some of the measurements taken to check for normal growth include

- **The length of the longest leg bone, called the femur**
- **The head circumference**
- **The head diameter, called the biparietal diameter**
- **The abdominal circumference**

Comparing these measurements to standards assures your practitioner, and you, that the fetus is growing as he should.

Checking for genetic markers

Genetic markers indicate an increased risk of congenital problems, but as with blood tests, genetic markers only indicate the risk potential; they don't diagnose the disease. Some ultrasound markers are known as "soft" markers because they're often misinterpreted and not as diagnostic as other signs. Soft markers may also be transient and no longer seen in later ultrasounds. Following are genetic markers, including soft markers:

- **Thickness of the skin on the back of the neck:** Called nuchal translucency, thicker-than-normal neck skin indicates an increased risk of Down syndrome.
- **Cardiac defects:** Around 50 percent of Down syndrome babies have cardiac defects, which may be visible via ultrasound.
- **Bowel abnormalities:** Around 12 percent of Down syndrome babies have gastrointestinal defects that may also be spotted on ultrasound.
- **Shortened arm and leg bones:** Children with congenital abnormalities often have arms and legs that are shorter than normal.
- **Missing nasal bone:** Failure to see the nasal bone or a shortened nasal bone on ultrasound may indicate Down syndrome.
- **Polyhydramnios:** An increased amount of amniotic fluid may be associated with congenital defects.
- **Kidney abnormalities:** Dilated kidneys, missing or small kidneys, and other anomalies may indicate genetic disorders.

Determining the sex on ultrasound . . . or not

While the ultrasonographer's priority is looking for information that shows the baby is growing properly, your consuming interest during the first prenatal ultrasound may be the baby's sex.

Ultrasonographers who do prenatal ultrasounds are well versed in not blurting out the sex of the baby and usually ask if you want to know. Most generically use *he* or *she* to avoid calling the baby *it* if you don't want to know, so don't assume anything by the choice of words if you've requested that you not be told. You can feel legitimately concerned if she starts using the term *they,* though!

Ultrasounds are generally not done just to satisfy parental curiosity, but rather to catch any potential problems early on. If the baby's sex can't be determined in the first ultrasound and you absolutely must know in advance, your insurance will likely require you to pay out-of-pocket for another ultrasound.

If you had your heart set on a girl and it's as plain as the nose on your face, even to your untrained eyes, that a little boy is on the way (or vice versa), remember that it's normal and okay to feel a twinge of disappointment. Try to keep it to yourself and concentrate on what you're probably seeing — a healthy, normally developing child.

If one of you really wants to know and the other doesn't, strategize before the appointment so you're not arguing in front of the ultrasonographer. One method of keeping the news to just one person is to have the ultrasonographer write down the sex and put it in an envelope. That way, one of you can look and find out, and the other person doesn't have to.

This tactic also works if neither of you want to know at the moment, but you're concerned that your curiosity may get the better of you later. If you have the answer, you can look at it any time, but you don't have to.

Having Sex in the Second Trimester

For many women, the libido is back on the ascent during the second trimester, which will be a big sigh of relief for any guy who has patiently waited through nausea, exhaustion, discomfort, and a lack of sexual energy for some long-awaited sex. In fact, some women become very sexual during this time because they're flush with hormones and feeling in touch with their bodies.

Maintaining a healthy sex life during pregnancy

Forget what you may have heard — sex during pregnancy is safe as long as your partner is having a normal pregnancy. Her desire

to have sex may change by the day due to fluctuating hormones, tiredness, or body aches. She also may struggle with being a sexual being as she transitions into the role of mother.

The most important thing to do is to keep talking about sex. As you get back into the swing of things, be open and honest about what you both need. Explore ways to satisfy each other's romantic and physical needs, even if your partner isn't up for sex.

Don't be surprised if your partner needs to take it slowly in the beginning. Stop at any signs of discomfort. As the baby bump continues to expand, you'll likely find yourselves exploring new positions that offer support for your partner's stomach. Many women are most comfortable on their sides or even up on their knees, and can use pillows for stomach support.

If your partner desires oral sex, it is absolutely safe. Just make sure not to blow air into the vagina because this can cause an embolism, which can be fatal for the baby and the mother-to-be.

Addressing common myths and concerns

We'll just get the myths out of the way right now: Your penis is not long enough to hit or poke the baby during sex. The baby cannot see your penis when you're having sex, and he isn't afraid of your penis during sex. Your semen will not get all over the baby upon completion of sex.

Sex is perfectly healthy during pregnancy. Your baby is protected by an amniotic sac that's sealed tightly by a thick mucus plug, which keeps out foreign and unwanted intruders. In a few instances, however, sex during pregnancy isn't recommended. Talk with your partner's doctor or midwife prior to having sex if your partner has dealt with any of the following issues:

- **Miscarriage:** If your partner has ever had one, or a medical professional has said she is at risk for having one, check before sex.
- **Bleeding:** Sometimes vaginal bleeding ranging from normal to potentially life threatening can occur during the early months of pregnancy. Sex can cause the cervix to bleed, which can be alarming if you're already worried about bleeding.
- **Preterm labor:** If your partner gave birth to a previous child prematurely, get clearance to make sure having sex is safe.

- **Leaking amniotic fluid:** Any time amniotic fluid is leaking, the sterile barrier between the baby and the outside world is broken, and infection can enter into the uterus and infect the baby. No sex after her water breaks!
- **Placenta previa:** With the placenta close to or overlying the cervix in placenta previa, having sex can cause life-threatening bleeding.
- **Weakened cervix:** Sometimes called an *incomplete cervix,* this condition means the cervix dilates before full term, which can lead to miscarriage. A stitch is often placed into the cervix to keep it closed. Sex can cause uterine contractions that disrupt the stitch.
- **Pregnant with multiples:** Because multiples often deliver early, you need to avoid anything that can upset the delicate balance between no children and two — or more — children, sex included. Semen contains substances that may bring on labor if the tendency for preterm delivery exists. Besides, your partner probably has enough going on in there already.

A female orgasm during low-risk pregnancy will not cause your partner to go into labor prematurely. Contractions of the uterus associated with sex are not the same as those experienced during labor (and your partner is *very* thankful for this!). However, orgasm achieved by any method can start contractions that can lead to preterm labor in high-risk pregnancy, so put the vibrator away for the duration as well.

Some doctors recommend avoiding sex during the final weeks of pregnancy due to the prostaglandins in semen, which are hormones that can stimulate contractions. On the flipside, if your partner is overdue, your doctor may "prescribe" sex as a means to jump-start the contractions.

Exploring Different Options for Childbirth Classes

Yes, you are expected to attend childbirth classes. The good news is that today's market offers a variety of choices that are welcoming to both mother and father. And they aren't just about learning how to breathe! These classes are an opportunity to ask questions, build confidence, and connect with other couples going through the same experiences you are at the exact same time.

Regardless of the type of class you sign up for, you'll be taught the basics in the following areas:

- Techniques for coping with labor and delivery pain
- Your role in assisting your partner
- What labor feels like/signs of labor
- When to call your doctor/midwife/doula
- Choosing the birthing option that's right for you and your partner

Selecting the class that's right for you has a lot to do with the kind of childbirth experience you and your partner want to have. Whatever class option you select, make sure to meet with the instructor prior to signing up (and paying the fee!) to make sure he's the right teacher for your needs. Ask what is covered in the class, how many couples are in the class, where the class is held, and how many weeks the class runs.

Following are the most popular types of classes offered:

- **Lamaze:** Developed in the 1940s by a French obstetrician, Lamaze focuses on empowering women to be confident in their abilities to birth children. Its teachings are rooted in natural childbirth options, and it follows the philosophy that women shouldn't be required to have routine medical intervention in childbirth.
- **HypnoBirthing:** Sometimes called the Mongan Method, this class teaches couples how to use relaxation and visualization — self-hypnosis — to have a natural, intervention-free childbirth when possible.
- **The Bradley Method:** Also focusing on medication-free, natural childbirth, this class focuses on the roles diet and exercise play in childbirth, as well as breathing techniques. Generally includes heavy emphasis on the father's role.
- **International Childbirth Education Association (ICEA) classes:** Although they don't adhere to a particular philosophy, these classes offer certified instructors. Check with the teacher to find out what to expect.
- **BirthWorks:** The philosophy of this program is that women instinctively know how to give birth and that they can be empowered to understand their bodies and respond accordingly to their own labor experience.
- **The Alexander Technique:** These classes focus on utilizing techniques that reduce tension in the body and offer the mother-to-be freedom of movement during childbirth.

Chapter 5

The Fun Stuff: Nesting, Registering, and Naming

In This Chapter

- Preparing your home for baby's arrival
- Registering for what you really need to survive
- Having fun at the shower (if you choose to attend)
- Getting your lengthy baby-name list narrowed down to one

As the calendar inches closer to baby's arrival, usually around month five of the pregnancy, many soon-to-be parents get the urge to bring order to the home. What may start as getting the nursery ready often triggers an avalanche of do-it-yourself projects and more items added to the ever-growing registry list.

And to make this whole baby thing even more real, this is the time to think about names. In this chapter we tell you how to get through the planning and preparing without any major blowups.

Preparing the Nursery and Home, or "Nesting"

Put down the twigs and leaves — it's not that kind of nesting. This nesting is all about making the concept of baby a real thing in your everyday life.

Nesting can give you a sense of progress in the seemingly endless pregnancy and serves as the first of many acts of giving and loving that you will show your baby. It can also be a great motivator for finally getting the kitchen cabinets repainted and replacing the broken bathroom tile.

Making the house spic and span — and then some

For many pregnant women, the biological need to nest can be powerful. It can also veer into the seemingly irrational as your partner donates or trashes perfectly good linens, rugs, and towels because they may have unseen germs. Some women even get the urge to grab a toothbrush and some disinfectant and literally scrub the house top-to-bottom. This is perfectly normal.

Try your best to be supportive without breaking the bank on unnecessary purchases. If your towels aren't in need of replacing, suggest having them professionally cleaned instead. Sometimes, however, the best thing to do when your pregnant partner is going through a bout of nesting-induced hysteria is to just let her do it. It's a natural process, and, as with all things, this too shall pass.

However, don't just sit back and watch. She may not ask, but she definitely wants you to help with the cleaning and organizing. Even if you don't think everything she's doing is necessary, she may be unable to see why it's not as important to you as it is to her. Simply ask her how you can help or just join in with the express knowledge that this is a fleeting phase of late pregnancy.

This is also a time when your partner feels the need to launch a new set of rules regarding safety and cleanliness, such as no more shoes in the house or no more dogs allowed on the sofa. If your partner feels very strongly about something you disagree with, work together to find a compromise.

Some pregnant women are so bothered by the idea of pet hair, cat litter, and the suspect grooming habits of animals that they may start talking about re-homing the family pet. As best as you can, try to delay any decision-making regarding your pet's future until after the baby arrives. Hormones change following pregnancy, and the last thing you want is a crying partner feeling guilty about giving up Rover in the heat of the moment. Offer to take over the duties of pet maintenance for the remainder of the pregnancy and reevaluate monthly.

Pregnant women have to be a little more cautious than normal while doing work around the house. Take note of the following household projects and their do's and don'ts:

- **Painting:** Pregnant women should avoid the urge to paint the nursery — or any wall, for that matter — because among other potentially harmful chemicals, latex paint may contain mercury, and old paint may contain lead; both of which can

cause birth defects. Sanding and breathing in particles are also no-no's. If your partner is going to be around while you coat the walls, make sure the room is well ventilated and that no food or beverages are consumed in the room where you're painting.

- **Cleaning:** Using eco-friendly cleaning products is always better, so start during pregnancy. Not only will your partner avoid exposure to harsh chemicals, but you'll already be prepared for the day when baby is crawling around and putting everything in his mouth.
- **Lifting:** It's a myth that lifting heavy objects lowers a baby's birth weight or causes birth defects. (Also, raising her hands over her head doesn't cause the baby to become tangled in the umbilical cord.) But a woman's center of gravity changes as her stomach grows and her tendons and ligaments soften. Lifting objects heavier than 25 pounds in the last few months of pregnancy can throw off her balance and result in a fall, so have her leave the heavy lifting to you.
- **Pet care:** According to the U.S. Centers for Disease Control & Prevention, pregnant women should not clean a cat's litter box due to the risk of toxoplasmosis, a parasite in cat feces that can cause congenital defects in the baby. To further decrease the chance of toxoplasmosis, make sure you clean the litter box frequently, keep your cats indoors, and avoid adopting new cats during pregnancy.

Setting up the nursery

Fun *should* rule the day when it comes to setting up the nursery, but overanxious parents-to-be often try to tackle too much at once. Begin your nursery designing with a planning session. Draw a bird's-eye floor plan of the room and start filling in the space with all the things you need. Decide the placement of all of the furniture, and before you run out and start buying, measure the allotted spaces to make sure you don't end up with an overstuffed debacle à la the Griswold family Christmas tree.

Clearing and painting the room

Unless you're starting with an empty space, the next step is to empty the room and find a home for all of your displaced things. This chore is the least fun thing to do, but don't put it off. Having an organized room just for your baby will make you feel less anxious about bringing him home.

When the room is empty, painting is a cinch. Since pregnant women shouldn't paint, this is your job. If you don't have the time

or desire to paint, find a friend, family member, or local painter to do it for you.

After the room is painted, have the carpets and rugs deep cleaned, or refinish the floors if they need it.

Buying and assembling the furniture

When the paint's dry and the floors are ready, it's all about shopping and assembly.

Budget some alone time for assembly if possible. Cribs often come with instructions that seem to be written in Swahili, and they don't just pop together. They're solidly constructed, which is good for baby's safety but bad for your frustration threshold. Take your time and figure on spending a few hours on assembly. Lay out all of the parts and read through the instructions (yes, actually read through the instructions!).

Most of today's instructions offer picture-only guidance, which can be quite vague and frustrating. If you can't understand what you should do based on the company's illustrations, don't just do what you think should be done. Take the time to call. Not only is the safety of your child at stake, but your warranty, too!

Assemble the crib in the nursery because many cribs are too wide to fit through doorways, and won't you be frustrated if you have to take it apart and do it all over again!

Opinions differ on bumper pads, the quilted bands that are strung around the bottom of the crib. The Canadian government discourages their use due to the chance of suffocation, and a 2007 study in the *Journal of Pediatrics* determined them to be unsafe. Others believe that with the use of a crib positioner, which keeps baby sleeping on his back, bumper pads cause little increased risk.

Whether or not it's worth the risk is up to you and your partner, but it is a risk. If you use bumpers, make sure you remove them if you notice your baby creeping toward the bumper in his sleep. Another option is to use mesh bumpers, which are not padded but do offer a breathable barrier between baby and the crib's slats.

Some parents opt to use cosleepers, which are small, three-sided cribs that butt up to your bed, keeping the baby very close at hand. This arrangement is ideal for late-night feedings but less ideal when considering the amount of your personal space you have to sacrifice.

Arranging the nursery for two or more

Not all nurseries accommodate just one little baby. Whether welcoming multiples or adding a second child into a preexisting nursery, creating a space that works for more than one takes a little extra effort.

Multiples

The only real challenge in accommodating multiples is making room for them to sleep. Changing tables, dressers, and closets can easily be shared when you invest in closet organizing systems to allow more items to be stored in less space.

For twins, some people opt to use a single crib with a crib divider that literally splits the bed down the middle. It's great for space-limited parents, and research shows that twins sleep better when placed near one another as they were in utero. However, crib dividers are a short-term solution because as the babies grow, each needs more space.

If money and space allow, you have many options for twin cribs that are smaller versions of full-sized units and are generally built side-by-side. And if you're having more than two, you may want to look into bunked cribs, which offer an individual space for each baby. Most are not notably stylish, but if you're having more than two babies, stylish cribs are probably the least of your worries.

Separate-birth siblings

If you're going to have an older child cede space to the newborn, the situation won't be all that different from having multiples. Most of your work concerns organization and maximizing storage space with closet organizing systems, baskets, and bins. However, investing in a cosleeper (a three-sided crib that attaches to the side of your bed) or a portable crib can be a lifesaver when the older child and the baby aren't on the same sleep schedules. And if your older child is still a baby, it also allows for a secure place for the older child when you're tending to the newborn.

Baby-proofing 101

You have some time before baby starts getting into things, but that doesn't mean that the nesting period isn't the perfect time to baby-proof. In fact, doing it early allows you plenty of time to adjust to the complicated life of cabinet locks, outlet covers, and doorknob locks.

To make sure your baby's safe, take the following precautions:

- Get down on the floor, look at the room from baby's level, and clear all potential hazards.
- Install rubber stoppers at the top of doors to keep baby's fingers from being pinched.
- Remove rubber tips from doorstoppers at floor level because they're choking hazards.
- Install mesh baby gates in dangerous locations.
- Plug in outlet covers on all outlets below waist level.
- Install cabinet locks.
- Add a toilet-lid lock.
- Make sure all rugs and mats have slip-proof pads underneath.
- Add foam coverings to the edges and sides of sharp furniture.
- Apply doorknob covers to keep toddlers from being able to open doors.
- Find an out-of-reach location for pet supplies and the cat litter box.
- Remove any toxic plants or chemicals that are within baby's reach.
- Cover the bathtub waterspout with a plastic cover to avoid head injury.
- Put your trash cans in an inaccessible place — to baby, not to you.
- Keep bags and purses off the floor.

Monitoring options

Baby monitors have come a long way in the past few years. Your options range from hi-def, flat-screen video units to the classic walkie-talkie-like models. If you live in a larger home, a video monitor may make more sense to save you a lot of trips to the nursery to check on noises. Even in smaller homes, it can be useful to have a video screen to check if that little noise was a minor disturbance or something requiring your immediate attention.

Regardless of your choice, make sure that the unit you purchase can effectively communicate at the distance between the nursery and the other rooms of your home. Many monitors now can transmit up to 400 feet.

When in doubt, move it or remove it. Get into the habit of looking for small items on the floor, closing doors, putting the toilet seat down, and putting all potential choking hazards out of baby's reach. After years of not having to think about where you throw your keys, retraining your brain takes a while, so start now.

Understanding the Art of the Baby Registry

If the mere suggestion of free stuff has you lacing up your sneakers to run out to the nearest baby goods store, slow down. Registering isn't as easy as it sounds. Babies need a lot of gear, but they don't need everything, so you need to think through your particular wants, needs, and style before you point the scanner and click.

When you get into the store, registering can be an overwhelming, almost paralyzing experience. Some parents-to-be first realize how unprepared to care for baby they feel when forced to choose between different styles of bottles, diapers, and baby monitors. Some couples enter panic mode and just start registering for one of everything because they feel like their baby *might* need it.

You only get free stuff once, so be sure to make the most of it by getting prepared before you register. The more online research you do about the differences between various products, the more competent and confident you will begin to feel about your parenting duties to come. Registering is the perfect opportunity to familiarize yourself with exactly what it takes to raise a baby.

Doing your homework ahead of time to get exactly what you want

When it comes time to register, everyone who has been a parent will tell you the things that you won't be able to live without. In truth, you *have* to have very few items in order to raise a baby, but a lot of modern inventions can make raising a baby easier.

First, consider your space. If your nursery is too small to fit an entire bedroom set and a glider, you and your partner need to prioritize. The size of the room helps dictate the size and number of items you can add to it, as well as the style of crib, dresser, changing table, curtains, and every other accoutrement you can imagine. If a rocking chair is the one thing you must have, plan the rest of the room around that to make sure you have enough space.

Register for the essentials first and don't make your registry too long, or you run the risk of not getting everything you need. Also, don't register for too many clothes, because although clothes are necessary, everyone will want to buy clothes first, and you may not get other more vital things. People often throw in an outfit along with whatever registry gift they purchase, anyway.

Spend time thinking about how you're going to use your stroller. If you're a runner, do your homework about the best running stroller for you and try them at the store. If you live in a city, make sure the stroller is durable enough to handle bumpy, uneven sidewalks, but not too big to make you the enemy of your fellow pedestrians. If you drive a lot, make sure the stroller folds up small enough to fit in your car and still leave room for shopping bags.

And before you register for anything, check safety ratings and parent reviews online. Visit Consumer Reports' baby section (`www.consumerreports.org/cro/babies-kids/index.htm`) for recalls and safety information.

Finding out what you need — and what you think you won't need but can't live without!

When you've never before had to care for a baby, knowing what you need — and how many of each thing — is nearly impossible. Use the basic checklist in this section as your guide.

A system for travel

Travel systems that offer a compatible stroller, infant car seat, and car seat base in one package are a popular option for new parents. If you're on a tight budget, a travel system is an ideal solution to get everything you need for less than $200. However, many are quite bulky, and the included strollers generally aren't top-of-the-line quality.

Travel systems come in many styles, so start by picking the car seat of your choice. Make sure it has a five-point harness system and that it's the appropriate size for your vehicle. Consider the size of the stroller, too, and make sure it fits comfortably in your trunk. Make sure to collapse the stroller in the store before you buy it to see how small (or big) it is when not in use.

Note: We don't mention certain items, such as a high chair, jumpers, and play mats, because you don't need them right away. However, if you have room to store them, pick the ones you want and register for them. Remember, though, that when you meet your baby and get to know him, your idea of what he might like may change. The play gym you picked out before you met him may not really suit him. It's kind of like signing him up for college before he's born; you may think Harvard is the best, but he may not like it.

Following are the items you absolutely must include on your registry (in our opinion, at least).

Sleeping and changing essentials:

- Cradle/bassinet/cosleeper/crib
- Two to four fitted sheets
- Crib mattress
- Two to four swaddling blankets
- Nursery monitor
- Changing table or station
- Two to three changing pad covers

Furniture:

- Nursery seating
- Baskets/bins for closet organization

Clothing:

- Eight to ten onesies
- Six pairs of socks
- Three to six newborn hats
- Four to six warm, footed pajamas
- Two to six bibs
- Six to eight burp cloths
- Hangers

Toiletries:

- Diapers (As many as you have room to store!)
- Wipes

- Diaper cream
- Baby powder
- Baby shampoo
- Baby lotion
- Infant manicure set
- All-natural hand sanitizer

Just in case:

- Digital thermometer
- Dye-free infant Tylenol
- Dye-free gas relief drops
- First-aid kit

On-the-go goodies:

- Infant car seat
- Stroller
- Backseat mirror
- Car window sun shades
- Diaper bag
- Portable baby wipe container
- Travel-size hand sanitizer

Feeding:

- High-quality breast pump (if breast-feeding)
- Milk storage bags (if breast-feeding)
- Nursing pads (if breast-feeding)
- Boppy support pillow
- Lanolin and/or gel nursing pads
- Bottle brush
- Bottle drying rack
- One each of six different kinds of BPA-free bottles
- Four nipples for each type of bottle

Not all babies take to every type bottle; you may end up trying many different brands before you find the right one. Avoid registering for too many of the same brand in case your baby refuses

to use them. You can always return any unopened bottles and nipples if your baby takes to the first or second brand you try.

Discovering five things you don't have to have but will adore

Yes, some things are luxuries, but they can become necessities if you use them every day and they save your sanity. These five items may well fit into your "don't need it, gotta have it" category:

- **Ergonomic bouncy chair:** Not all bouncy chairs are created equal. Finding one that sits baby upright (great for gas relief) and allows him to grow with the chair will save you down the road — but not upfront. A bouncy chair is a perfect sanity-saver for the shower-starved parent and a great place for naps and playtime for baby.
- **Hands-free baby carrier:** Whether in a sling, a front carrier, or a pouch, carrying your baby in a hands-free carrier allows you to get work done around the house and move about more freely. Most babies love the body-to-body contact. Make sure to try them on first to make sure the carrier you're getting fits your body.

  Recent recalls of baby slings have called their safety into question, so make sure you get a model that keeps the baby upright and able to breathe freely. When a baby slumps in a curled position, her airway can be compressed.
- **Snap-and-go stroller:** This stroller provides only the skeleton of a traditional stroller with no seat. Instead, it has bars for a car seat to snap into, as well as a bottom basket. Infants aren't in the bucket-style car seat for very long, which makes the idea of having a second dedicated stroller seem a bit extravagant. But it's the smallest stroller on the market, which makes it ideal for car travel and easy use. You literally snap the car seat into the stroller and you're ready to roll.
- **Wipe warmer:** This may seem unnecessary, and in reality, it probably is. A lot of babies, however, cry less during diaper changes when the cold, wet wipe straight from the package is replaced by the warm, cozy wipe straight from the warmer. It also helps keep the wipes from drying out when accidentally left open.
- **Yoga ball:** All babies are gassy, and nothing helps get the gas out better than bouncing. Save your legs and back a lot of undue stress by sitting on a yoga ball and bouncing the burps right out of your baby. It's also a great alternative to a nursery chair for those with space limitations and a great late-term pregnancy chair for the woman who can't get comfortable.

Checking out five things you don't have to have and will never adore

Some things, luxurious or otherwise, are just downright unnecessary. Especially the items that don't actually make a new parent's life any easier. Here are five things you should consider omitting from your registry:

- **Baby DVDs/CDs:** Before your child has the ability to ask for the latest Jonas Brothers album/Baby Einstein DVD to be played ad nauseum, why on earth would you voluntarily spend your time engaging with this entertainment? Babies shouldn't be watching TV, and your child will be just as happy listening to music from your collection.
- **Crib mobile:** It only takes one time of knocking into a crib mobile while putting your sleeping baby down to realize that it's more of a nuisance than it's worth. Instead, opt for a natural sounds teddy bear or other system that attaches to the side of the crib.
- **Infant shoes:** If your child gestates for 18 months and comes out walking as nimbly as a newborn horse, you will need lots of for fancy footwear. For the rest of you, forgo the shoes. Most babies are annoyed by socks, let alone shoes, and for the most part, babies under the age of 6 months will spend most of the time in sleepers with attached feet.
- **Car-charger bottle warmer:** If your baby is breastfed, the milk will most likely be frozen or straight from mom, and the warmer won't help. If your child is formula fed, you will be making bottles as needed. Either way, how often will you need warm milk in the car? Most babies will be just as happy with room-temperature milk. Unless you plan on using it for your coffee, skip this one!
- **Baby bathtub:** Why exactly does your baby need a smaller version of the same device you already have in your home? Many parents opt to bathe with newborns and most others use a clean sink in lieu of the tub. As baby grows, your existing tub will work just as well. Besides, it's not like you're going to give baby his bath-time privacy while you read *Sports Illustrated* on the back patio.

Surviving the Baby Shower

These days, baby showers often aren't just for the mom-to-be and the other women in your life. If you want to be involved, by all means, tell the people planning your shower that you want it to be

a unisex affair. If you don't want to attend, that's okay, too, as long as your partner is fine with that decision. Deciding how much you want to be involved is up to you and your partner, but don't forget that the more involved you are on the front end, the more connected to and involved with that baby you will be down the road.

Traditional showers are female-centric and a bit on the cheesy side. Men often don't go because they aren't really welcome. So if you don't want to spend an afternoon sniffing diapers filled with melted candy bars, let the planners know what kind of shower you and your partner desire. It can be anything from a lunch at a nice restaurant to a traditional streamers-and-balloons affair and anything in between.

If you opt to have a coed shower, make sure that everything about the event is inclusive to people of both sexes. Here are some simple ideas to make your shower welcoming to all:

- Send invitations that are gender neutral.
- Invite all of the fathers you know to ensure there are more men than just you at the shower.
- Pick a fun, unique setting or theme, such as a park or a backyard barbeque.
- Plan some separate men-only and women-only activities.
- Open gifts with your partner. It's awkward to send her up there alone and for you not to be part of the fun.
- Set up an assembly station where the new gifts can be put together after they are opened (this idea works best if you have the shower at your home).
- Play a creative game, such as constructing babies out of clay or holding a diapering competition to see who can wipe, powder, and diaper a doll the fastest.
- Have guests write down a funny story from their childhoods and then try to match the guest to the story.

Naming Your Baby

When people find out you're having a baby, the first thing they ask is, "Is it a boy or a girl?" Question number two is inevitably, "Do you have names picked out?"

Choosing a name for your baby is one of the most fun and most challenging decisions you'll ever make in your entire life. Soon-to-be parents spend hours upon hours combing through books and Web sites, searching for the perfect name and making lists of their

top choices. And with so many options, the list can easily become mind-numbingly long and a point of contention. Getting two people to agree on the same first and middle name for a baby can devolve from a congenial conversation into something resembling a Congressional hearing.

The following section helps you and your partner choose the perfect name for your baby with as little stress as possible.

Narrowing down your long list

Just like a to-do list at work or that never-ending list of weekend projects you've been meaning to tackle for years, a long list of baby names will only distract and overwhelm you. Keeping the list at a reasonable length makes you more likely to engage in a meaningful conversation about the names that truly are in play.

Remember that you're not really choosing between 30 names. Just because you really like all of them doesn't mean you don't like some more than others — you just may not realize it yet. Stop trying to choose between Evan, Graham, Dexter, and Jude all at the same time. Instead, pit two names against each other at a time and choose one. It's like filling out your March Madness bracket; you don't pick the champion without first picking the winners of the early rounds. This tactic allows you to begin crossing some names off the list while continually pitting new names against the winner of the previous round.

At this point, you and your partner shouldn't take the opinions of others into consideration. The name is your choice, and unless you're ready to justify your choices, get frustrated with other people's input, and stand up in the face of criticism, keep the contenders to yourselves until you've made a final choice.

Reconciling father/mother differences of opinion

In a perfect world, your favorite name is also your partner's top choice. The chances of that happening, however, are slim to none. When differences of opinion arise, don't get defensive. Be able to articulate why you like the name, and even do your research about the history of the name, the name's popularity, and any family history regarding the name.

If your partner still doesn't like it, or you don't like a name she adores, allow each other absolute veto power. With so many names from which to choose, don't waste your time fighting a

losing battle. And besides, do you really want your partner to cave in and name your child something she despises?

For more background information on baby names, check out the following resources:

- **Social Security Administration's Popular Baby Names** (`www.ssa.gov/OACT/babynames`): For some people, the relative popularity of a name can have a huge impact on the decision-making process. The SSA provides a comprehensive look at the top 1,000 names from 1880 to the present year and can help you keep your kid from being one of 17 others in her kindergarten class with the same name — if that's important to you.
- **The Baby Name Wizard** (`www.babynamewizard.com`): This interactive site takes the info from the SSA site, pumps it into an innovative chart and provides site-user input about how names are perceived, an encyclopedia-like "Namipedia" entry for each name, and a "Namemapper" that charts the popularity of names by state.
- **Baby Names Country** (`www.babynamescountry.com`): This site is an exhaustive resource for unique baby names and their meanings from around the world.
- **Baby Namer** (`www.babynamer.com`): An encyclopedic reference of names that allows you to create a digital list as you find names, as well as offering similar names, famous people with the same name, and possible drawbacks of using the name, including bad nicknames.

Discussing choices with friends and family

If you think it's hard talking about names between the two of you, just wait until your loved ones start offering their two cents' worth. No matter what name you choose — be it classic, modern, or something in between — someone you know is going to tell you she doesn't like it. You'll probably hear it from multiple people, friends and strangers alike.

Don't feel the need to defend your choice. In fact, the more you defend it, the more likely the person is to continue to challenge you on your choice. Instead, focus on why you chose that name and don't be afraid to let other people know the matter is not up for debate. A playfully delivered, "I guess it's a good thing this is my baby and not yours" can put them in their place without too many hurt feelings.

Even after the baby is born, the name will be under scrutiny. From co-workers to cashiers at the supermarket, everyone will inquire about your baby's name, and you'll be confronted with a variety of reactions. Remember that everyone has his own association with the name of your child, but at the end of the day, your only association with the perfect name you choose will be the perfect baby on whom you bestow that name.

Some people are reluctant to share baby names with others for fear that they may get "stolen" by another friend or family member. If your partner has this concern and you do not, be very careful about sharing the name you choose. Though you may think it's silly, she won't take it lightly.

Chapter 6

Expecting the Unexpected

In This Chapter

- Handling maternal medical issues
- Dealing with difficult ultrasound discoveries
- Knowing what to expect if baby comes early
- Managing multiples
- Resolving money matters without panicking

You may assume that things will go off without a hitch during pregnancy and childbirth, but the fact is that many pregnancies experience some sort of complication. Complications may be related to your partner's health, the baby's well-being, or to the pregnancy itself. Some complications are relatively minor, but others can pose a serious threat.

In this chapter we look at some of the things that can go wrong in pregnancy and guide you through to supporting your partner while dealing with your own fears.

Managing Pregnancy-Related Medical Issues

Problems that affect your partner's health sometimes develop with frightening speed. Other times problems develop insidiously and build to a crisis point. Neither is easy for a dad-to-be to deal with, especially when you have to keep your own fears under control so you can help your partner deal with hers. We take a look at some of the most common maternal pregnancy problems in the next sections.

Pregnancy-induced hypertension

Pregnancy-induced hypertension, often called PIH, is a newer term for elevated blood pressure in pregnant women. It is closely related to a long recognized disease, *preeclampsia,* also called

toxemia. PIH is elevated blood pressure that develops in 5 to 8 percent of women after the 20th week of pregnancy. The signs of PIH are hypertension, retained fluid in the face and extremities, and protein in the urine.

Your partner is more likely to develop PIH if:

- This is her first pregnancy.
- She's older than 40.
- She had high blood pressure before she got pregnant.

PIH is dangerous because it reduces blood flow to the baby and also to the mom's major organs, including the liver, kidneys, and brain. In severe cases of PIH, decreased blood flow to the baby can cause *intrauterine growth retardation,* known as IUGR, which means low birth weight or stillbirth. Your partner may experience

- Severe headaches
- Blurred vision
- Light sensitivity
- Abdominal pain
- Decreased urine output

New onset of any of these symptoms requires a call to your medical practitioner. Women with PIH often end up on modified or complete bed rest (see the section "Mandatory bed rest") or may at least have to stop working or work a reduced schedule. Resting on the left side increases blood flow through the placenta, and decreasing sodium intake can help lower blood pressure. Blood pressure medications may be prescribed if pressure rises too high. She will probably need more frequent doctor visits and possibly more frequent ultrasounds to check on the baby's well-being.

Rarely, women with PIH need hospitalization to control the symptoms and decrease the chance of eclampsia, which is severe PIH with seizures. Eclampsia can be life threatening for your partner and the baby and may require immediate delivery even if the baby is premature. Part of your job is to watch for changes in your partner's mental status, such as confusion, irritability, or disorientation, because these changes may precede a seizure.

Gestational diabetes

Gestational diabetes, high blood sugar that develops during pregnancy and disappears after delivery, affects 2 to 5 percent of pregnancies. Glucose testing for gestational diabetes is normally done

in the second trimester. Women who are diagnosed may be treated with insulin injections to lower blood-sugar levels.

The problem with high blood sugar in pregnancy is that it affects the baby, who will also develop high blood-sugar levels. Gestational diabetes can affect the baby (and you) in several ways:

- The baby may grow larger than normal, which can make for a difficult delivery and increase the chance of a cesarean delivery.
- Babies whose moms have gestational diabetes are more likely to be born early and can have a severe and potentially dangerous drop in blood-sugar levels after the delivery.
- The baby may have to be monitored in the neonatal unit for a short time until his blood sugars stabilize, which is probably not the way you envisioned your time in the hospital.

If your partner is older than 35, is overweight, or has a family history of diabetes, she's more likely to develop gestational diabetes. Studies indicate that gestational diabetes is often a sign that she may develop type 2 diabetes later in life.

The introductions of daily injections and monitoring can add a whole layer of annoyance to pregnancy, for both you and your partner. If she cooks, her cooking will probably become a whole lot healthier, which you may or may not appreciate. If you're the chef, you may be expected to devise a new repertoire of healthy yet appealing meals. The bonus is that you both probably will be healthier by the end of pregnancy if you follow her new diet.

Placenta previa

Placenta previa is a condition in which the placenta implants too low on the uterine wall (see Figure 6-1). Usually the placenta, which transports nutrients to the baby, implants near the top of the uterus. If too low, all or part of the placenta can cover the opening to the uterus, the cervix, and cause bleeding.

Bleeding from placenta previa is painless, can happen without warning, and can be severe enough to require immediate delivery. A known placenta previa can necessitate bed rest and possibly a prolonged hospital stay to try and hold off delivery until the baby is less premature.

A marginal placenta previa, one that's near but not covering the cervix, may allow for a vaginal delivery, but most of the time a cesarean will need to be done. And sex is out of the question, since anything that causes contractions or any cervical movement can start heavy bleeding. Your partner is more likely to have a previa if

- She's had a previous cesarean delivery.
- She's older than 35.
- She smokes.
- She's of Asian descent.
- She's having more than one baby.

Mandatory bed rest

If your partner has a risk of early delivery or other problems, your medical practitioner may put her on bed rest. Bed rest can mean anything from not going to work and taking it easy to not getting out of bed at all, even to go to the bathroom, depending on the seriousness of the medical condition.

Having your partner on bed rest is difficult for both of you. However, if bed rest is advised, take it seriously. Bed rest brings its own risks, mostly the risk of blood clots from inactivity, so doctors don't suggest it lightly.

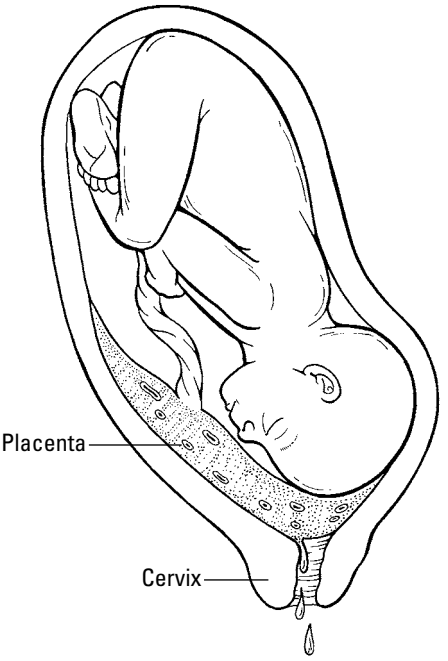


Figure 6-1: Placenta previa.

And while bed rest may sound like fun, especially if you're running around trying to cook, clean, take the dog out, run errands, and set up the nursery, trust us, she's not happy that she's unable to help put away the freshly washed baby clothes and hang the pictures on the wall.

Setting up a bed rest station

Your bedroom may not contain all the elements needed to entertain a sometimes bored, often dejected woman who's just itching to get up and paint the nursery. But any space can be turned into a home inside your home, or inside the hospital, if necessary. Make sure her living space has all the following comforts:

- **A method of communication:** Unless your house is really small, yelling back and forth isn't the best method of communication. Walkie-talkies are great, and cellphones work too.
- **A table to hold food and drink:** A drawer for snacks means she won't have to call for help every time she's hungry, and a cooler filled with drinks by the bed also gives her a little independence. Some tables fit over the bed, but a table next to the bed works fine, too.
- **Entertainment:** A TV, reading material, cards, games, puzzles, and a computer all help pass the time.
- **Extra pillows:** Spending time in bed is really hard on your back, especially when you're pregnant! Invest in extra pillows to facilitate position changes. And take the Star Wars pillowcase off, too; give her something pretty and cheerful.
- **Space to work and something to do:** No, she can't load the dishwasher from the bed, but she'd probably love to fold baby clothes!
- **Pen and paper for shopping ideas and other thoughts:** She may see something on TV or think of something she'd like to try for dinner, so give her a way to write down ideas as they come to her.
- **Exercise ideas:** Even if she can't run around the bed, she needs to keep the blood flowing to prevent blood clots in the legs. Depending on what her doctor says is okay, encourage position changes, ankle circles, and calf flexes several times a day. Discourage a cross-legged position, which decreases blood flow.
- **Venting room:** In this context, *venting* has nothing to do with fresh air and everything to do with letting her get frustrations off her chest. Constant negativity should be discouraged, but frustrated people need to express their aggravation, and better she vents to you than to her doctor — or her mother! So be available to her, not only just to keep her company, but also to let her vent when she needs to.

Many women on prolonged bed rest get depressed, especially if they have to stay in the hospital rather than at home. Make sure to keep her in the loop of baby stuff; if it's okay with her doctor, have friends visit regularly. You can even suggest that her baby shower be held while she's on bed rest, to give her something to look forward to. (See the sidebar "Setting up a bed rest station" for more ideas on helping her through the restrictions of bed rest.)

Her job is vital, though, and it's simple — stay put so the baby stays put for as long as possible. So make her feel like she's pulling her weight, because she is. In case you've never noticed until now, women often feel guilty even when they have no reason to. If your partner has to worry about how all the extra work is affecting you, she won't be resting peacefully, and staying calm and relaxed is essential on bed rest.

Handling Abnormal Ultrasounds

Many couples don't really relax about a pregnancy until they see the baby on ultrasound. But some couples don't come away from the ultrasound appointment with reassuring news. While ultrasounds aren't perfect and can miss some abnormalities, they recognize many problems.

In most pregnancies the ultrasound isn't done until the second trimester, usually around 18 weeks. By this time all the major structures of the baby are in place and can be evaluated. Ultrasounds may be done earlier if your partner is bleeding or if her doctor has any other concerns about the pregnancy. If your medical practitioner sees anything suspicious on ultrasound, she may schedule a level 2 ultrasound, which is done in the same way as a regular ultrasound but takes a more detailed look at the fetus.

Always research your insurance company's policy on ultrasounds during pregnancy, because some may not cover routine ultrasounds or repeat ultrasounds done just to find out the baby's sex. Knowing what's covered and what isn't prevents shocks to your pocketbook when an unexpected bill arrives in the mail.

Birth defects

Hearing that your baby has a problem is devastating. Even if a birth defect is minor, you or your partner may mourn the loss of the "perfect child." This reaction is normal, and neither of you should feel guilty. If a serious defect is found, you'll need to make decisions together about what to do.

Following are some of the most common birth defects in the United States, according to the March of Dimes:

- **Heart defects:** 1 in 115 births
- **Musculoskeletal defects:** 1 in 130 births
- **Club foot:** 1 in 735 births
- **Down syndrome:** 1 in 900 births; risk increases with age of mother
- **Spina bifida (abnormal opening in the spine):** 1 in 2,000 births
- **Anencephaly (lack of part of the brain):** 1 in 8,000 births

The most important thing to do when you get bad news is to find out exactly what you're dealing with. You may need to see a perinatologist, a doctor who specializes in complicated pregnancies, and possibly a genetic counselor.

You and your partner may not be on the same page when it comes to making decisions about birth defects. One of you may be more optimistic about the situation and the other more pessimistic. Your feelings will be a jumble, and emotions will run high. Try to support your partner in whatever she's feeling, but don't discount your own feelings and grief, and don't feel like you can't let your feelings show. No one expects you to be emotionless at a time like this, and crying with your partner can be a bonding experience.

Expect to go through the five stages of grief: denial, anger, bargaining, depression, and acceptance. Getting to acceptance can take a long time and a lot of anger. Give yourself the time you need.

Talking to someone outside the situation who listens and doesn't tell you what to do, like a friend, religious advisor, or relative, can be a godsend. And most important of all, don't play the blame game. Congenital birth defects are rarely anyone's fault.

Fetal demise

Even more devastating than the discovery of birth defects on routine ultrasound is the discovery of a fetal demise. The term *fetal demise* is usually used to describe the death of the fetus in utero after 20 weeks. There are many potential causes of fetal demise, and few if any can be anticipated or avoided.

Fetal demise may be discovered because the baby doesn't seem to be moving much, bleeding starts, or amniotic fluid begins to leak,

but it can also be found during a routine gynecological check up. Fetal demise occurs in 6.8 per 1,000 pregnancies overall.

Most fetuses are delivered vaginally after labor induction. Parents are encouraged to hold their baby and give him a name, but at no time will this be forced on you if you don't feel it's the right thing for you to do. Your partner will be given medication to dry up her milk supply and will be put in a room off the maternity floor in most hospitals. Most hospitals will let her go home as soon as she's physically stable.

In many cases parents are better able to get though a fetal demise if they know exactly why it occurred, but sometimes the reason isn't obvious. Not knowing why can be very difficult. Again, blame has no place in the aftermath of a fetal demise.

Preparing Yourself for Preterm Labor and Delivery

More than 12 percent of all deliveries in the United States are preterm, which means they occur before 37 weeks. Of those:

- 70 percent are born between 34 and 36 weeks.
- 12 percent are born between 32 and 34 weeks.
- 10 percent are born between 28 and 31 weeks.
- 6 percent are born before 28 weeks.

The chances of delivering a very small preemie are low. Babies born between 28 weeks and term may require prolonged hospital stays, but most ultimately do well.

Recognizing the risks of preterm delivery

Many preterm deliveries occur without any known cause, but in a good percentage of cases, doctors can pinpoint the reason. The following situations all increase the risk of preterm delivery:

- **Structural abnormalities:** An abnormally shaped uterus or an *incompetent cervix,* one that starts to dilate from the increase uterine weight, can cause labor.
- **Multiple birth:** A large percentage of twin, triplets, and other multiples deliver before 37 weeks.

- **Infections:** Urinary tract infections can start uterine contractions if not promptly treated.
- **Hypertension:** High blood pressure can reduce blood flow through the placenta to the baby, causing poor growth that may necessitate early induced delivery.
- **DES exposure:** Diethylstilbestrol (DES) was a drug given to millions of women to prevent miscarriage between 1938 and 1971. Women whose mothers took the drug may have structural abnormalities that cause preterm delivery.

Handling feelings of guilt

Guilt is common after a preterm delivery, just as it is after any other setback in pregnancy. Again, don't get caught up in what you and your partner could have done to prevent it, or whose fault it is that you went for that long walk the day before the delivery. Even if one of you did something foolish, rehashing it now is pointless.

Put your energies into working with your partner to help your baby get healthy as quickly as possible. Visit often, and if support groups are available, get involved; studies show that parents involved in support groups have less anxiety, anger, and depression.

Navigating the NICU

The neonatal intensive care unit (NICU) is like nothing you've ever seen before. Although hospitals put more emphasis than they used to on keeping NICUs quiet and more like the womb, they are, by necessity, fairly noisy, with alarms going off, lights on day and night so hospital personnel can see what they're doing, and at the center of it all, your little baby. She may be hooked up to just a single monitor, or perhaps so laden down with medical equipment and IV lines that you can scarcely find the baby, as shown in Figure 6-2.

The best way to deal with the NICU is to focus on your little part of the world. Get to know your baby's nurses, and stay near your own baby's isolette. Asking what's wrong with other babies is really bad etiquette, and the nurses won't (or shouldn't) tell you, anyway.

Preterm babies are often moved from the hospital where they're born to a level 3 nursery, a nursery with advanced technology to handle complicated preterm issues. This can make your life complicated, especially if the new hospital is some distance from your house, but your baby's care is ultimately worth it.

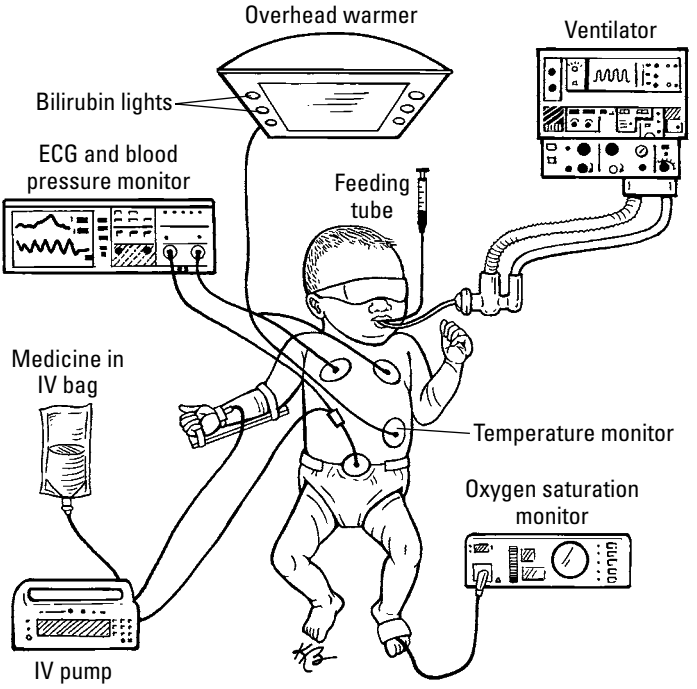


Figure 6-2: A preemie baby in the NICU.

Some hospitals with large regional NICUs have facilities that allow parents to stay overnight for a small charge or for free. Ronald McDonald houses are examples of facilities available near some hospitals.

If your partner is still in the hospital and can't see the baby right away, make sure you take lots of pictures, not just of the baby, but also of the neonatal unit and, if possible, of the people taking care of her. This way she can get a real sense of where the baby is and picture her in an actual place.

Some regional NICUs provide video feed to community hospitals so that moms who are separated from their babies can still maintain a connection until they have a chance to see the baby in person.

Expect the first time you hold your baby to be extremely awkward; she may be festooned in IV lines, and you'll probably be scared to death of her. Don't worry; it gets easier with time. She'll have less equipment attached, and you'll get to be a pro at dealing with dangling wires.

Knowing what to expect with a preemie

Preemies don't exactly look like the babies you have pictured in your mind, especially if they weigh less than 5 pounds. If your baby is born before 35 weeks, this is what she may look like:

- **Skinny:** Babies born before 35 weeks often don't have a good layer of fat.
- **Big eyed:** The lack of fat in her face gives your preemie a wide-eyed look.
- **Thin skinned:** The blood vessels are more visible in a preemie's skin.
- **Hairy — except on her head:** Preemies often are still covered with *lanugo,* a fine downy hair that helps keep her warm before she develops enough subcutaneous (under-the-skin) fat. Babies born before 26 weeks, on the other hand, may have no hair anywhere, and may have very red, gelatinous looking skin.
- **Boys may have underdeveloped genitalia:** Don't worry, dad — they'll grow.

If you think the baby looks really odd, check with the nurses for reassurance that everything's okay, but not within your partner's earshot. No matter what she looks like, she's going to think she's the most beautiful person on the planet.

Parents often have a sixth sense or are just more observant of the little changes in their babies and may notice a change in their baby's condition before the staff does. Don't be afraid to speak up if you feel something's not right!

Clarifying common problems

Premature babies often have respiratory problems because their lungs aren't well developed. Artificial ventilation may be started almost immediately and will gradually be decreased as the baby tolerates the decrease in extra oxygen. Some babies need special types of ventilation to overcome resistance in their lungs.

Most premature babies have feeding problems. Tiny babies, under 28 weeks, may not be fed by mouth for weeks or months, because their digestive systems are too immature to handle food. Intravenous feeding is given instead, and as the baby grows, tube

feeding is started. Nippling is begun very slowly, because it can tire a preemie and use up her energy stores.

Many babies grow very slowly in the NICU. Infections, stress, and any number of complication can slow growth. Reading the weight chart and seeing the weight increase by a few grams can be the highlight of a NICU parent's day.

Learning the ropes — er, wires

Sometimes knowing what's what when it comes to the wires and machines attached to your baby can calm your anxiety. Your average preemie may sport the following wires and attachments.

Breathing apparatus

If the baby can't breathe on his own, he may be attached to a ventilator via a tube that goes through his mouth or nose down to his lungs, which delivers a certain number of breaths per minute, or to nasal prongs, which deliver extra oxygen to his lungs via — naturally — prongs that fit into his nose. Try very hard not to do anything that may dislodge the breathing tubes.

Monitoring equipment

Since preemies have an unfortunate habit of forgetting to breathe, often even babies who don't need breathing equipment are hooked up to a monitor that flashes a series of incomprehensible numbers, some with little flashing hearts next to them. The monitor is attached to the baby by wires that lead from the baby's chest, and possibly also from his hand or foot, or even from his umbilical cord if a line was placed there right after birth.

The machines monitor pulse (that's the flashing heart), respiration, (the number of times the baby breathes each minute), and oxygenation levels. Preemie heart rates are from 110 to 160 beats per minute, on average. Respirations are 40 to 60 per minute. Oxygenation in the 90s is good. Blood pressure may also be continuously monitored in very sick babies.

The baby's temperature may also be monitored frequently, if not continuously. Because preemies have little in the way of fat stores, they get cold easily, and stress and the extra work of being sick and trying to grow can use up energy that may otherwise help keep them warm. The incubator or bed the baby's laying on also has its own thermometer to make sure it doesn't get too hot or too cold.

Intravenous lines

Most NICU babies receive intravenous medications and nourishment, at least at first. IV lines can be very precarious in preemies

and need to be replaced frequently. The medications infused are sometimes hard on the veins, which "blow," necessitating a new IV. The NICU nurses don't do it on purpose, believe us; spending time putting a new IV in a preemie is rarely on the "fun things to do in the NICU" list.

If your baby has an umbilical line, he may not have a peripheral line (a line in the extremities or head), but umbilical lines can't be used for very long because they're a potential source of infection.

Preparing for preemie setbacks

Just when you think things are finally moving in the right direction, your preemie may get sick. Because preemies have decreased ability to fight off infection, and because they're attached to invasive equipment that can serve as a portal into the body, infections are very common among preemies. Some common NICU complications include the following:

- **Respiratory infection:** The tubes allow entry of germs into the lungs; pneumonia may develop and need antibiotic treatment.
- **Respiratory disease:** Long-term ventilation can save your baby's life but can also contribute to bronchopulmonary dysplasia, damage to the lungs that can take months or years to fully heal. This problem is more common in tiny babies known as micropreemies. Some babies with respiratory disease are discharged to home while still receiving oxygen, which is decreased gradually as they develop the ability to breathe better on their own.
- **Necrotizing enterocolitis:** Called *NEC* by the NICU staff, this inflammation of the immature digestive system usually occurs after feedings are started. NEC can seriously damage the intestines. Feedings are temporarily stopped so the gut can heal, and IV feedings are given instead.
- **Intraventricular hemorrhage (IVH):** IVH is a bleed into the brain that can range from mild (graded I) to very serious (graded IV). Around a third of babies born between 24 and 26 weeks have a bleed, but any baby born before 34 weeks can have an IVH. Bleeds may occur at the time of delivery or afterward.

Taking baby home

Preterm babies don't always have to stay in the hospital until they reach their original due date, and they don't always have to weigh 5 pounds before being discharged, either. NICUs generally assess the baby's condition, the parent's ability to handle possible

problems, and the parent's willingness to learn the baby's care so they can do it at home.

Many parents take home babies who are still being tube fed or who are on monitors to make sure they keep breathing. Others don't feel at all comfortable with technical equipment and would rather have their child in the hospital for a little longer to be monitored. In fact, feeling completely unprepared to take home a preemie who has spent weeks or months in the NICU is very common.

If you or your partner starts to go into panic mode about homecoming, get involved with a preemie support group if you haven't already. Knowing that other families have done this and the whole family has survived is very reassuring. And seeing a former 2-pounder tooling around the block on his bike is the best possible assurance that most preemies come through their early trauma just fine.

Seriously, going home with the inept pair of you is not the worst thing your baby will have to face in life, so just do it. Keep that NICU number on speed dial for a while, though!

Hi, Baby Baby Baby: Having Multiples

The birth rate of twins, triplets, and more has exploded with the advent of in vitro fertilization (IVF) and other advanced reproductive technology. Seventeen percent of twins and 40 percent of triplet births are results of infertility treatment. In 2006 the multiple-birth statistics in the United States broke down as follows:

- Twin births occurred in 3,200 per 100,000 deliveries.
- Triplets comprised 143 per 100,000 births.
- Quadruplets occurred in 9.89 of 100,000 births.

If you're expecting multiples, find a support group pronto. Not only are they a great source for used twin or triplet baby paraphernalia, which can be extremely expensive, but they're also a source of a lot of practical info on how to handle more than one baby.

Multiple identities: What multiples are and who has them

Although infertility treatments are the largest risk factor for multiples, you're more likely to have multiples if

- **Your partner is black.** Black women have the highest natural twinning rate of the different racial groups; Asian women have the lowest.
- **Your partner is older than 35.** Twins occur naturally around 3 percent of the time in women 25 to 29, and 5 percent of the time in women 35 to 39.
- **Fraternal twins (nonidentical) run in her family.** Your family history doesn't seem to have any bearing on the statistics. If she's a fraternal twin, she has a 1 in 17 chance of having fraternal twins.

Twins can be either fraternal or identical. Fraternal twins are created from two different eggs and are no more similar than any other two siblings. Identical twins are the result of one embryo splitting into two at a very early stage of development. Siamese twins, also called conjoined twins, are always identical twins who didn't completely split as embryos. Conjoined twins are usually identified on ultrasound before delivery.

Obviously, boy-girl twins are always fraternal, but if you have two of the same sex, it may be difficult to tell at first whether they're identical or fraternal. The majority of twins, especially twins from IVF cycles, are fraternal, although IVF also increases the risk of having identical twins. DNA testing is the only definite way to determine if twins are identical or fraternal, although sometimes it's obvious twins are fraternal, if they look quite different.

Many IVF parents who implanted only two embryos have been surprised to find themselves carrying three fetuses. If this happens to you, don't accuse the doctor of putting in an extra embryo he had lying around! What happened was that one of the embryos split into identical twins.

Health risks for mom

All the usual pregnancy complaints are intensified during a multiple pregnancy. Annoying issues such as morning sickness, weight gain, heartburn, constipation, shortness of breath (especially on any type of exertion), urinary problems, and hemorrhoids are all likely to be magnified.

Many of the health risks of pregnancy for your partner increase with the number of fetuses she's carrying. Multiple pregnancies are more often medically complicated by:

- **Gestational diabetes:** The increased placental size and hormone production may raise the risk of gestational diabetes in multiple pregnancies.

- **Pregnancy-induced hypertension:** High blood pressure after 20 weeks of pregnancy. One in three mothers of multiples develops PIH.
- **Anemia:** Maternal low red blood cell count.
- **Hemorrhage:** Severe blood loss at the time of delivery.
- **Placental abruption:** Women with multiples are three times more likely to have the placenta come off the uterine wall prematurely, possibly resulting in severe hemorrhage.
- **Cesarean deliveries:** Cesarean deliveries are pretty much a given in higher order multiple births because it's unlikely all the babies will be head down, and high order multiples are so small that even if they're all head down before birth, one or more are very likely to flip as soon as the first baby is delivered and the rest have more room, possibly necessitating an emergency cesarean.

For high-order multiples (triplets or more), bed rest during pregnancy is very likely.

Risks for the babies

Twins are five times more likely than single babies to have problems at birth or to die before or soon after delivery. Multiple pregnancies often deliver early, since the womb has less room for all the occupants, and preterm babies are known to have more complications, so these factors account for some but not all of the risks multiples face. Statistics show that

- Approximately 60 percent of twins deliver before 37 weeks.
- Thirty-six percent of triplets deliver before 32 weeks.
- Eighty percent of quads and more deliver before 32 weeks.

Twins are also more likely to have the following complications:

- Twin-to-twin transfusion syndrome can occur only in identical twins who share the same placenta. One twin receives too much blood, the other too little. Both can cause problems.
- Birth defects such as cerebral palsy are much more common in multiples, and the risk increases with the number of fetuses.
- Cord accidents can occur, such as knots in the cord or entanglement in a cord. Cord accidents reduce blood flow to the fetus. Identical twins, who develop in one amniotic sac, are more likely to become entangled in their own or their twin's cord.

Your medical practitioner may well suggest that you deliver at a medical center equipped for high-risk births, but if she doesn't, you should still plan to do so. Knowing that your babies will have all the technological advances that may be needed in place from the moment of delivery can really reduce the stress you and your partner feel.

Babies can be transported, if necessary, but it's stressful for the babies and for the parents. And if one baby is transported and the other isn't, you'll be trying to split your visiting time between two hospitals, which is unnecessarily stress inducing.

Keeping Cool in Monetary Emergencies

Not all pregnancy emergencies involve medical crises: Some are all about cold, hard cash, or the lack of it. You may have taken a quick glance at your health insurance policy before you got pregnant, just to make sure you had the sterling coverage you thought you had, and you may have even checked the limits of coverage, without ever dreaming that you might rack up a hospital bill of more than a million dollars for one little baby.

Worse, you may have let your policy lapse just before getting pregnant — surprise! With unemployment around 10 percent in 2010, many people have no insurance coverage.

It's possible (probable, even, if you're normally a healthy twosome) that you have no idea what your insurance actually covers. Take time to dig through the drawers and find that policy, because pregnancy illnesses and hospitalization costs can blow your socks off. Many hospitals today have counselors who help educate you on your fiscal responsibilities before they let you walk out the door, but it's nice to know your coverage ahead of time.

If you find yourself without insurance or with minimal coverage, ask your healthcare provider or your local hospital about your options sooner rather than later, so you know ahead of time what your options are. Community resources are likely available to help with prenatal care or baby's care if you are experiencing financial hardship, and you may get the most benefit from them if you look into these resources ahead of time.

Checking out your insurance limits

Most insurance policies have their limits clearly listed, including an amount listed as a lifetime benefit. Insurance policies also

may list your maximum obligation, or deductible, for the year; for example, you may have a yearly cap of $5,000 on your out-of-pocket expenses for a year, meaning your insurance company pays everything else. However, you may have to pay every penny of your deductible before benefits kick in.

Covering the cost of unexpected medical expenses

Even the best insurance plans leave you footing a certain portion of the medical expenses. Over the next six months, don't be surprised to receive separate bills from every wing and department of the hospital in which you stayed.

A 2001 study reported that as many as one third of bankruptcies are related to medical debt. Even if you have insurance, using up your limits can leave you with a hefty bill. Most hospitals have a social worker or debt counselor who will work with you on bills that result from being underinsured or if you have no insurance. Most have debt repayment plans, and many will reduce the bill in some circumstances.

You may be able to get some aid from the hospital's charity program or, if your child has an unusual medical condition, from a foundation involved in the disease.

The main thing to do when faced with a bill that equals the national debt is not to panic. You have options, and you need to investigate them. You also need to be upfront with the hospital from the beginning about your coverage, so you have time to resolve things before the hospital threatens to hold your partner or baby hostage. (Don't worry, they won't.)

Parents of newborn baby girls have been charged for circumcisions — mistakes happen, and they can be difficult to find. At the grocery store, you may not be overly pleased if your receipt only listed your total charge and not each item individually, but that will be the case with your hospital bills. If at any point your bill doesn't make sense — or it seems like you are paying for the same thing twice or for something you didn't receive — ask your hospital's billing department for an itemized receipt. It will be a lengthy document to comb through, but it allows you to challenge mistakes and suspect charges, and it may save you money.

Chapter 7

In the Home Stretch: The Third Trimester

In This Chapter

- Seeing how baby gets ready for delivery in the third trimester
- Putting on weight and dealing with hormones: Mom's last three months
- Understanding your insurance benefits
- Choosing a pediatrician early

The last three months of pregnancy are when reality hits like a ton of bricks and you and your partner realize, albeit still rather dimly, that a real baby is coming to live with you. A baby with her own personality, a separate person who is developing definite likes and dislikes even before birth and will be able to express them even when she can't say a word.

In the third trimester, all the major organs and appendages are in place, and all the baby has to do is grow. Mom is also doing her own growing, with an attendant list of common discomforts and complaints that you'll become well acquainted with. In this chapter we look at baby's growth, mom's growth, and your part in dealing with your family's expansion.

Tracking Baby's Development during the Third Trimester

At the start of the third trimester, your baby is fully formed, although you wouldn't think so if you got a look inside the womb. The eyes are still fused, the skin is gelatinous, and the body fat is nonexistent, but everything that the baby needs to develop into a normal newborn is present and accounted for. The following sections provide the highlights of fetal development in the last three months of pregnancy.

Adding pounds and maturing in the seventh and eighth months

Week 27 starts off the final trimester of pregnancy, and don't think your partner will let you forget for one minute that she's been hauling this child around for six months already. While week 27 marks the beginning of the end of a full-term pregnancy, it also marks the end of the "easy" trimester.

So if you thought you heard lots of complaints in months four, five and six, you ain't seen nothin' yet! And her complaints are justified. The baby grows from around 10 inches long and 1.5 pounds at week 27 to around 18 inches long and 4 to 6 pounds by week 36. That's a lot of growth in just nine weeks, and your partner will be feeling it.

In the seventh and eighth months, the baby develops in the following ways:

- **Fully develops the lung tissue necessary to breathe outside the womb:** By 36 weeks, most babies can breathe independently without oxygen supplementation.
- **Matures the digestive tract and kidneys:** The ability to breathe, suck, swallow, and eliminate in tandem is essential for life outside the uterus.
- **Begins to see:** The eyes open around week 31, and the baby begins to perceive light and darkness.
- **Jumps in response to loud noises and recognizes familiar voices:** Go ahead, talk just to him — he'll turn toward your voice after he's born if he's familiar with it, and "Honey, get me a beer" aren't the only sounds you want him to associate with you.
- **Puts on some fat:** Your baby gains weight in these nine weeks (and so does your partner) because the baby is both growing and developing fat stores to help him regulate his temperature after birth.

Figure 7-1 shows the development of your baby in these final weeks.

Getting everything in place in the ninth month

The ninth month is the home stretch. In these four weeks the baby assumes the head-down position for good — at least you hope she does. After 36 weeks, she's usually too big to go flipping around, although some babies do manage to turn themselves right-side

up, which, for birthing purposes, is upside down, or *breech.* (See Chapter 9 for more about breech deliveries.)

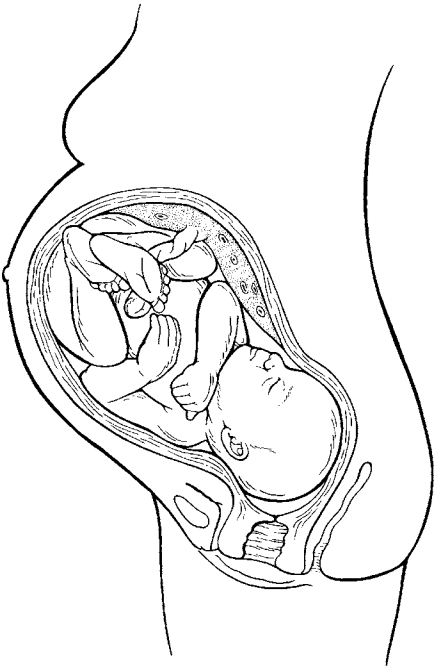


Figure 7-1: The fetus looks more and more like a fully developed person in the third trimester.

Your baby doesn't have much left to do in the last four weeks but grow and perfect already-in-place systems. In the last month, your baby will:

- **Have descended testicles, if he's a boy:** Earlier in pregnancy, the testicles develop in the abdomen and descend gradually into the groin before assuming their final position outside the body. Boys whose testicles don't descend by the time of birth are evaluated periodically. Surgery may be required if they don't descend by a certain age because the increased body temperature can damage reproductive organs in males.
- **Start to develop wake-sleep patterns:** Most babies seem to be more active at night, which may give you some idea of what you're in for.
- **Shed body hair and gain some head hair:** Lanugo, the soft downy hair that covers the fetus earlier in pregnancy, starts to disappear. Hair on the head may be abundant or nonexistent.

Dark-skinned babies often have more hair at birth than future blondies.

- **Swallow amniotic fluid, urinate, and practice breathing:** Babies get ready to eat by swallowing amniotic fluid, which also gives the kidneys practice in elimination as urine is excreted into the amniotic fluid.
- **Be active:** Some babies are thumb suckers even before birth. She may yawn, grimace, and grab the umbilical cord in her hand. Kicking gets harder as space becomes tighter, and she's likely to stay in position — hopefully head down — without turning during the last month.
- **Drop lower into the pelvis:** In anticipation of labor, the baby may drop down so that her head is pressing more directly on the cervix. This pressure helps thin and dilate the cervix, and also helps prevent the umbilical cord from falling below her head if your partner's water breaks, a dangerous situation known as a cord prolapse. (See Chapter 9 for more about cord prolapse.)

Finding Out What Mom Goes Through in the Third Trimester

The baby isn't the only one who changes in these final months, of course. Although your partner's changes on the outside are obvious, if somewhat unnerving at times (Can she really get any bigger than this? Won't her skin break apart?), the changes on the inside are just as dramatic, if not more so.

Getting acquainted with your "new" partner, now known as mother-to-be-with-a-vengeance, can be as complicated as getting to know the baby after he's born. Keep in mind at all times that she's going though physical and emotional upheavals the likes of which you will never be able to fathom, but you need to try.

Understanding your partner's physical changes

A pregnant woman at the end of the second trimester still looks pretty much like her normal self. Your partner may not even be wearing maternity clothes at this point, letting large shirts (yours, probably) and pants a size or two larger than her normal size cover her cute little belly. All that changes in the third trimester for most women, although some lucky women never look all that pregnant, even when delivering 8-pound babies.

Between the seventh and ninth months, expect these changes in your partner's physique and physical condition:

- **The uterus can be felt** a few inches above her belly button at the start of the third trimester, and up under her ribs by the end.
- **Legs cramps** occur because of nerve compression by the growing uterus.
- **Backache** is common because of the strain from the additional weight in front.
- **Constipation and hemorrhoids** can occur due to sluggish, compressed bowels. Pain and rectal bleeding can accompany hemorrhoids. Stool softeners and lots of roughage can help.
- **Urination** becomes almost a full-time job. She may need to get up in the night to urinate.
- **Varicose veins** may pop out on her legs; they may itch or ache. Spider veins, small broken capillaries, may also occur on her face, neck, and arms.
- **Itchy skin** is a huge problem for some pregnant women in the third trimester. Creams help keep the skin moisturized and decrease itching.
- **Heartburn** becomes more severe, but despite old wives tales, it's in no way related to the amount of hair the baby will have!
- **Feet and ankles often swell,** especially if you're having a summer baby. Encourage her to rest with feet up as much as possible.
- **Her center of gravity shifts,** making falls more likely. Hide her high heels and, if she'll let you, take her arm when walking, like a proper gentleman.
- **Shortness of breath comes with exertion,** because the baby is pressing on her lungs. When the baby drops, she may feel relief, but the tradeoff is increased frequency of urination.
- **She may have trouble sleeping,** even though she's always tired. Try tying a 6-pound, baby-shaped weight to your abdomen and you'll quickly understand why.
- **Breasts may start leaking** a few drops of colostrum, the first fluids produced after birth. They may also look humongous, since they contain around 2 pounds of extra weight — each!
- **Vaginal discharge increases,** so expect the reappearance of sanitary pads in the linen closet.
- **Interest in sex** may be at either extreme; it may be the last thing she's interested in, or one of the things that interests her most. Hormones are funny that way. (See Chapter 4 for more about sex during pregnancy.)

Contractions may also begin to occur on and off, starting first with Braxton-Hicks contractions, which don't change the cervix and are felt mostly in the front of the abdomen rather than in the back.

As the due date approaches, more contractions may come and go, usually with just enough frequency to have you leaping for the suitcase and putting it in the car before they peter out. Don't worry, the real thing will start soon enough!

Heeding warning signs

Though many complaints of late pregnancy are normal and expected, some are not. Make sure your partner contacts her medical provider if she experiences any of the following symptoms:

- **Vaginal bleeding:** In the last few weeks of the pregnancy, her doctor should be told about any type or amount of bleeding, with the exception of *bloody show* (blood-tinged mucus). Bleeding can indicate a placental detachment, called a placental abruption, or placenta previa, a low-lying placenta. (See Chapter 6 for more about both conditions.)
- **A sudden severe headache:** Strong headaches can be a sign of preeclampsia. (See Chapter 6 for more on the risks of preeclampsia.)
- **Severe abdominal pain:** This can be a sign of placental abruption, the premature separation of the placenta from the uterine wall, which can be life threatening for mother and baby.
- **Swelling of her face, hands, and feet:** Some swelling at the end of pregnancy is normal, but facial swelling can also be a sign of preeclampsia, especially if accompanied by sudden weight gain, headache, or a rise in blood pressure.
- **Leaking fluid:** This symptom usually indicates the bag of waters has broken. This is normal at the end of pregnancy, but not in the seventh or eighth month. Always call if she notices more discharge than normal or is leaking fluid. After the water breaks, the baby is more susceptible to infection because its protective sac is breached. If labor doesn't begin with 24 hours, her medical practitioner may consider inducing labor.

Bracing for your partner's emotional changes

Hormone levels are very high in the last few months of pregnancy, and, for many women, with hormones come mood swings. Be prepared for the following emotional changes in the last trimester:

- **Irritability:** When you don't feel your best physically, everything irritates you. Try not to be one of the "everythings" that drives her crazy.
- **Weepiness:** Women find many reasons to cry in the last few months of pregnancy. They cry because they're happy, or sad, or frustrated, or angry. They cry for reasons they can't even express to you, which can, of course, be frustrating to you, but you'll get over it.
- **Self-image issues:** Pregnancy changes a woman's body image, sometimes for the better, sometimes not. Some women resent the loss of the perfect figure, while others are happy that pregnancy provides an excuse for the extra weight that's always bugged them. Expect to hear her make negative comments, and don't respond to them in kind. The answer to "Do I look fat?" is never "Yes."

Some degree of moodiness, sadness, or depression is normal, but mood changes in late pregnancy should be fleeting, not permanent. As many as 10 percent of women become clinically depressed during pregnancy and need medical intervention, and up to 20 percent develop some depressive symptoms that may also need medical treatment.

Symptoms of clinical depression include sadness that doesn't lift, feelings of hopelessness or guilt, difficulty sleeping, constant fatigue, or behavior not typical for her. Don't ignore depression that seems extreme or that doesn't lift after a few days. (See Chapter 12 for more on depression after pregnancy.)

Pregnant dad symptoms: Couvade syndrome

In the past few years, some attention and study has been given to the idea that expectant dads may develop symptoms similar to those of their partners. This phenomenon, known as *couvade syndrome,* may affect as many as 90 percent of dads-to-be. Weight gain, nausea, backache, and other pregnancy symptoms may be experienced by dad as a psychological or physical reaction to his own weight gain, which may be due to eating more from stress or just from keeping up with his partner. Whatever the reason, rest assured in the third trimester that if you have "pregnancy pains," they too will soon be coming to an end.

Antidepressant medications can be given in pregnancy if her medical practitioner feels the benefits outweigh the risks. Because certain antidepressant known as *selective seratonin reuptake inhibitors* may increase the risk of heart defects, respiratory problems, low muscle tone, irritability, and eating difficulties in the newborn, the Food and Drug Administration issued a warning about the use of SSRIs in pregnancy in 2004.

Sympathizing with her desire to have this over, already

Around the seventh month, many women start expressing a strong desire to have this pregnancy over and done with. Before you jump in with long-winded explanations of how the baby isn't fully developed yet, it's too early, and other pompous statements about why being pregnant for just two more months is a good idea, realize that she isn't really wanting to have the baby early (well, maybe she is, a little); she's just tired and frustrated with being pregnant.

The last few months of pregnancy are no picnic, and unfortunately, you can't truly understand what she's going through. When she starts talking about getting this baby out by hook or crook the minute she hits 37 weeks, take it with a grain of salt. She's every bit as concerned about the welfare of this baby as you are, and she's not going to do anything rash.

Let her vent without giving her a lecture, and in five minutes, she'll probably be telling her mom how pregnancy has been the best time of her life. That's how hormones go sometimes.

Dealing with tears, panic, and doubts

Doing anything for the first time can be stressful, overwhelming, and scary. Facing labor, delivery, and motherhood for the first time certainly qualifies. Yes, you're also facing fatherhood for the first time, and dealing with the prospect of labor, seeing your partner in pain, and a host of doubts and fears, but her concerns are fueled by hormones and the knowledge that some form of delivery, be it labor or surgery, is the only way to emerge with a baby after nine months of pregnancy. The inevitability of the end of pregnancy can be overwhelming at times.

Your partner won't be the first woman to ever express the feeling that she can't do this, that having a baby was a mistake, or that she's changed her mind about the whole thing and wants to call it off. These feelings will intensify when she's in labor, so if you deal with them rationally now, you'll be better prepared for them then.

These feelings are temporary, but they're overwhelming when they hit. All new parents fear they won't be good at their new role. The two of you can approach this fear together by taking the following practical steps:

- **Read baby books and online pediatric sites.** You'll still go to pieces during the first colic episode, but if you know what to expect, it's a little easier to handle.
- **Take a class.** Most hospitals offer pregnancy classes that touch on at least the basics of breast-feeding and newborn care.
- **Visit friends with babies.** If you have friends or relatives with infants, hang out with them and pick their brains, if you trust their judgment.
- **Talk to your mom and dad.** Although time dims the memories of parenting, your own parents may be able to vaguely recall their early parenting days and give you some advice based on their own experiences. After all, you turned out okay, didn't you? If you didn't, don't ask them.
- **Talk it out.** Experience may change your mind about a number of parenting issues, but you'll feel more prepared if the two of you try to set out some basic ideas about how you want to raise the baby. This helps avoid drama-filled discussions when one of you wants to put the baby in your bed at 3 a.m. and the other doesn't, and also gives you the sense of having some grasp of what parenthood is all about. Expect your ideas to change frequently in the first actual weeks of parenthood, though.

Facing your own fears about fatherhood

Today's new dads may not have had involved fathers as role models as they were growing up, which can lead to uncertainty about exactly how to approach the fatherhood thing. The idea that dad should be as involved in child rearing as mom is a fairly new one, and you may feel uncertain about what your role is.

Because no two families are alike, you and your partner will design your own family model. You set your own standards here, so don't worry about what a "good" dad does or how other people approach fatherhood. You're going to be a "good" dad, so however you decide to embrace the parenting role will be the right thing for you and your partner.

Allow your partner to vent and express doubts and concerns, but never fail to reassure her that you know she'll be a great mom, that she was born to do this, and that you'll be helping her every inch of the way. Feel free to express your own fears and doubts about being a really good parent, but never in a "Can you top this" way.

Many women at the end of pregnancy have very vivid dreams about the baby or develop fears that something may be wrong with him. You can't do much about these fears except let her talk them out and reassure her that no matter what happens, you're there for her and the baby. However, if your partner becomes fixated on thoughts that she may harm the baby, or that something is wrong with the baby, she may be experiencing a severe depressive disorder. Make sure she sees her medical practitioner promptly.

Getting Your Paperwork in Order

Filling out forms and investigating your insurance benefits aren't ideal ways to spend a Saturday afternoon, but when the alternative is trying to fill in the blanks while your partner is enduring the beginning states of a painful labor, well, doing them now is a no-brainer! The more prepared you are from the business end of having the baby, the smoother the admissions process at the hospital will go.

Likewise, the better you understand your insurance coverage, the less likely you are to receive an unexpected (and unexpectedly large) hospital bill upon your return home.

Understanding your insurance

Although navigating your insurance plan may sound as impossible as understanding your income taxes, it's an important predelivery step for couples. Talk with someone from your human resources department at work as well as with your insurance company to fully understand your coverage.

Unites States law says that pregnancy cannot be deemed a preexisting condition by insurance companies, so if you or your partner switched jobs or insurance plans in the middle of pregnancy, you're probably still covered. However, the law is limited to group policies, not individual policies, and has multiple loopholes, so be sure to carefully research your coverage.

Your personal insurance plan dictates the following factors:

- **Length of stay in the hospital:** The Newborns' and Mothers' Health Protection Act is a U.S. federal law that requires all insurance companies to cover the hospital stay for 48 hours after a standard delivery and 96 hours after cesarean. It does not, however, require that insurance companies cover any or all of the birth itself.
- **Where you can give birth:** Unless you want to get stuck footing a huge portion of the bill, make sure that the hospital or birthing center of your choice is an approved facility by your insurance company.
- **Who can attend your birth:** Not all doctors are covered by your insurance, either, so make sure that yours is. If you're opting for a midwife, investigate the coverage your insurance provides and make sure your midwife is willing to work with your insurance company. In rare cases, some insurance plans cover part of a doula's fees.
- **What drugs are covered:** It may seem like your insurance is obligated to fully cover any drug or medicine your doctor provides your partner, but that's not always the case. Find out how much of the total cost of an epidural will be covered, because they're quite expensive, and you may need to plan ahead for the costs you may incur.
- **Elective procedures:** Whether it's a scheduled cesarean or a circumcision, not all insurance companies cover procedures that can be deemed as elective.
- **Percentage of total cost:** 80 percent coverage may seem like an awesome deal, until you realize your entire stay cost $10,000 and you're now on the hook for two grand. Knowing what to expect allows you to save ahead so when the bills start arriving, you won't have to scramble.

Midwives are generally less expensive to employ than a doctor, and if your insurance covers the cost of a midwife, you likely will save money going that route. Many midwives even deliver in hospitals and partner with a doctor to ensure emergency care when needed.

Home births are the cheapest option of all options but are generally recommended only for women who fall into the low-risk pregnancy category. However, if you and your partner are opting for a home birth, check with your insurance provider to find out how it handles such situations and what is covered in case of an emergency.

In the case of multiples, the cost will increase by a great deal because the babies are more likely to stay in the neonatal intensive care unit. Again, assuming 80 percent coverage, you could be

responsible for 20 percent of a bill that quickly escalates into the six figures. Also, keep in mind that after mom is discharged, the costs of travel and staying at or near the hospital while your baby/babies are in the NICU are up to you.

Here are some other important questions to ask your health insurance provider:

- Do you need to notify the provider upon admission into the hospital?
- Are childbirth classes covered by your plan?
- Will any portion of a doula's services be covered?
- Is lactation consultation covered?
- What newborn care is covered in case of emergency?
- Are any prescriptions or medications not covered?
- Are any procedures (circumcision, scheduled C-section), or prenatal tests (amniocentesis) not covered? Are there exceptions?

During benefits open season at your work, which usually occurs sometime around the end of the year, check into the labor and delivery coverage of any alternative insurance plans offered by your company and consider switching plans or providers to one that best suits your needs. It may save you thousands of dollars in hospital bills.

Preparing for the costs if you don't have insurance

Under no circumstances is living without health insurance a preferable idea, especially if you're pregnant or have children. However, due to myriad reasons, ranging from job loss to self-employment, a small portion of people find themselves pregnant without coverage.

The costs of all of the tests, ultrasounds, and doctor visits leading up to and following childbirth are an enormous expense, and many medical providers won't even accept you as a patient if you're paying out-of-pocket. However, others are happy to work out a payment plan, which may require a larger upfront deposit. Your provider options may be limited, but with a little legwork you can find someone.

Aside from the cost of your partner's doctor, you have to make similar arrangements with the hospital for your stay and any medicines, procedures, or operations you may undergo. The same goes

for the anesthesiologist, who may require that you pay the fee for an epidural upfront, running you between $1,000 and $2,000, depending on the provider. And after baby is born, he'll need more checkups and vaccinations, and you'll have to find a pediatrician who accepts patients without insurance.

With all those expenses, an insurance plan you buy on your own will probably pay for itself. In the case of job loss, pay for COBRA coverage for as long as it's offered to your family. ***Note:*** Some states also offer low- to no-cost healthcare for low-income families that covers the majority of childbirth costs.

Guaranteeing a smooth admissions process at the hospital

Think back to the last time you arrived at a crowded shopping mall with a parking lot packed to the gills with cars and you ended up walking ten minutes just to get to your store of choice. Now imagine that you drive right in and, miracle of miracles, the parking spot closest to the door is waiting for you.

If you want that experience upon arriving at the hospital when your partner is in labor — and believe us, you do — you need to make sure you fill out all of the preadmissions paperwork at your hospital or birthing center. This keeps you from having to fill out forms and answer an endless array of questions when you should be focused on the woman in pain.

A good time to make sure everything is in order is during your prenatal visit to the birthing center. The visit is not only a chance to get to know a few of the faces you may be seeing, but also the perfect firsthand opportunity to make sure that your partner is in the system.

Also, you want to make sure that you contact your delivery doctor or midwife prior to going to the hospital. Many doctors want a call as soon as labor begins; others just want a 30- to 60-minute heads-up before you head to the hospital. And because many labors begin (and end!) in the middle of the night, you want to give your doctor or midwife ample time to wake up before heading out the door.

At some point during the admissions process, you may be asked to leave the room so the nurse can talk to your partner alone. Although it may seem off-putting at first, this procedure is very important. Unfortunately, domestic violence is far too common, and one of the nurse's duties is to ensure that the woman in labor and the baby she's bringing into the world are in a safe environment during labor and delivery. Don't take it personally!

Whose Baby Is This, Anyway? Dealing with Overbearing Family Members

From the time you share the news of your coming baby, you'll be inundated with advice and visitors. Nobody will want to be more hands-on than your family, and it may grow tiresome and become a source of angst very quickly the closer to labor and delivery your partner gets, and especially when you get home from the hospital and crave some family time.

Mothers, grandfathers, aunts-to-be — they all get nervous, too. Unfortunately, their offers of assistance and their constant presence can keep you and your partner from some much-needed quiet bonding time before baby arrives. Your lives are about to change forever, for the better (baby, baby, baby!) and for the worse (goodbye sleep and frequent sex!), and you need time to enjoy the waning bits of childlessness you have left.

Your families love you, and their well-meaning, obtrusive advice, visits, and purchases are the only way they know how to show you just how excited they are to meet the new little person you're bringing into the family. However, if members of your family are becoming too involved or over-the-top for your tastes, be sure to thank them for the love and support and simply let them know that you and your partner need to take some time for yourselves before the baby comes.

Depending on how big and how emotionally connected your family is, consider starting a phone tree to share news earlier in your pregnancy to save you from having to call every single relative in your phone book every time you go in for an ultrasound (see Chapter 8 for details on creating a phone tree). Telling the same story over and over to 13 aunts, cousins, and neighbors may take the fun right out of your fun news. That said, don't cut off communication altogether. Make sure to call the most important people in your life as frequently as you see fit. It's an exciting time for everyone, and you won't want to tarnish a loved one's joy by letting him get all the news secondhand.

Picking a Pediatrician

Choosing a pediatrician before the baby arrives may seem unnecessary, but with so much going on in the weeks before and after delivery, you want to get it checked off the list in the third trimester.

It may take more time than you think to find someone who agrees with your stances on breast-feeding, vaccinations, and the necessity of certain in-hospital procedures.

Also, your baby will need to be cleared for checkout from the hospital by a pediatrician, and the sooner you start working with the doctor of your choice, the better. Building a relationship between a pediatrician and your baby increases the likelihood that your child will get the care she needs. And what better time to start than in the hospital?

Get a list of approved pediatricians from your insurance company and start your research. Talk to other parents in your neighborhood, as well as friends who live close by. As best you can, choose a pediatrician who is close to home, because you will be making the trip many times during the first year. Research feedback the doctor has received online, too. Considering the sheer number of hateful things people are willing to post online, take nasty reviews with a grain of salt, but do take note if a doctor has an overwhelming amount of negative feedback.

Next, schedule an interview with two or three doctors of your choosing. Here's a list of questions that you should ask any potential pediatrician to ensure you get the care you want for your baby, both during your hospital stay and beyond:

- How long have you been a pediatrician?
- How many doctors are part of your practice?
- What are your hours on the evenings and weekends?
- Is there an on-call doctor at all times? Is there a charge for after-hours calls/services?
- Are you a family practice doctor or solely practicing pediatrics?

  New parents may find it easier for the whole family to be treated by the same doctor. If you and your partner have strong feelings about this, make sure to ask if you can be seen too.
- Do you offer same-day appointments for illness?
- Are you often double booked?
- How long is the average wait?
- Will I always see you at each visit, or will my baby be seen by other doctors, nurses, or junior staff members?
- What is your stance on formula feeding? How long should our baby be breast-fed? What formulas do you recommend?

  Whatever decisions you and your partner make about feeding your child, it's vital that you have a pediatrician who will support your choices.

- Are you flexible with immunization schedules?

  Some parents choose to delay vaccinations or use alternate schedules. Make sure your pediatrician is onboard with your immunization wishes.

- When do you recommend beginning to feed solid foods?

  Depending on the doctor, you may be told to start feeding your child solid foods beginning at 4 months or as late as 6 months. Research varies on what is best, so get educated and make sure your pediatrician will support your feeding schedule.

- Do you require breast-fed babies to take vitamin D supplements?

  Breast-fed babies are often prescribed a supplement for vitamin D, however, not all pediatricians and parents agree that it's necessary. Do your research on what feels right to you and make sure your pediatrician agrees with your decision.

- Do you employ a lactation consultant or offer lactation support?
- What is your stance on use of antibiotics in children?
- How often are the play facilities cleaned?

Also, feel free to show your potential pediatrician your birth plan. Her reaction to your decisions, such as whether or not to give the baby a vitamin K shot right after birth or whether or not a baby needs erythromycin on his eyes, may help guide your decision. (See Chapter 8 for more on the choices detailed in a birth plan.)

Choose a doctor who most closely aligns with your wants and desires for your baby. You don't want to have to start the search all over again just because a pediatrician doesn't agree with your decision to delay vaccinations or give your child formula.

Chat up the other parents in the waiting room to find out the real dish on how long they have to wait at each visit, how often they actually see the doctor, and their overall impressions of her caregiving style. Parents are brutally honest, and they are your best source of information.

If you have a long-time family physician with whom you have a personal relationship and you don't plan to have be your child's pediatrician, let him know before the baby arrives. Not only is it respectful, it will help you avoid the awkwardness of having both your family doctor and your pediatrician show up at the hospital.

Chapter 8

The Copilot's Guide to Birthing Options

In This Chapter

- Making basic decisions about labor: Who, what, how, and where
- Creating a birthing plan
- Picking the people who get to be at the birth

Labor is nothing like it used to be. From the au naturel days when biting down on a bullet was the "medication" and the 1950s when every woman was sedated up to her eyeballs while dad spent the night in the bar, labor has evolved into a family event that involves medications that really take the pain out of labor, sleepovers for dad, and champagne dinners the night before discharge.

One thing about having a baby is sure: There's no one right way to do it. For every person who wants to deliver at home on her grandma's favorite quilt, another person feels that *epidural on demand* is the best phrase in the English language. Whatever you and your partner dream up as the ideal labor experience, rest assured it probably won't be the weirdest idea your birthing practitioner has ever heard.

You have more childbirth options today than ever before. Natural deliveries, home deliveries, and give-me-everything-you've-got deliveries are all possible. And the good thing is, no one is going to hold your partner to the ideas you both thought sounded good before labor started. If she decides she wants an epidural after all, all she has to do is scream — er, say so.

Although the number of options is much larger than in previous years, some of them may not be feasible in your situation. For instance, if your partner has certain medical conditions, such as preeclampsia, or if the baby has congenital birth defects, they really need to be under a doctor's care in a hospital, even if your

partner had her heart set on a home delivery. Be sure to talk to the doctor early in the pregnancy about your plans so that she can advise you on their feasibility and safety and let you know if circumstances change.

In this chapter we review the options that are available and help you decide what works best for you and your partner. We also provide tips on crafting a birth plan and deciding who's allowed in the delivery room.

Making Sure Your Birth Practitioner Is a Good Fit

Discussing your plans with your current birth practitioner as soon as you figure out what they are is important. For one thing, he may not be interested in participating if you're planning something out of his comfort zone, and you may need time to find someone who thinks childbirth in the backyard sounds like fun. If your midwife balks at assisting you during a delivery that features a medically unnecessary planned cesarean, you need to find one who doesn't.

Though many doctors are more flexible about childbirth options than they used to be, most doctors still have a fairly narrow comfort range, one that likely includes fetal monitoring, intravenous infusions, and limited time in the hot tub. The practices used by midwives, on the other hand, have become more mainstream in many areas, and a midwife may practice only slightly differently than an obstetrician.

Screening potential practitioners

Whichever birth practitioner you choose, the best way to know if you're in the right place is to ask. Both you and your partner should be there when discussing options, because if the practitioner isn't on board with your plan, he may think he can just wait and talk some sense into the absent parent. Presenting a united front, especially on non-negotiable items (such as home birth, for example) is best done as a couple. Consider asking these questions:

- **Where do you deliver?** Most doctors only deliver at one or maybe two hospitals. It wouldn't be practical for them to run around from place to place. If you choose a midwife, find out whether she delivers at homes only or also at hospitals, and make sure she can do it where you want to be.

- **What's your cesarean rate?** The cesarean rate in the United States and other developed countries is appallingly high. While cesarean sections are often necessary and lifesaving, they have a higher risk of complications for your partner and the baby. A significantly higher rate than your area's average is a warning sign that your doctor may be too quick with the knife.
- **How many inductions do you do?** Nobody wants to be pregnant forever, or even nine months, but pregnancies were designed to end naturally. Some doctors do way too many inductions, especially on Friday mornings. Your convenience isn't always the goal when the doctor offers to induce labor, and induced labors have a higher cesarean rate, and cesarean deliveries cause more maternal and fetal complications.
- **Who's on call?** Does the doctor come in when her patients go into the hospital, or is labor managed by residents? Early in labor, some doctors have the resident check their patient and call them for instructions; this isn't necessarily a problem, but knowing it ahead of time will keep you from badgering the nurses about when your doctor's coming in. For midwives, find out if she has an assistant or backup person to cover for her if she can't attend.
- **How do you feel about [fill in the blank]?** If you have an unusual request, politely approach your practitioner with this line, rather than demanding, "We want [whatever]." If you want to both spend labor in the hot tub naked, now would be a good time to get your practitioner's feedback on this idea.

Make sure you and your partner are agreed on what you want before discussing plans with your practitioner, and discuss it well before labor starts. Arguing in front of the nurses and trying to talk her out of an epidural at 6 centimeters is considered really bad form by the hospital staff, and they may not let you use the coffee machine or show you their hidden stash of emergency snacks for fainting fathers if they don't like the way you talk to your partner!

Working with a midwife

A midwife delivery in the hospital or birthing center can be a wonderful option. Midwives really are committed to fewer interventions in labor and give much more personal care. However, your partner may become so attached to her that you feel a little left out. Don't let that happen unless you're fine with being the third man; go to appointments and get to know the midwife yourself so she knows you're interested in being a real part of the partnership.

If you and your partner are thinking about delivering with a midwife, check the American College of Midwives (`www.midwife.org`) or Midwives of North American (`www.mana.org`) for options in your area. Using a search engine or checking chatboards on sites such as `www.mothering.com` for information is often the best way to get other people's opinions and experiences on what using a midwife or having a home birth is like.

A personal interview is always the best way to get a feel for not only the nuts-and-bolts information about education and experience, but also a sense of whether your personalities will "mesh" for the next nine months. When you interview your prospective midwife, ask the following questions:

- **What's your training?** Some midwives have nearly as many degrees as your doctor, and others have no formal training at all. But don't necessarily reject a midwife because of a lack of diplomas: Some people have a natural ability to deliver babies, love the work, and have all the knowledge necessary for a safe outcome, as long as there's medical backup nearby.
- **How long have you been doing this?** The longer the better. You see everything if you work in obstetrics long enough.
- **What's *your* backup plan?** If she says it isn't necessary to have a backup plan, reconsider this person. Having a backup plan is always necessary.

Getting some additional help with a doula

Although the word *doula* may have you picturing some sort of metal-studded medieval torture device, a doula actually can be a soon-to-be dad's secret weapon — one that can take some of the pressure off your very tense shoulders. A doula is a person, generally a woman, with a comprehensive understanding of the birthing process. She is hired by the couple to provide emotional and physical support throughout labor. Think of her as your very own in-hospital, labor-specific Google search/motivational speaker. Services doulas offer include:

- Allowing you to participate in labor and delivery as much or as little as you are comfortable
- Assistance in creating a birth plan
- Staying with you and your partner throughout labor and delivery (the doctor and nurses will not be present the whole time)

- Facilitating communication of the birth plan and the decisions of the mother and father to the doctor/midwife and nurses
- Giving light massage to both you and your partner during labor and delivery
- Postpartum education and assistance with newborn care, breastfeeding, and adjusting to family life

If you think doulas are only necessary for deliveries in which the father isn't involved, think again. Labor is a complex process, and as it progresses you and your partner will be asked to make many decisions about procedures and medications for which you may not feel fully prepared. A doula can inform you about both the risks and benefits involved, as well as help you explore other options that may better suit your birth plan.

Doulas also provide your partner constant support while giving you the opportunity to step out of the room to grab a quick snack or take a breath of fresh air. For long labors, a quick 15-minute nap can make the difference for a worn-out dad-to-be. Doulas ensure that someone who understands the process and your birthing choices is with your partner at all times — even when your eyes are closed.

And doula-ing has a medical benefit, too. Research shows that couples who have a doula present during childbirth tend to have shorter labors with fewer complications as well as a reduction in the use of labor-inducing medications, forceps, vacuum extractions, and cesarean sections.

After your new family returns home, most doulas make a postpartum visit that provides support for mom and baby, and she also provides telephone support for a specified duration following birth.

Not all doulas are created equal. Make sure to interview multiple candidates and ensure that they're certified by Doulas of North America (DONA). Make sure that she has had a criminal background check. For more information about hiring a doula, visit the DONA Web site: `www.dona.org`.

Choosing Where to Deliver

A century ago, everyone delivered at home. Fifty years ago, everyone delivered in the hospital. Today parents can choose either option, or may deliver in a special birthing center designed to mimic the comforts at home while still providing cutting-edge medical treatment if needed.

Delivering at a hospital

Hospitals today love to stress how much like home they are while still having all the most up-to-date equipment at their fingertips. And though hospitals have come a long way in improving the overall birthing experience, they're still not home. Some, however, are better than others at creating a welcoming, open-door policy for family, so check out the local possibilities, keeping in mind that your doctor can only practice where he has privileges and that in the long run a doctor you trust is far more important than lavender quilts and a pull-out sleeper chair. Here's what to look for when you visit different hospitals:

- **Is it secure?** Most hospitals have beefed up security, especially around the maternal and child health area. Hospital bracelets are embedded with alarm triggers, codes have to be activated to enter certain areas, and the staff all dresses in one color so you know who belongs there. It should *not* be possible to just walk onto a maternity floor without a pass. You want security to be tight, even if it's a pain in the neck.
- **What are visiting policies?** What you're looking for depends on your preferences. Do you want your entire family and a three-piece band present, or are you hoping to have just the two of you at the delivery and in the mother-baby unit afterward? Keeping family out is much easier if you can quote "hospital rules."
- **How much access does dad have?** Many places allow dad 24-hour visiting privileges, but some don't. Find out the rules ahead of time so security isn't called to remove you.
- **Is the staff helpful?** You can tell a lot by the attitude of the staff even on a short visit. Do they smile and say hello, or run over your foot with a gurney without even an "excuse me"? You're going to spend way more time with the nurses than with your doctor in labor — in fact, she's in and out so fast you may not be quite sure she was there at all — so your experience will be more pleasant if the nurses are good. Although you may still draw Nurse Ratched for your labor nurse, it's less likely at a hospital with a mission statement and policies that promote a positive atmosphere. If you're planning to use a midwife, find out how the staff will work with her.
- **Is anesthesia in house all night?** Surprising as it may be, some small hospitals don't have an anesthesiologist in the hospital all night. The anesthesiologist may have to be called in from home if your partner wants an epidural during the night. And if the hospital has only one on staff, she may be

doing an appendectomy just as your partner starts getting really uncomfortable. Know ahead of time so you can ask for an epidural early, if need be.

- **How's the décor?** Consider the appearance of the hospital room after everything else has been taken into consideration. Pretty surroundings are nice, but you'll be too busy to notice them. And that pretty quilt will be removed from the bed, because the staff doesn't want anyone bleeding — or worse — all over it.

After you make your decision, visit the hospital again. Knowing exactly what your room will look like and even recognizing some familiar faces removes a layer of stress as you get ready for delivery. Most hospitals and birthing centers offer tours, but you can call and schedule a private tour of the facility as well.

While you're there, take note of the eating options, parking guidelines, and prenatal and postpartum classes offered by your hospital or birthing center. This allows you to plan ahead and offer your well-wishers the information they need as well as make full use of the facilities' offerings.

Many hospitals offer prenatal lactation classes that are taught by the on-staff lactation consultant who will visit your room after delivery. The classes are usually free and quite short. Encourage your partner to attend a class in order to learn the basics of breast-feeding as well as to initiate a face-to-face relationship prior to the consultant's postpartum visit. Your partner will be much more comfortable asking questions and discussing any issues she and baby are having if she has met the consultant previously.

Exploring alternative options: Using a midwife at home

The idea of having your baby at home may appeal to you and your partner. Home delivery may be an option for you if you meet all the following strongly suggested guidelines:

- You have found a midwife who's willing to deliver at your home.
- You live fairly close to a medical facility in case of emergencies.
- You're not delivering in Montana in January or any other area where roads are impassable during the part of year you're due.
- You're both calm, sensible people who are really committed to the idea of home birth.

The trouble with labor is that while 99 out of 100 times everything goes perfectly, you need to be prepared for that one time when things go bad so quickly you can't believe your eyes. Having nearby medical help is really essential, unless your midwife can do a cesarean in under 30 minutes in an emergency.

Make sure your midwife has a backup plan to cover contingencies such as sudden illness or other problems that would prevent her from getting to you for the delivery. Does she have a partner or someone who covers her? Discuss circumstances that may cause you to change your mind about home delivery, from ominous weather to last-minute cold feet.

If you plan to use a midwife at home, be sure to get good answers to the following questions (in addition to the questions listed in "Working with a midwife" earlier in this chapter):

- **What type of equipment will you bring with you?** You can be sure a ventilator and fully equipped operating room won't appear out of her black bag, but basic medications like intravenous fluids and Pitocin to prevent heavy bleeding after delivery and oxygen, plus equipment like an ambu bag to breathe for the baby in case of problems after birth, should be in every midwife's bag.
- **How long do you stay?** "As long as you need me" is a good answer. She should stay at least an hour or two to make sure your partner and the baby are behaving normally and to get nursing started. On the other hand, you may not want her moving in with you — that's your mother-in-law's role. She should also visit for the next few days to recheck both mother and baby in case of any late-developing problems.

Looking at Labor Choices

Standard labor practices vary depending on who is delivering and where you deliver, but no matter the situation, you and your partner will have to make a number of decisions and can opt to make dozens of others if you have preferences. Educate yourselves on common procedures and their pros and cons by talking with the doctor and doing some reading. One of the biggest issues for women in labor is deciding whether or not to have an epidural or other pain medication. In this section we discuss that as well as another big issue, water births.

Going all natural or getting the epidural

The decision about pain medication is one area where, although you're welcome to have your say — if you say it nicely — the decision is really up to your partner. As long as she's not planning to do anything unsafe, she's the one who has to go through labor, not you, so the drug decision should be hers.

The *all-natural* method of childbirth, which avoids unnecessary pain medication and medical interventions such as episiotomies, seems to have peaked about the time the hippie movement went mainstream and started buying BMWs, but letting nature take its course in childbirth still has many proponents. Women have been having babies naturally since forever, and many women find going through labor without any medication empowering.

Classes that teach breathing and relaxation techniques as a natural way to deal with pain, such as the Bradley Method (see `www.bradleybirth.com` for classes near you), are available. A doula, midwife, or obstetrician who's supportive of natural childbirth can also be a good source of information on the pros and cons of delivering naturally and the classes available in your area. Some classes focus on specific breathing patterns (can you say, "Hoo hoo hee"?), while others stress learning to listen to your body, relaxation methods, and the benefits of staying upright during labor.

Around 50 percent of women in labor these days have *epidurals,* an injection that numbs the nerves from the abdomen down to the thighs. Epidurals are usually given when labor is well established, around 4 centimeters, because contractions can slow down if it's given too early. Some doctors, though, order epidurals earlier and then start Pitocin, a labor-induction drug, if contractions slow down.

Epidurals are better than they used to be; they can be run as a continuous infusion on a pump so they don't wear off and need to be re-injected. Some hospitals offer "walking epidurals," where the dose given still allows patients to walk, which is better for keeping labor going than lying in bed.

Some women turn down the epidural but are given intravenous pain medications to help with labor pains. One problem with IV medications is that they can depress the baby's ability to breathe after birth, so they can't be given too close to the time of delivery.

Taking it to the water

Water birth is delivery of the baby while the mother is in a large tub of water. The baby is delivered while under the water, which is considered by proponents of the practice to be less traumatic to him because he's spent nine months in water. Although water birth sounds like a warm, back-to-nature experience, no cultures actually practice water birth. This fact doesn't mean that water birth doesn't have some appealing possibilities, mostly for mom-to-be, who gets to spend most of her labor floating in a tub of water. Many women find spending some time in labor in water reduces pain and aids in relaxation.

Babies have never been traditionally born into a vat of water, and although most babies don't breathe until they're out of the water, a few baby deaths have been related to water birth. Laboring in water and getting out for the actual delivery may be a safer option to consider.

Some women absolutely should not have a water birth. The list includes:

- Women giving birth prematurely. (See Chapter 6 for more on preterm delivery.)
- Women with genital herpes.
- Women whose babies have passed *meconium,* the first stool, before delivery. These babies need their mouth and nose suctioned as soon as the head is delivered, to help prevent meconium aspiration into the lungs.

Creating a Birth Plan

A birth plan is a document that outlines the procedures, medications, and contingency plans that you and your partner are comfortable with throughout labor and delivery. It details your ideal birth experience while acknowledging the unpredictability of the process.

A birth plan is not a set of marching orders for your nurses, doctor, or midwife, so keep it simple and friendly. You share this document with your entire birthing team, and not all doctors and nurses are thrilled at the prospect of a couple telling them how to do their jobs.

Creating a birth plan requires that you and your partner discuss what you're comfortable with and make many important decisions prior to your arrival at the hospital. The last thing you want to do is to leave life-altering, labor-changing decisions to be made during an emotionally wrought time.

Visualizing your ideal experience

Labor and delivery are like reading a choose-your-own-adventure novel; every decision you make can lead you to a slightly different outcome.

As corny as it may sound, you and your partner should spend some time with your eyes closed trying to picture what your perfect experience would look like. Try to be realistic — a pain-free, 60-minute labor is highly unlikely, and making that dream a reality is beyond your control. Instead, focus on the things you can control.

When creating a birth plan, consider the following basic questions:

- What types of medication is your partner willing/wanting to have administered?
- Do you want to cut the umbilical cord? Do you want to bank the cord blood? (See the sidebar "To bank or not to bank" for more information.)
- Does your partner want final approval before the doctor performs a vacuum extraction? This involves a suction device that helps pull the baby out, which can cause painful tearing of the vagina as well as temporarily misshapen baby heads. It is a safe and, in some cases, necessary procedure, but many women want to have the choice as to whether or not it is performed.
- Does your partner want constant or intermittent fetal monitoring? Fetal monitoring tracks baby's stress levels during childbirth, and constant monitoring will limit your partner's ability to move freely during labor.
- Does your partner want to veto an episiotomy? An episiotomy is a surgical incision that enlarges the vaginal opening to allow the baby to come out more easily. It used to be a common procedure, but most studies show that letting the body tear naturally is a better option. An episiotomy is quite painful during recovery and not an attractive option for most women unless absolutely necessary for the health of the baby.
- Does your partner want to be able to get up and walk around while laboring?
- Are you opting to forgo circumcision?

To bank or not to bank

Cord-blood banking is the freezing of the blood in the umbilical cord, which is full of your baby's stem cells and can be used to treat disease (80 serious diseases including leukemia, other cancers, and blood disorders) down the road. It's becoming more popular in the United States, but is it necessary?

To purchase the collection kit (which you take with you to the hospital in order to collect the cord) and the first year storage fee will cost you between $1,000 and $2,000, with an annual storage fee of at least $100. Some research shows that using a matching donor's stem cells is just as effective as the stored blood, but due to the raging debate about how stem cells are collected, this is an effective way to ensure access.

In addition, your baby's cord blood can be used to treat other stem-cell matches in your family. It's more or less an insurance policy that, most likely, you'll never have to use. If banking the blood is outside of your financial possibilities, don't sweat it. Some research even suggests that letting all the blood from the cord flow into the baby before cutting is better for the baby's health, in which case, the blood isn't available to be collected, anyway.

In order to make sure you both feel positive about your childbirth experience, you need to prepare answers to these important questions. Many procedures may be done as a matter of course that might not jive with you and your partner's desires, so invest the time beforehand in order avoid any regrets that you could have prevented.

Many prenatal classes include exercises that help you visualize your ideal experience, and some even offer help developing your birth plan. When selecting a class, ask the instructor if these activities are included as part of the course. Having a third party involved, be it a doula or your prenatal instructor, may help you and your partner narrow down your list of what's truly important and turn those priorities into a cohesive, effective birth plan.

Drafting your plan

After you and your partner have decided what your ideal birth looks like, you need to put it into writing. Try to use language that's friendly, concise, and represents your flexibility.

Births don't usually go exactly according to plan, so allow wiggle room for the unexpected to make sure the nurses and doctors know that your priority is having a healthy baby at the end of the day. Here are some basic tips for writing your birth plan:

- Write a nice, short introduction that introduces who you are and thanks your team in advance for following your plan.
- Include a brief overview that states your basic, overall desires for the kind of labor and delivery you and your partner want.
- Break the main body into three sections: labor, delivery, and postdelivery.
- Under each heading, make the major points into a bulleted list for easy reading.

Keep it to one page unless you know ahead of time that your labor and delivery are going to be complicated and therefore require more steps.

Since the majority of what's being outlined in the birth plan is up to your partner to decide and ultimately undergo, get involved in this project by taking the lead. Make her favorite dinner and start a dialogue. Ask her questions about what she wants and tell her what you want, too. Take notes during your discussion and then start composing your birth plan. It won't happen overnight, but it will let her know how involved you want to be.

Use the following birth plan as an outline for creating an effective, concise document for your team:

The Johnson Family Birth Plan

The Midwives at Methodist Hospital Family Center

Parents: Rachel & Evan Johnson

Doula: Holly Barhamand

We're looking forward to having our baby at Methodist Hospital with the midwife group and staff! We know you see a lot of birth plans and we thank you for reading ours.

We anticipate a normal birth and would like to allow the process to unfold naturally. However, in the unlikely event of a complication, we will cooperate fully after an informed discussion with the birth team has taken place. We are also willing to sign release forms if legally required in order to avoid "routine" procedures we opt against.

Overall, we would like no medication, exam, or procedure to be administered to mother or baby until it is explained to us and we have given our consent. Thank you in advance for all of your hard work and excellent care!

Labor:

- *I would like to attempt labor without pain medication — I will ask (loudly, I'm sure!) if I feel I need something.*
- *We prefer intermittent, external fetal monitoring to continuous or internal. We consent to admission strip monitoring.*
- *I decline all vaginal or other internal exams except with my expressed consent at the time.*
- *I prefer to avoid IV. If IV is necessary, please use a saline lock.*

Delivery:

- *I would like to have freedom of movement and position during delivery — squatting, hands and knees, and so on.*
- *I very strongly prefer natural tearing to an episiotomy.*
- *We very strongly prefer delaying cord cutting until the cord has stopped pulsating (consent for exception will be considered if baby is in distress or excess meconium is present).*
- *We decline Pitocin, uterine massage, and pulling the cord.*
- *If surgery is required, Evan and Holly (our doula) need to be present. I prefer regional anesthesia rather than general, except in case of an emergency. Please use double-layer sutures when repairing my uterus.*

Postdelivery:

- *Please place baby on mother's abdomen immediately. We would like the baby to remain with parents at all times. We would like to start breast-feeding as soon as possible and delay potential interruptions.*

We respectfully request the following:

- *No routine suctioning of the baby's mouth and nose (unless needed)*
- *No erythromycin eye ointment*
- *No vitamin K injection (unless there is bruising or birth trauma)*
- *No vaccinations are to be given at this time*
- *No blood to be drawn from baby. We consent to PKU test and are happy to discuss desired timing of this test with nursing staff.*

Thank you for your sensitivity to our preferences and for bringing your knowledge and care to this great event in our lives.

As important as this day is, you are not a celebrity, and your unrealistic demands won't be met with a smile and a nod. Nor will your team take any unnecessary risks that could harm mother or baby just to meet the requirements of your birth plan. Keep your birth plan focused on the elements of the birthing process that can be controlled, take each hurdle one at a time, and if and when things begin to deviate from the plan, help your partner to make the best decisions possible by getting as much information about the risks and benefits from the knowledgeable members of your team.

Sharing your birth plan with the world

Unfortunately, labor usually doesn't begin on that imprecise due date you've been hanging your hat on for the last nine months. Babies can come early, and with so much to get ready for, you may find yourself putting off creating and sharing your birth plan. Make time to write your birth plan toward the beginning of the third trimester, which will give you plenty of time to share it with your birthing team and any inquiring relatives and friends.

Going over your plan with the birthing team

Have your birth plan in place far in advance of your due date so that you can share it with your doctor or midwife during the seventh or eighth month of pregnancy. That gives you time to discuss the plan and address any concerns he may have. If you're hiring a doula, schedule a prenatal visit to go over the document.

Upon arrival at your delivery room, give a copy of your birth plan to the nurse assigned to your room. Hang a copy on the front of your door if permitted, as well as on the wall in your room, preferably near where your partner will deliver.

Getting off on the right foot is always a good first step. Deliver your birth plan to the nurses on duty with a plate of fresh-baked goodies. Making cookies or cupcakes can be a welcome distraction during early labor at home and can make the overworked, underpaid nurses more welcoming of your birthing decisions.

Informing family and friends of your plan

Choosing not to have an epidural, opting to use a midwife, or allowing a doula into your birthing room and not your partner's mom/sister/best friend can cause quite a stir. Anything you choose to do or not do that departs from other people's birthing experiences not only is "new and weird," but also can make them feel like you think the way they did it was wrong.

Conveying your plans early and often is key to getting everyone on the same page — or at least reading the same book — by the time the big day rolls around. Even if you can't get everyone to agree with your decisions, don't sweat it. Thank everyone for their concerns, but assure them that you would never make a decision that wasn't both educated and in the best interest of your partner and child. And, at the end of the day, when the baby arrives nobody will care how he got here.

Unless you're openly soliciting advice from others in your lives, talk about the plan as if it were a done deal. Talking about considerations and decisions you're making with a larger group of people means that although you may get a wide spectrum of opinions, you'll also get an even wider spectrum of criticism when your decision doesn't adhere to everyone else's recommendations. However, you and your spouse have the right to decide the birthing option that works best for you. When your plan is in place, simply tell the people in your lives where, when, and how you plan on having the baby.

If you and your partner are worried about the reaction your mother-in-law will have to the news of your plans to have an at-home water birth, don't be afraid to share the news of your personal birth plan via e-mail. That way she's allowed to have her reaction without making you feel judged. Also, the more unconventional your birth plan is, the more information your family and friends will want about your choices. In those instances, it is best to formulate a detailed, concrete birth plan before sharing the information.

Many people are quite opinionated when it comes to whether or not to have a medicated labor as well as whether or not you plan to circumcise. Don't feel the need to argue your position; the decision is ultimately yours, and what you want most is to do what's best for mother and baby in your eyes. Consider telling people that you plan on seeing how the events unfold and that you'll address mom's and baby's needs as you see fit on delivery day. After all, nobody knows what your partner will need or want until she needs it.

Get educated on your options and be honest with your friends and family. If all else fails and someone still insists you're wrong, have a confrontation. Arguments aren't enjoyable, but you'll be happier if you have it hashed out before the big day arrives.

Picking the Cast: Who's Present, Who Visits, and Who Gets a Call

Labor and delivery aren't the times for a family reunion. Having a baby is exhausting, emotional, and the one time in your lives when you need to focus on each other and your baby more than anything else in the world. Which means that you and your partner probably won't want many people in the room with you. To avoid any arguments or awkwardness at the hospital when you should be focusing on other matters, decide in advance who you'll allow in the room for delivery, who can visit at the hospital, and how you're going to spread news of the birth to everyone who isn't present.

Deciding who gets to attend the birth

Deciding who gets to be in the room is a big decision that's not yours to make. Your partner's the one nearly naked under a spotlight in a room of people, so she gets to make the call on who is allowed to be in the room during labor and delivery. And gentlemen, let's face it — she just may not want your mother there, no matter how much your mother would like to be present. As labor progresses, most women won't care who sees what because they will be so focused on birthing the baby, but it's still best for her labor to have only the people she wants to have present. Any stress or distraction in early labor can slow down the process.

In addition to you, the doctor or midwife, a doula (if applicable), and nurses, some women opt to have a sister or close friend in the room who can provide her with much-needed emotional support. Other women decide to have one or both parents present. Again, check with your hospital or birthing center to see who (and how many) they allow to be present for a birth.

Telling family members or friends that they need to leave isn't easy, but if your partner doesn't want someone in the room, it's your job to politely ask him or her to exit. For instance, if her father won't stop offering unsolicited stories about how painful his foot surgery was in comparison to her labor and she's on the verge of clobbering him with forceps, pull him aside, thank him for being there to support you both, let him know that your partner sends her love, and then firmly explain that she's feeling the need to have silence in the room for the remainder of the delivery.

Of course this message won't go over well, but it's not about other people at this point. Put your partner's needs first and worry about hurt feelings later. Besides, the moment baby arrives, nobody will remember anything other than how perfect and amazing your new bundle of joy is.

Planning ahead for visitors

Many people opt to have no friends or family members present in the delivery room. But it also goes beyond that. Being inundated with visitors at the hospital may seem like a nice thing in theory, but in practice it can become overwhelming in a snap. You will be tired, and your partner and baby will need rest, so make sure to take enough time for yourselves.

Also, having too many people handle your newborn only increases the risk of spreading illness. Invite only the most important people in your lives to the hospital and save the rest for a home visit in the following weeks. Thank anyone who offers to come and tell them that you look forward to spending time with them in the coming weeks. Simply telling someone that your new family will need rest, not visitors, should do the trick.

However, if someone shows up unannounced who you would rather not have at the hospital, don't be afraid to tell her that you have to keep visits short, say five minutes or so, because your partner and baby need time to rest. Schedule a follow-up visit if you wish. If there is someone who you don't want allowed into your room, for safety reasons or otherwise, be sure to alert the staff of the person's name and description.

There's never been a better time in your life to focus inward, so don't spend time worrying about what other people will think about your decisions. You can always make up later if someone is offended.

Planting a phone tree

Spreading the news far and wide can be both exhausting and time consuming, and after a delivery you and your partner likely won't be up for talking to everyone you know. Nor will you have the time! Nonetheless, everyone you know will request to be alerted within seconds after baby's arrival into the world.

Here are some simple tips to make a phone tree, which will require you to make only one call in order for the news of baby's arrival to begin branching out into the world.

1. **Start by gathering all the names and phone numbers of people you want contacted after your baby is born.**
2. **Start a list, with the first person as your primary contact.** He or she will be the one person you call upon baby's arrival.
3. **Write two names side-by-side under the primary contact.** These are the people your primary contact will call.
4. **Branching off those two people, write two more names under each.** The two people your primary contact calls will each have these two phone calls to make. Continue making the phone tree, assigning each person two calls.
5. **Pass out copies of the phone tree to everyone on the list and instruct them that when they get the call, they're responsible for calling the next two people right away.**

   The phone tree still works if your callers have to leave phone messages, but the delay will slow down the rest of the communication.

If your list of contacts is short, consider having each person call just one other person.

Social network announcements

Sending an update to 500 of your nearest and not-so-nearest friends every time you have a witty musing about your favorite celebrity may be fun on the average day, but it may not be appropriate during labor and delivery.

Your partner may want you to keep the world abreast of the baby developments while she's in labor, but the most women will prefer that your focus be on soothing her and not navigating your smart phone.

A word of warning: As easy as it is to communicate using social networking sites, sharing major news, such as the birth of your child, via Facebook or Twitter will be offensive and hurtful to some of the more important people in your life. Finding out your best friend's baby arrived via a status update that already has 75 comments will leave those who truly love you feeling a bit cold. Take their feelings into consideration when making announcements throughout the pregnancy process. Make sure to hold off any major announcements until your phone tree has been initiated.

However, after news of the baby has spread through the appropriate channels to the appropriate people, social networking sites are a great way to show off your new bundle of joy to the adoring masses. It may cut down on the number of visits and phone calls you will receive when you're basking in the glow of new fatherhood.

Part III

Game Time! Labor, Delivery, and Baby's Homecoming

The 5th Wave By Rich Tennant

"They said we might notice some changes a week before she went into labor. Sure enough, 5 days ago, gas prices went up 6 cents at the pump, my lawn mower stopped working, and the guy across the street had his house painted."

In this part...

If you want to be prepared for labor and delivery as well as the first hectic days at home, this part gives you all the necessary details. From knowing what to do when labor starts to feeding concerns and understanding the contents of the baby's diaper, the chapters in this part equip you to handle the big and little events and changes that take place in all your lives in a very short time span.

Chapter 9

Surviving Labor and Delivery

In This Chapter

- Determining when labor is really happening
- Providing the best support possible
- Understanding the normal physical and medical aspects of labor
- Dealing with labor pain
- Needing a cesarean section

No matter how many birth plans you write (refer to Chapter 8 for more on writing a birth plan), and how many times you suffer through your relative's birth stories, labor always comes as a surprise. For many guys, it's the first time you see your partner in real pain. Even worse, you know it's your fault — because she reminds you of that fact every five minutes. The end result will be worth it, though, so fasten your seat belt and get ready for the roller-coaster ride of labor and delivery.

No two labors are alike, so we can't say exactly what will happen in your partner's labor. The only thing most labors have in common is a beginning and an end, and still, labor can begin in a number of ways and can end in an operating room, birthing center, back seat of the car (not to scare you), or in your own bedroom. Although details differ, knowing approximately how labor will go can reduce your anxiety by, well, maybe a little bit.

When It's Time, It's Time — Is It Time?

Although you may think you won't have trouble telling when your partner is in labor, you may. Contractions often get closer as labor progresses, but sometimes they don't. Some women are in a lot of pain in labor, and some aren't.

All this confusion over the start of labor may have you leaping into the car every time your partner sighs during the last month of pregnancy; an actual moan may have you reaching for the phone to call 911. Take 911 off speed dial, though; labor isn't always clear cut, but you can follow a few general rules when it comes to heading for the hospital:

- **If her water breaks, call your medical practitioner.** If you're having the baby in the hospital, they'll probably want her to come in, even if she isn't having contractions. However, many women prefer to go through early labor at home, even after the water breaks. Discuss this with your medical practitioner. After the water breaks, she has an increased risk of infection and a small chance that the umbilical cord can *prolapse,* or fall below the baby's head.
- **If your partner's a beta strep carrier, go to the hospital as soon as her water breaks.** During pregnancy, women are tested for beta strep, a common bacteria that can be carried in the vagina. The bacteria normally causes no harm in healthy women, but after the water breaks, beta strep can ascend up to the fetus and cause serious infection, so intravenous antibiotics need to be started right away.
- **If your partner's in severe pain, even if the contractions are not regular, call your medical practitioner.** Pregnancy complications such as the placenta separating from the uterine wall, called *placental abruption,* can cause severe pain and can be life threatening.
- **If bleeding like a menstrual period occurs, call your medical practitioner.** A small amount of blood-tinged mucus is common when the mucus plug is passed, but heavier bleeding needs medical evaluation.
- **When contractions are regular and getting closer, call your medical practitioner.** They don't have to be — and may never be — five minutes apart.

Avoiding numerous dry runs (yes, it's us again)

Calling your medical practitioner before going to the hospital and following his advice can save you many embarrassing excursions in and out of the labor and delivery ward. Think no one ever gets sent home without a baby? Think again. Think no one has ever gotten sent home ten or more times in a single pregnancy? Think again, again. And yes, the staff will remember you from last week, and the week before, et cetera, et cetera.

Many women have contractions in the last month of pregnancy. If your partner's contractions aren't becoming stronger or getting closer together, this probably isn't the real deal. Unless her water breaks, she's in severe pain, or she's bleeding, wait until contractions get stronger and closer together. Just being in the labor and delivery ward really doesn't speed up the birthing process.

Knowing when it's too late to go

When your partner can't walk or talk through contractions that are progressively stronger and closer together, it's really time to go to the hospital. You'll know this instinctively when she says, "It's time to go *now*." But if by some chance she's a woman with short labors and says she feels pressure, has to have a bowel movement, or starts to push, dial 911, unless you personally want to deliver the baby in the back seat or the hospital lawn. (Coauthor Sharon has seen both situations.) Most emergency medical technicians have delivered babies before, or at the very least have read the manual that tells them what to do.

If the EMTs don't arrive in time, get your medical practitioner (or anyone's medical practitioner, actually) on the phone and follow her instructions. Rapid deliveries are usually uncomplicated, and your job may consist of calming your partner and not letting the baby fall on the floor.

In addition:

- **Don't pull on the cord or cut it.** Cutting the cord, dealing with the placenta, and worrying about vaginal tears can be done by people more schooled in such things than you.
- **Dry the baby off and keep him warm.** Skin-to-skin contact with mom is ideal.
- **If the baby isn't breathing, flick his heels.** Don't slap him or turn him upside down, even if you've seen it in the movies.

Don't dwell too much on the possibility of an unexpected home delivery. The odds are very small that a first labor will progress so quickly that the baby delivers at home.

Supporting Your Partner during Labor

Women in labor need lots of support. Your partner needs to hear that she's doing well, that things are progressing as they should, and that she really can do this. Even if her mother, sister, doula, and five of her dearest friends are with her, she needs *you.* Support means different things to different women, though, and your job is to figure out what she needs while in labor and do it.

Figuring out how she wants to be supported

Your partner may not be in a very talkative mood during labor, so asking her what she wants you to do may get you kicked right out of the room. This is one time in her life when she wants you to think for yourself and take action without being told what to do. Take the lead by offering choices. Ask her if she wants

- A back rub
- A massage
- A hand to hold
- You to sit behind her and support her back
- An epidural
- You to kick her mom out of the room
- Ice chips
- To get in the tub
- Any of the other labor options you discussed before today

Not taking the insults seriously

Women are not responsible for anything they say during labor, but you are, so don't get upset with any suggestions she makes about your anatomy or comments on your ancestry. And she doesn't really mean what she said about your mother, either.

Pain makes people say things they don't mean and may not even remember, so don't file away her remarks for another day. Vocalizing the pain in this way is both healthy and normal.

Looking at What Happens during and after Labor

Although childbirth classes and books do their best to tell you what will happen in labor, the reality is hard to describe in a book. But since it's our job to give you all the facts you can handle, the following sections describe what the normal stages of labor look like.

First stage

The first stage of labor encompasses the time between the first labor pain and complete dilation, when your partner will begin to push. Because quite a few things happen during the first stage of labor, it's further broken down into early, active, and transition stages of labor.

Early labor

Early labor is defined as the time between the start of labor and dilation of the cervix to 3 centimeters. This is the longest part of labor, sometimes lasting a day or two. During the early stage, contractions are often far apart and irregular. These early contractions thin and dilate the cervix. In late pregnancy, the cervix is thick, and the opening between the uterus and vagina is closed.

Normally the cervix thins before it begins to dilate, but there are no hard and fast rules. Many women are already somewhat thinned and dilated before labor begins.

Active labor

Things really start to move along during active labor, which is defined by regular contractions that become stronger and dilate the cervix from 4 to 10 centimeters. Active labor takes four to eight hours on average, although subsequent labors are often much shorter. A woman in active labor usually can't walk or talk through her contractions. She also may become a creature you haven't met before, one who knows words that may totally surprise you.

You need to be active in active labor, too. If your partner is doing natural childbirth, she needs help staying focused and breathing through the contractions. Don't just tell her to breathe; breathe with her. Some women want you to count off the seconds, others don't. Be guided by her responses, even if they're a little impolite at the height of a contraction.

If she's having an epidural, your help will also be appreciated. See the section, "What to expect during epidural placement" for the do's and don'ts.

Transition labor

Transition, the hardest stage, is the last part of active labor. Transition lasts from 7 centimeters to full dilation, or 10 centimeters. If your partner has a good epidural, this stage will probably breeze by, but if she's going natural, transition can be difficult. Transition can last anywhere from a few minutes in someone having a second or subsequent baby to a few hours in a woman having her first child. Typical side effects of transition include

- Shaking
- Vomiting
- Intermittent urges to push

Second stage

Second-stage labor lasts from the first push to the final delivery. Second-stage labor lasts anywhere from two minutes to three-plus hours. Women with epidurals often push less effectively, and medical practitioners may let the baby "labor down" without pushing if she's comfortable and the baby is doing okay.

Push, push, push!

Active pushing requires help from you, but don't actually push along with her, or you may have hemorrhoids almost the size of the baby after delivery. The nurse may ask you to help support your partner's legs or to support her back slightly.

The people in attendance at the delivery usually do lots of enthusiastic cheering when mom starts pushing. You'll find it easy to be enthusiastic when the baby's head finally begins to appear, although a little apprehension about how that big thing is going to make its way out of your partner's body is also normal.

Not all women are into the cheerleading scene, though, and actually prefer just to hear a single voice (yours) offering encouragement, or perhaps prefer no loud noises at all. If she looks aggravated during the cheers (beyond the effort of pushing), ask her what she wants. Then do it, and ask everyone else to comply.

Most delivery rooms have mirrors near the foot of the bed so that your partner can see what's going on. When your medical practitioner takes her seat at the end of delivery bed or table, she may

block the mirror, but most mirrors can be adjusted so your partner has a better view if she wants it. Pushing is difficult with your eyes open, so she may not see much of the actual birth.

If you want to cut the cord, make your wishes known, although many practitioners will ask you automatically. If you're turning a little green, don't feel like you have to cut the cord. In fact, if you're turning a little green, please go sit on the floor, or in a chair, so the staff doesn't have to tend to you.

Getting a little lightheaded during delivery is not a sign of weakness. Many guys don't eat enough while their partner's in labor, and you may be standing for several hours helping her push. Deliveries are very messy; vomit, poop, and blood can make a pungent odor that can be hard to deal with, even for the most experienced labor and delivery staff. Try not to add to the mess by passing out and taking the delivery tray with you.

It's a miracle!

Birth is miraculous. There's no other way to put it. Even practitioners who have seen thousands of births are still awed by it at times. Watching a new human being come into the world is an amazing privilege, especially when he's *your* new human being.

Crying at deliveries is not unusual. Of course the baby usually cries and family members often do too, but sometimes even the staff cries if they've gotten really attached to a particular couple. Don't expect your doctor or midwife to get all teary eyed, although it does happen in some cases.

Don't be surprised if your first feeling upon seeing your baby is dismay, either. New babies are not always the most beautiful of creatures. (We discuss newborn peculiarities in Chapter 10.)

If the baby is okay, your practitioner may give your partner the baby to hold and possibly to try to nurse, if she wants to try immediately. Some centers prefer to dry off, weigh, and assess the baby before bringing him back to mom to nurse. Either way, within the first 15 minutes, the baby will be dried off, weighed, and wrapped up so one or both of you can hold her or your partner can start nursing.

Wrapping things up after the birth

The placenta is delivered usually within 15 minutes of the birth. Contractions may accompany the loosening and passage of the placenta, but if your partner had an epidural, she may not notice.

If the placenta doesn't pass within 15 minutes, some medical practitioners give additional medication to help loosen the placenta or gently tug on it. Both the medication and tugging can cause uncomfortable cramping. Other practitioners give the placenta more time to release on its own before starting more medical interventions.

Very rarely, a condition called placenta accrete occurs in which the placenta can't be removed from the uterine wall. In severe cases, a hysterectomy is done because the placenta can't be removed and severe bleeding often develops.

If your partner has a tear, or if an episiotomy was cut to give the baby a little extra room and avoid a tear, the wound needs to be closed after the placenta is delivered. It normally takes about 15 minutes to stitch everything back together. An injection of numbing medication is given before stitches are put in unless your partner's still completely numb from the epidural. If she didn't have an epidural, passing the placenta and stitching may be mildly uncomfortable or annoying.

Many facilities now do delivery and recovery in the same room, so the bed will be refreshed and your partner's gown changed after the mechanics of the delivery are all taken care of. And she can eat! If she wants something special, you may be sent out to get what she wants, or, better yet, send one of her friends or her mom out so you can stay to admire your new family.

Helping baby right after delivery

If the baby doesn't breathe well at first (many don't, so don't panic), she may be taken right over to the warmer to be given a little oxygen. Don't worry; the staff will bring her back to your partner as soon as she's stable.

As normal as it is to ask a lot of questions and want to know exactly what's happening, try to stay to the sidelines so you're not interfering with your baby's care. You want the staff to focus on taking care of the baby, not talking to you.

Most issues that affect babies right after delivery are related to breathing. Not breathing inside the womb to breathing on one's own is a big transition, and some babies take a few minutes to get the hang of it.

Oxygen may be given by *blow by,* which means a tube is placed near the baby's nose but not too close to her eyes. If she needs extra help, oxygen is given with a bag and mask connected to an oxygen source; the mask fits over her mouth and nose, and the staff squeezes the bag to force oxygen into the lungs.

If the baby doesn't pink up and start crying quickly, she may be taken to the special-care nursery for further evaluation. You will usually be welcome to accompany her and find out what's happening, but don't forget your partner, still lying on the table feeling as confused and upset as you are and possibly getting stitches in her bottom at the same time. Make sure you keep her informed about what's happening and let her know you haven't forgotten about her. She may want you to follow the baby so you can report back and tell her what's going on.

Undergoing Common Labor Procedures

In the interests of making you familiar with all possible aspects of labor and delivery, some of the procedures you can expect to see during labor are detailed in the next sections.

Vaginal exams

Vaginal exams are often uncomfortable, especially when they're done during a contraction, but they're the only way to tell what's happening during labor. The cervix is checked for dilation, which is the only way to assess labor progression. Although your partner may not be overly fond of vaginal checks, you may love them because they give you new information to convey to friends and family in the waiting room or on the other end of the phone.

IVs

If you're delivering in a hospital in the United States, your partner will most likely have an *intravenous infusion,* or IV for short. The IV serves the following purposes:

- **Supplying fluids:** Many hospitals restrict fluids when labor begins, and getting dehydrated is easy when you're working extra hard and not taking anything in. If an epidural is given, prehydration is necessary to avoid a drop in blood pressure, which can decrease oxygen flow to the baby.
- **In case of cesarean delivery:** With the percentage of cesarean deliveries now more than 30 percent in the United States, there's a very good chance your partner will end up with a cesarean. If the surgery is done as an emergency, with time being of the essence, having an IV already in place saves time.

- **Covering the hospital's legal obligations:** If a woman has serious bleeding, an emergency cesarean, or just about any complication, an IV is necessary to give fluids to replace possible blood loss and maintain normal blood pressure, which often drops if spinal anesthesia is given for the surgery. Many hospitals routinely give IVs before they are really needed because, unfortunately, we live in a litigious society, and in the case of a malpractice suit, the lawyers will want to know if she had an IV in place for just such possible emergencies.

After an IV is in place it shouldn't be terribly uncomfortable, so if it is, let your partner's nurse know. Sometimes just retaping the catheter so it's at a different angle helps with the discomfort. Women who want to walk without dragging around an IV pole or spend time in the hot tub can have the IV hep-locked, which means the end is capped off and the bag of fluid detached. If needed, the heplock is flushed with solution to make sure it's still working before the bag is reattached.

Membrane ruptures

Although many women fear that their water will break someplace embarrassing, like in church or in the middle of aisle three at the grocery store, only around 10 percent of women's membranes rupture before labor starts. Often the membranes are broken by medical personnel using what looks like a crochet hook to snag the membranes and tear them. This procedure isn't painful for your partner or the baby.

Membranes are ruptured if your practitioner wants to check the fluid inside the sac for the presence of meconium, a sign of potential stress, sometime before or during labor. Between 6 to 25 percent of babies pass meconium before delivery; the older the meconium, the yellower and less particulate the fluid is. Newer meconium may be dark green, sticky, and form particles that can be sucked into the baby's lungs, causing respiratory problems at birth. The presence of either old or new meconium can cause respiratory problems at birth, so the fluid is always checked for meconium as soon as the membranes rupture.

If meconium is present, your practitioner will suck out the baby's nose and mouth as soon as the head is delivered to decrease the chance of inhalation. Keep in mind, however, that meconium can be inhaled before birth; there's no way to prevent this from happening because babies take practice breaths while still in the womb. Most of the time, the baby clears the meconium from the lungs, and no problems ensure, but it can cause severe lung infection and problems with circulation that require mechanical ventilation until the lungs heal, usually within a few days.

The membrane may also be ruptured to try to speed up labor, although labor doesn't always go faster after the membranes are ruptured, or so internal monitoring devices can be placed. (See "Fetal monitoring" for more about the ways your baby's heartbeat can be monitored before birth.)

Rupturing membranes can lead to harder, more painful contractions that don't actually speed up the process, so ask your medical practitioner why he wants to do this if you have concerns about it.

Fetal monitoring

Fetal monitoring devices record the fetal heart rate and the frequency and duration of the contractions. Don't let yourself become so enamored with the technology that you forget about the person at the other end! Many men love gadgets and start watching the monitor like it was the educational channel. (See the sidebar "Understanding fetal heart rates" in this chapter for more on what's normal and what's not.)

Monitoring your partner and the baby externally

External monitoring systems consist of two recording devices fastened around your partner's stomach and plugged into a fetal monitor, which provides a continuous printout of the fetal heart rate and the contractions. The monitor records the duration of contractions and the time between them but doesn't tell you the strength of the contraction. Each contraction resembles a hill or a bell-shaped curve, starting low, rising slowly, and then returning to baseline. Because the device sits on your partner's abdomen, attached with a belt, her body shape and position can affect how the contractions look on the monitor. Contractions that look like very large mountains on the monitor don't always indicate really strong contractions, and tiny hills don't mean the contractions aren't very strong.

The external fetal heart monitor tracks and records the fetal heart rate but has some limitations as well. It doesn't record the baby's exact heartbeat, but an average of beats. Variability, the difference in heart rate over a certain time period, can't be determined by external monitors, and beat-to-beat variability can help ascertain how well the baby is handling labor.

A heartbeat that stays the same with little variation may indicate that the baby is stressed. Short periods of decreased variability also occur when the baby is asleep. (And yes, babies do take short naps during labor!) The fetal heart rate may also have a short period of minimal beat-to-beat variability if your partner gets a dose a narcotic pain medication.

Understanding fetal heart rates

A normal fetal heart rate ranges from 110 to 160 beats per minute (BPM). Variations in the heart rate often occur for a short period of time before returning to baseline. Babies all have different baselines, so a heart rate of 115 BPM may be normal for one baby, but *bradycardic,* or unusually slow, for one whose baseline is 160 BPM.

Brief increases in the heart rate are called accelerations. They occur when the baby moves, if he runs a fever, or if he develops an infection. If the baby's heart beats too fast, your medical provider may say the baby is *tachycardic,* or *tachy.* Tachycardia can become dangerous because less oxygen is pumped out of the heart with each beat.

Brief drops in the heart rate often occur at the peak of the contraction and are caused by temporary pressure on the baby's head during active labor as the baby's descends into the birth canal. Bradycardia may also be caused by cord compression, if the baby compresses the cord with some part of his body and oxygen flow is temporarily decreased.

Bradycardia that lasts just a few seconds is not considered alarming, but bradycardia that lasts after the end of a contraction or that starts after the peak of the contraction, recovering shortly after the end of the contraction, can indicate decreased blood flow through the placenta.

Any unusual change in the fetal heart rate can be better assessed with continuous monitoring with an internal fetal monitor, which records an exact representation of the baby's heartbeat.

The external monitor also can't always distinguish between mom's heart rate and baby's. If your partner has a rapid heartbeat because of fever, anxiety, or other reasons, or if the baby has bradycardia, an extremely low heart rate, it may not be obvious that the external monitor isn't recording the right heartbeat.

Monitoring internally

Internal monitors resolve the shortcomings of external monitors by giving more accurate information. Internal contraction monitors are inserted directly into the uterus, which makes them able to record the exact strength of each contraction. You may be disappointed to watch those huge mountains that appeared to be very strong contractions shrink down to little blips on the monitor, indicating that the uterus is contracting only mildly, or you may be excited to see the opposite.

Internal fetal monitors fasten a tiny wire into the baby's scalp that records the exact fetal heart rate. This ensures that variability displayed is an accurate representation of the fetal heartbeat. An

internal monitor can also differentiate maternal and fetal heart rates, if it's difficult to tell whose heart rate is recording on the external monitor.

Some centers use internal monitors routinely, while others use them only if they're having trouble picking up the heart rate or assessing the contractions. Internal monitor complications occur rarely, and include infection at the site of insertion or hematoma, a large bruise.

Coping with Labor Pain

Although you and your partner discussed pain medication options before the big day (and we discuss making the decision on pain medication in Chapter 8), nothing is written in stone when labor actually starts. A staunch au naturel supporter may find herself asking for an epidural the minute she hits the labor floor, and a woman who was sure she's epidural material may find herself breathing through labor and deciding she'd rather do without one. Don't ever be surprised by the decisions of a laboring woman.

Enduring it: Going natural

Going natural was all the vogue in the 1970s but fell out of favor when epidural anesthesia became available in all but the smallest hospitals. Natural delivery still does have some advantages, and there are good reasons to consider an unmedicated delivery. Your partner may decide to go natural for the following reasons:

- Babies whose moms haven't received medication may be more alert and may nurse better. Medication does cross the placenta to the fetus before delivery.
- Moving around during labor is easier if you're not medicated. Epidural anesthesia usually keeps you in bed, although "walking epidurals" are offered by some centers.
- Pushing is easier without an epidural, although some centers let an epidural wear down enough for mom to be able to push.
- Water therapy can't be utilized if you have epidural anesthesia.
- Going through labor unmedicated can be an empowering experience.
- Some women have bad reactions to medications in general and don't want to take anything they don't really need.

One good thing about going natural is that with a first labor, it's almost never too late to change your mind and request an epidural. If she decides she want an epidural at 9 centimeters, in many centers, she can have one.

Dulling it: Sedation (No, not for you)

Sedation takes the edge off labor without numbing the lower part of the body. Typical sedatives given in labor include Demerol, Nubain, or Stadol, which can be given intramuscularly or intravenously. IV administration takes effect quickly and lasts one to two hours.

Sedation may be given if it's too early in the labor to give epidural anesthesia. Sedation can take the edge off the pain and help your partner get a little sleep, but it can also slow contractions in some cases.

Because sedation can reach the baby, narcotics and narcotic-type medications often are not given if delivery is expected within the hour because the baby may not breathe well.

Blotting it out: Epidurals

Epidural anesthesia consists of medications given through a catheter placed in the spinal canal. The pro of epidurals is obvious: They decrease pain. They do have other benefits as well, in some cases. For example,

- Epidurals can help a tense mom relax. Tension can slow labor; women who are especially tense may benefit from an epidural to help them relax.
- Epidurals provide continuous pain relief. In many cases, a continuous infusion of medication prevents the medication from wearing off.

Medications used in epidurals

Several different types of medication are used in epidural anesthesia. Anesthetics such as lidocaine or bupivacaine may be combined with narcotics such as fentanyl or morphine. Narcotics decrease the amount of local anesthetics needed to achieve adequate comfort. Narcotics given in an epidural don't cause drowsiness the way sedatives do.

What to expect during epidural placement

An epidural can be given at any stage of labor, but usually isn't given in very early labor because it can slow progress. Some doctors will start Pitocin, a drug to induce labor, when epidural anesthesia is given in early labor.

A large amount of IV fluid, approximately one bag, is infused rapidly to offset the drop in blood pressure that may occur with epidural anesthesia. This infusion can be uncomfortable because the fluid is at room temperature and feels cold.

Dads are very much in demand during epidural placement to give mom a person to lean on so she can get into the proper "curled shrimp" position for catheter placement (see Figure 9-1). The epidural catheter is placed into the epidural place on the midback by inserting a metal needle into the epidural space and then threading the catheter through the needle. Only the soft plastic catheter remains in the back. She must remain sitting up and still, even through contractions, for a period of five to ten minutes while the catheter is placed.

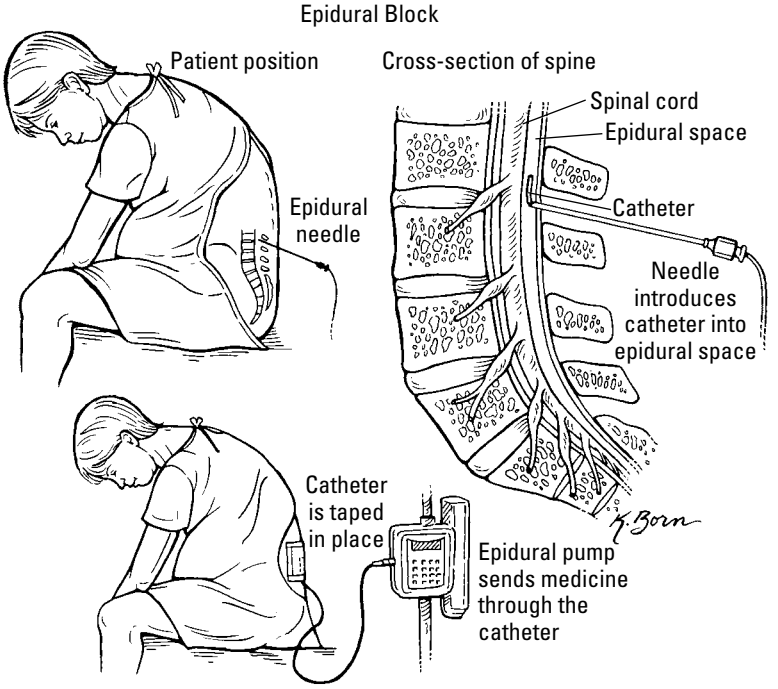


Figure 9-1: Placement of the epidural catheter requires remaining curled up and still for a short period.

After the catheter is taped in place, the anesthesiologist assists her back to a lying down position and assesses her blood pressure and comfort level for several minutes. In many centers, the epidural catheter is attached to an infusion pump that delivers a continuous infusion during labor to help maintain adequate pain relief.

If you feel at all shaky or nervous while your partner receives the epidural, or if you start to get lightheaded from standing in one position too long, ask someone else to take over supporting mom so you can sit down before you fall down.

Sometimes placing the catheter is difficult due to your partner's anatomy, and more than one needle stick may be necessary. This isn't anyone's fault, and getting the catheter correctly placed is important, so you can help by staying calm and keeping your partner calm, too.

When the catheter is in place, a test dose is given, and your partner's blood pressure is carefully assessed, because epidural anesthesia can cause blood pressure to drop. She has to wear an automatic blood-pressure cuff on her arm for a short period, and she may find this very uncomfortable. If her blood pressure is low, she may be tilted slightly to her left side.

Possible side effects of an epidural

Following are some of the side effects of epidural anesthesia:

- **A rise in temperature:** It's difficult to tell whether infection or the epidural is causing a rise in temperature, so intravenous antibiotics must be given to avoid complications in case an infection is present. Any time mom runs a fever, the fetus may also develop one, from the increase in womb temperature.
- **Nausea and/or vomiting:** These symptoms may also occur in labors without epidurals.
- **Shivering:** The fluid infusion or the epidural can cause shivering. Your partner will appreciate extra blankets, especially if they're straight out of the warmer.
- **Hot spots:** Sometimes women have an area that doesn't "take" to the epidural, and they need to change positions so that the anesthesia goes to a different area and numbs the nerves that haven't been numbed well. In the worst-case scenario, the epidural may need to be re-placed.
- **Difficulty urinating:** Most women can't urinate well after the epidural is given, and a full bladder can get in the way of the baby's head and slow the pushing stage of labor. A Foley catheter may be placed to drain urine, or the bladder may be emptied intermittently.

Deviating From Your Birth Plan/Vision

Everyone has some vision of how labor is going to go, even if it isn't committed to paper. But most labors don't follow the book, or the birth plan. Knowing this ahead of time helps you avoid serious disappointment. Consider the birth plan as a guideline of what you would like to happen, with the proviso that mom's and baby's well-being come first.

Some women feel guilty about taking pain medication in labor if they were gung-ho to go natural before delivery. If your partner wants to take pain medication but is hesitating because she feels like she's letting the birth plan — or you — down, encourage her to follow her instincts. Remind her that no one knows what labor is like until she's in it, and that most women do end up taking pain medication in labor. After all, labor hurts!

On the other hand, your partner may have gone from au naturel woman to "give me the drugs!" seemingly in the blink of an eye, and you may be the one having a hard time with it and try to encourage her to stick to the plan. Don't do it. Encouragement is fine if she's just going through a rough spot in transition, for example, but if she's made her decision, your job is to support her in it. You may have devised the birth plan together, but she's the one going through labor, not you.

If your practitioner participates in a call group and baby comes at night or on the weekend, you may have a different practitioner for the actual delivery. After having established a relationship with a doctor over the past nine months, having a stranger do the delivery can be frustrating, especially if your partner specifically chose a doctor for his approach to labor. However, rest assured that whoever delivers your baby will do everything he can to ensure a safe and smooth delivery. Discuss this possibility with your practitioner in advance to find out what to expect.

If your partner ends up having a cesarean section or if the baby has any type of problem, large or small, she may feel that something she did in labor caused the problem. Assure her that this is not the case (because it won't be). Things go wrong in labor that are no one's fault; they can't be predicted or, in most cases, prevented. Your job is to tell her that she did exactly what she should have and that she has no reason for regrets. And if you have any niggling doubts about the wisdom of her labor choices, keep them to yourself.

Having a Cesarean

Cesareans now comprise more than 30 percent of all deliveries in the United States, so the odds of having one are high. Although cesareans are major surgeries, they're generally safe for your partner and the baby. However, babies born by cesarean section may retain more fluid in the respiratory tract than babies born vaginally, and the fluid can be aspirated into the lungs, causing breathing difficulties.

Maternal complications such as infection, anesthesia complications, blood clots, and excessive bleeding can also occur, as with any surgery.

Scheduled cesarean section

Cesareans may be scheduled ahead of time if you know your partner's going to need one. Knowing she's going to have a cesarean ahead of time helps you to get things ready for her homecoming, knowing that she's going to be extremely sore as well as tired. Your partner may not want to navigate stairs for the first week afterward, and won't be able to drive for several weeks.

Reasons for planned cesareans

Reasons for a scheduled cesarean include previous cesarean delivery and abnormal fetal position, such as breech (feet first) or transverse (sideways) lie. Most of the time, but not always, these are determined ahead of time, but babies have been known to switch positions just a few days before delivery.

Occasionally, women ask for a medically unnecessary cesarean delivery. Some doctors will perform these procedures, but having surgery you don't need is never a good idea. Cesarean delivery is riskier for the baby because fluid doesn't get squeezed out of the lungs before delivery, setting up potential respiratory difficulties.

Multiples are almost always delivered by cesarean, even though twins who are both vertex (head down) can certainly be delivered vaginally. However, after the first twin is delivered, there's an abundance of room in the womb, and the second twin may flip or turn sideways with the joy of having all that space to himself, necessitating a cesarean for baby B. No mother wants to experience both a vaginal delivery and a cesarean with all the attendant discomforts on the same day, so most twins are scheduled for C-sections.

Setting the date

Choosing your baby's birth date can be exciting, but consider the following caveats:

- Don't choose a weekend day. Most practitioners won't schedule surgery for the weekend.
- Don't expect to bypass the last three weeks of pregnancy with an early delivery date. More practitioners are trying to schedule cesareans no earlier than 38 weeks, to avoid preterm (before 37 weeks) delivery and potential complications.
- Understand that the baby may come before your scheduled date. The baby hasn't read your birth plan and doesn't know that you want him to be born on an auspicious date, and he may decide to show up a week earlier.
- Realize that having an 8 a.m. surgery time scheduled doesn't always mean your surgery will be at 8 a.m. Emergency cases can bump you off the schedule, which is understandable, so don't get too upset if you're delayed because someone else's cesarean needs to be done first.
- You don't have to set a date. Some couples decide not to schedule their delivery but to have the cesarean done when labor begins so that the baby chooses the time. Your practitioner may not be quite as happy to see you at 3 a.m. as she is at 8 a.m., though.

Unplanned cesarean delivery

A large percentage of cesareans are unplanned, with the most common reason cited for an unplanned C-section as "failure to progress," which means labor wasn't progressing as expected. This can mean a baby too large for the pelvis, an unusual maternal anatomy, or a practitioner who's getting antsy about how things are going.

If labor goes on too long, complications such as infection become more likely, and doing a C-section is often less stressful than waiting for the situation to possibly deteriorate. And as all too many practitioners are well aware, the decision to do a C-section is less likely to be attacked in court than a delay in action that leads to problems with the mother or baby.

Fetal distress is an undeniable reason for an unplanned C-section, although true fetal distress is different from potential fetal distress that could possibly worsen if labor goes on. True fetal distress is marked by a run down the hall at top speed, minimal surgery prep,

and often general anesthesia, because it's the quickest way to put mom to sleep.

Potential fetal distress or mild distress usually results in a more leisurely trip to the operating room and a much calmer atmosphere, because the baby isn't in any real danger yet. And because you don't want him to reach that point, a C-section can be the best option. Trust your practitioner; if she says you need to do a C-section, do it.

Choosing a medical practitioner whose philosophy on cesareans as well as other medical interventions fits with yours is essential. Doctors do have different tolerance levels for deviations from the norm, and doctors who have a low tolerance for deviance generally have higher cesarean rates because they're less likely to watch and wait for a short time before performing surgery.

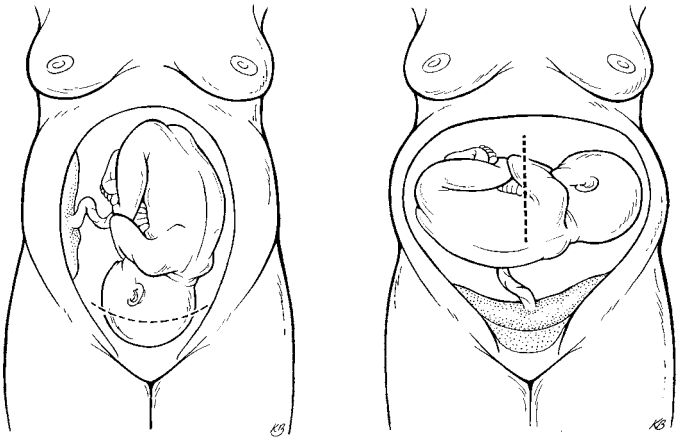
What to expect before the operation

Certain procedures must be done before cesarean delivery. Normally, a Foley catheter is placed to keep the bladder empty so it won't be injured during the surgery. If your partner already has an epidural, she won't even feel the catheter placement; if she doesn't, she may be mildly uncomfortable during the procedure.

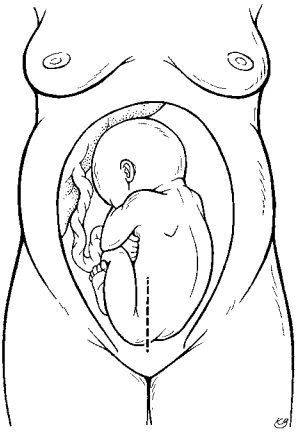
A preparatory mini-shave is done (if she hasn't already done it herself) to eliminate hair where the incision goes. Most cesarean scars are known as a bikini cut, a horizontal lower abdominal incision (see Figure 9-2). Occasionally a vertical skin incision is done if the baby or babies lie in a position that makes her — or them — difficult to reach, or if the surgery has to be done very rapidly.

Your partner may be given medications to reduce the chance of nausea and to neutralize stomach acids in case of vomiting and possible aspiration into the lungs. She will also be given an intravenous line if she doesn't already have one. If spinal anesthesia is used for the procedure, fluid will be quickly infused, which can feel very cold. Also, an adequate amount of fluid is necessary to keep blood pressure from dropping after the cesarean.

Your partner may be taken into the operating room by herself while you get dressed in a sterile outfit. When you're allowed in, you'll probably be given a seat right near her head so you can talk to her and support her without getting in anyone's way. Keeping the operative area sterile is extremely important during surgery, and the staff will take care to make sure you don't inadvertently contaminate anything.



a. Low transverse b. Classical



c. Low vertical

Figure 9-2: Most cesarean incisions are done just above the pubic hairline.

What to expect during the surgery

When the surgery actually gets underway, removing the baby takes between five and ten minutes. You won't be able to see much, because a sterile drape is placed between your partner's head and the rest of her body. When the baby is delivered, he may be brought close to your wife so she can see him, but she won't be able to nurse immediately or do any type of skin-to-skin contact due to the sterile operating field.

If general anesthesia is not used, your partner may feel tugging during the surgery. This is normal, but she may need lots of reassurance that it is okay.

Because babies born during cesarean sections have an increased risk of complications, a pediatrician or special-care nursery personnel may be present for the delivery. You'll be allowed to walk over to the warmer to see the baby, and in many hospitals, after the baby is weighed and cleaned, he'll be given to you to hold next to your partner.

Getting past disappointment

When you have the baby, you have her; it doesn't really matter how she got here. Your partner may not see it that way, though, and she may mourn the loss of the "perfect" labor and delivery and feel like she failed the labor test. With so many women having cesareans today, this feeling of failure is less common than it used to be, but if you and your partner had your hearts set on a certain labor scenario, a deviation from the script can be upsetting.

You can be a big help by accentuating the positives in the situation, by reminding her how well she handled the change in plans and how she put the baby's needs before her wishes.

Understanding why certain procedures were necessary can be very important in helping new mothers "grieve" the loss of a perfect delivery. Request a time to speak with the person who delivered your baby so that you and your partner can ask lingering questions about why the delivery went the way it did.

Chapter 10

Caring for Your Newborn

In This Chapter

- Getting to know your newborn
- Deciding on breast- or bottle-feeding, or both
- Cleaning up your baby and putting him to bed
- Alleviating your baby's discomfort from indigestion
- Preparing for first immunizations

Walking out the hospital door with a newborn who is still basically a stranger to you can be a scary experience. Getting to know your baby is a process that takes time. Fortunately you'll be putting in lots of time with this demanding stranger, and before you know it, you'll feel as if you've known this marvelous little person all your life. In this chapter we talk you through the seemingly mundane tasks that help you build a lifetime relationship with your new baby.

Knowing What to Expect When Baby's Born

Newborns don't look anything like the smooth-skinned, dimpled, smiling babies on TV. A new baby emerges from nine months in a dark, watery environment, and her skin shows it. She squints like she's just emerged from a cave. Although your newborn may not look exactly like the baby in your idealized dreams, she'll look perfect to you — at least after you get used to her in a day or two.

Looking at newborns

What should you expect when your newborn is put into your arms for the first time? Not the Gerber baby, that's for sure — although your baby will be, your partner will assure you, the most beautiful creature she's ever seen. You may seriously wonder about

her taste in human beings. Newborn babies have the following characteristics:

- **Small:** The average baby is around 7 pounds and 20 inches long. The reality of how small and fragile a newborn seems won't hit you until the first time you hold him.
- **Red and covered with — what's that white stuff?** Newborns are amazingly red. They come out a dark red and then turn a lighter red, which gradually fades to a normal skin color over a few days. Many newborns are coated, especially in the creases, with *vernix,* a creamy substance that protected newborn skin in water.
- **Wrinkled and peeling:** Since he just spent nine months immersed in water, his entire skin has the equivalent of dishpan hands, and as soon as he begins to dry out, his skin wrinkles because it's no longer waterlogged. His skin will crack and peel, especially around the bendable joints like the ankles and wrists.
- **Cone headed:** You thought the Coneheads weren't real, until you met your new baby. If your partner pushed for any amount of time, or if the baby was delivered by vacuum extraction, the baby's head may be pointed at the back, or she may have a little cone cup, like a jaunty little hat, to the side of her head. The baby's head will become round in a week or so. Cesarean babies usually escape the cone-head look.
- **Spotted, dotted, and blotched:** Newborns often have a variety of blotches, splotches, whiteheads and other marks that will fade over time. *Milia* look like little whiteheads on the baby's nose, chin and forehead. Don't squeeze these; they'll disappear on their own. The majority of black, Indian, and Asian babies have what look like black and blue marks on their legs or buttocks, called *Mongolian spots,* which fade with time. Red blotches on the back of the neck, eyelids, and between the eyes, called *stork bites,* are immature blood vessels that also disappear with time.
- **Not very well put together:** Newborns often seem like they may fall apart if a strong wind comes along. Their heads wobble alarmingly, and their arms and legs shoot off in all directions when they're startled. No wonder nurses wrap them up tight in blankets.
- **A bit, uh, out of proportion:** You may be saying, "That's my boy!" but baby boys may have overlarge genitals due to fluid retention, trauma during delivery, and hormonal influences. This condition is temporary. Girls often have swollen genitalia as well, but it's less noticeable. Also, girls may pass a few drops of blood from the vagina.

- **Swollen breasts:** Because of maternal hormones, both baby boys and girls often have swollen breasts that may actually produce a few drops of milk. This condition disappears within a few days.
- **May have no family resemblance:** Before you accuse your partner that the baby isn't yours, rest assured that many newborns look slightly Asian, even if their parents aren't. Puffiness and swelling around the eyes make them appear Asian, and the yellow tinge of jaundice that many babies have after the first day or two may have you convinced that someone has a lot of explaining to do. Puffiness will improve daily, and by the end of the week, you won't be able to stop telling everyone how much the baby looks like you.

Rating the reflexes

Newborns are active from the minute they're born. Your baby will yawn, grimace, and even seem to smile a little. (Yes, the smiles are really caused by gas at this stage, just like your mother says.) Babies also have certain reflex actions that are normal at birth. Your medical practitioner will assess the baby to make sure these reflexes are present. Lack of normal reflexes can indicate a problem that should be investigated. They include the following tests:

- **Babinski reflex:** When the bottom of her foot is stroked, the big toe rises and the other toes fan out. The Babinski reflex lasts for around two years.
- **Grasp reflex:** If the baby's palm is stroked, she closes her fingers, a reflex that lasts several months.
- **The Moro, or startle, reflex:** Your baby tremors slightly, throws back her head, and flails her arms and legs away from her side in response to a sudden movement or a loud noise. The Moro reflex lasts five or six months before disappearing.
- **Rooting reflex:** Stroking the corner of the baby's mouth makes her turn toward the touch; this helps her find the breast or bottle for feeding.
- **Step reflex:** When her foot touches a solid surface, she appears to step, lifting one foot and then the other.
- **Sucking reflex:** When an object touches the roof of the baby's mouth, she begins to suck. This reflex doesn't develop until around 32 weeks of pregnancy and isn't fully developed until 36 weeks.
- **Tonic neck reflex (TNR):** If the baby's head turns to the side, her arm on that side stretches out and the opposite arm bends at the elbow, which makes her look like she's fencing. The TNR lasts six to seven months.

Feeding a Newborn

Every baby needs to be fed, but the sheer number of choices to be made about feeding may have you begging your partner to consider nothing but breast-feeding for at least the next year. However, though breast-feeding is best for the baby, it may not be best for your partner.

While your opinion is probably valued, the final decision about breast-feeding is absolutely, unquestionably, your partner's. Many women just aren't comfortable with breast-feeding, and a woman who isn't comfortable usually won't do it well. Sure, breast is best, but bottle-feeding is a perfectly adequate method of feeding.

A number of considerations go into the decision to breast- or bottle-feed. If your partner has even the slightest interest, breast-feeding for the first few days so the baby receives *colostrum,* the first fluids produced, is a good way to start. Colostrum contains many nutrients and antibodies that are good for the baby. If your partner hates it, she can stop at any time, but she may love it! If she stops breast-feeding, though, it's hard, but not at all impossible, to get the milk flowing again. See Chapter 11 for more on making the decision to breast-feed.

Choosing to breast-feed

If your partner decides to breast-feed, you may be breathing a sigh of relief that the nighttime duties won't fall to you, but not so fast! Breast-fed babies usually eat more frequently than bottle-fed babies because breast milk is more easily digested. If you're cosleeping, or even if the baby is across the room, you'll probably be awake at 12 a.m., 3 a.m., and 6 a.m., too.

Even if you normally sleep like the dead and wouldn't wake up if the Titanic floated through your bedroom, getting up and offering support for at least one of the night feedings can be a wonderful contribution to your partner and make you feel closer to your baby. Get your partner a drink, help her get into a comfortable position, and talk to her if she wants conversation. Late-night talks are conducive to confidences and discussions you may not have time for during the day.

If you're working full-time, getting up in the night is hard but worth it. Getting to know your new little person and your partner better is worth the sacrifice, and this time too shall pass, faster than you can imagine.

Getting started

Although breast-feeding seems like it should be easy and natural, it isn't always. Many women today have no role models for breast-feeding; their moms may not have breast-fed, their friends may not be doing it, and you're not much help, either. Most hospitals have lactation consultants to help new moms get started breast-feeding. Some also offer at-home visits if needed. If you have a doula, she will also be invaluable in helping with issues that arise.

And of course, books like *Breastfeeding For Dummies* (Wiley) cover everything you need to know and are available for consultation day and night! The most common problems with breast-feeding include:

- **Latch-on problems:** Women with large or flat nipples often have a difficult time getting the baby to latch on. This is frustrating for mom and baby alike, and often ends with both in tears. If the baby isn't properly latched, he won't get a good milk supply. Patience, and in some cases, using a nipple shield, which fits over the nipple to give the baby something to grasp onto if nipples are very flat, can conquer latch-on problems.
- **Supply issues:** Most women have ample milk supply starting around the third day after delivery, but some need supplements to increase milk supply. Drinking plenty of fluids, getting enough rest, and eating herbs like fenugreek can help increase supply. Before a good milk supply is established, supplementing the baby's diet with formula or pumping rather than nursing is discouraged, because sucking increases the supply. Pumping isn't as effective as a baby's suck at stimulating milk supply. Breast milk is the original supply-and-demand system.
- **Parental anxiety:** Many new parents are obsessed with their baby's weight. Breast-feeding can frustrate parents who want to know how much milk the baby is getting at each feeding. However, you can still measure his intake if you have a baby scale; just weigh the baby before and after a feeding and compare. Don't change his clothes, not even his diaper, or the weight won't be accurate. A baby scale can save the sanity of weight-obsessed parents.

Supplemental bottles

After the milk supply is well established, supplemental bottles of formula or pumped breast milk can be given. Bottle-feeding is a nice way for you to be able to feed and bond with the baby occasionally, and it gives your partner a chance to get out of the house

or actually take an uninterrupted shower. Decreasing the number of nursing times a day reduces the milk supply, though, so don't overdo the supplemental bottles.

Don't be surprised if the baby doesn't quite understand what to do with the bottle at first. Bottle-feeding and breast-feeding require completely different tongue positioning and techniques on the baby's part. Some babies refuse supplemental bottles, which can be a problem if your partner gets sick or for some reason can't breast-feed. While you can feed a recalcitrant breast-feeder with an eyedropper, it certainly isn't fun for either of you. Some medical practitioners recommend an occasional supplemental bottle after nursing is well established so the baby gets used to taking an occasional bottle.

Many dads are a little envious of the closeness of the breast-feeding relationship and enjoy skin-to-skin contact while they feed the baby. Others find this just too weird. Whichever camp you're in, supplemental bottles can give you time to study your baby's face in detail and revel in the miracle you've created.

Pumping

Pumping to fill a supplemental bottle or if your partner goes back to work is easier than it used to be. Your partner can use an electric pump that's more efficient than the old bicycle-horn-type pumps. A really good pump can be really pricy but is worth it if your partner is going to use it a lot. Pumping is nowhere near as efficient as nursing is, so the amount produced may be much less than you think it should be. This difference is normal and not a sign that the baby isn't getting enough milk.

Pumped milk should be stored in feeding sized amounts, especially if you're freezing it, because you don't want to thaw out more than you'll use at one time. Use plastic or glass containers with well-fitted tops, but avoid anything containing bisphenol A (BPA). Collection bags made specifically for freezing breast milk are ideal.

Don't use plastic baggies or bags from disposable bottles, which may leak or contain substances that affect the nutrients in breast milk.

Breast milk can be stored at room temperature for up to six hours, in the refrigerator for up to eight days, and in the freezer for up to 12 months.

Bottle-feeding basics

Bottle-feeding has never been more complicated. Not only do you have to choose a formula and a nipple type, you have to worry about the materials the bottle is made of. Recent reports about the high levels of BPA (a chemical used in plastics) released when bottles are heated in the microwave or dishwasher has made choosing a bottle type more difficult. At least bottles no longer need to be sterilized on top of the stove: Ask your mom or grandma about how much fun that used to be!

Winning the bottle battle

Once upon a time, all baby bottles were made of glass. Then parents got tired of being beaned with glass bottles, and everyone worried about glass bottles breaking when the baby threw it out of the crib, so plastic bottles were invented about two minutes after the invention of plastic. Not only were they lighter and unbreakable, but they also came in pretty colors.

Then bottle manufacturers decided to mix things up a bit. Now bottles and nipples are no longer interchangeable, and bottle "systems" sometimes include plastic liners and inserts that reduce air intake and, hopefully, colic. Every bottle has to be used with its own system, and parents have to decide which works best for their baby.

Studies have shown cause for concern about plastic bottles releasing the harmful chemical BPA when heated. Some parents have switched back to glass, but manufacturers now create BPA-free plastic bottle systems. If you have older bottles and they're not BPA free, get rid of them. Spending more money on another whole bottle system is painful, but it's better than worrying about poisoning your child every time you warm a bottle in the microwave.

Choosing a formula

After you pick your bottles, you can start worrying about which formula to use. The array is truly formidable. For starters, you have to consider powder versus concentrate versus readymade. Following are the advantages and disadvantages of each type:

- **Ready to serve** can be very convenient for travel, if you use one can at a feeding. However, it's out of the question for everyday use for most people, because a month's supply is equal to the national budget of a small European country.
- **Concentrate** comes in small cans, and you dilute it with water before feeding. It's easy to use but more expensive than powder, though it's cheaper than ready to serve.

- **Powder** is the cheapest of the three options. If you're out of the house, it's easy to put the powder in a bottle and just fill with warm water when the baby's ready to eat. However, it comes in ginormous cans that take up half your kitchen countertop. It also clumps and takes more effort to shake smooth, a consideration at 4 a.m. when any effort seems like too much. Shaking the bottle to mix increases the bubbles and air inside the bottle, which can cause gasiness, so if your baby is already prone to gas, powder formula may not be for you.

After you decide on the form of your formula, it's time to choose one. This will not be easy; about a hundred different formulas are on the market, all claiming to be the best (although most grudgingly acknowledge that breast-feeding is also very good). Following are the general categories of formulas:

- **Regular:** Regular formula is made from cow's milk and contains 20 calories per ounce. Regular formula is usually fortified with iron. Some are also fortified with long-chain polyunsaturated fats that they claim enhance eye and brain development, but these claims are not well substantiated.
- **Enhanced:** Enhanced formula, often used for premature or failure-to-thrive babies, contains 24 calories per ounce.
- **Soy:** Soy-based formulas may be used by parents wanting to avoid animal proteins. However, soy contains estrogen, and some studies show that too much soy can be harmful to infants and children. Make sure to do your research before you switch to soy.
- **Hypoallergenic:** Babies who are allergic to lactose or soy may need protein hydrolysate formulas, which are easier to digest. Nutramigen, Pregestamil, and Alimentum are examples of protein hydrolysate formulas.

Preparing a bottle

The hardest part of preparing some bottles is putting the "system" together. Some bottles have inserts to put in, and others have little bags to put in place that hold the formula.

To make a bottle, read the instructions on the formula label. For powder, you mix a certain number of scoops with a certain amount of water, sometimes a foggy concept in the middle of the night. Concentrates are usually diluted 1:1, and ready-to-serve formulas don't get diluted at all.

Never try to "stretch" formula by adding more water than usual or by adding water to ready-to-serve formulas. You may deprive your baby of essential nutrition by doing so.

Many parents prefer to use distilled water, sometimes labeled as *nursery water,* rather than tap water, but if you have city water, it's probably not necessary. Boil the water from the tap if you're concerned about it, and use cold water rather than hot, which may contain more lead from the pipes. Let the water run for 30 seconds to reduce lead and other mineral contamination.

If you want to use well water, have a sample of it tested to make sure it doesn't contain high levels of nitrates or other minerals. Boiling well water concentrates nitrates instead of removing them, so it isn't recommended.

Knowing how much formula is enough

When your baby is brand new, he probably won't take more than 2 or 3 ounces at a time. The most important thing about bottle-feeding is to not try to force the last drop down your child's throat. With childhood obesity at an all-time high and a major health concern, the last thing you want to do is overfeed your child from an early age.

On the other hand, if he drains the bottle and acts like he's still hungry, give him a little more. Babies aren't machines, and they don't take the same amount of formula at each feeding. When he stops sucking and tries to push the bottle out of his mouth, he's had enough.

Changing Diapers

Changing diapers is the task new parents are probably least excited about. If you and your partner find yourselves playing "rock, paper, scissors" to determine which of you gets stuck changing the runny yellow poop that has overflowed out of the diaper and on to the sleeper, your shirt, and the new leather sofa, you're normal.

Diaper duty isn't fun, but it is necessary an appalling number of times a day when your baby is new, so rest assured you'll both get plenty of experience.

Circed or uncirced? Making the decision

Circumcision is a procedure in which the foreskin of the penis is removed. For Jewish parents, circumcision is a religious ritual usually done in a ceremony called a bris. For other parents, whether or not to have your baby boy circumcised is a personal choice. Twenty years ago, nearly all baby boys were circumcised, but today, more parents are questioning whether a surgical cosmetic procedure is necessary in a baby's first days of life. Around 50 percent of baby boys are now circumcised each year in the United States.

The main benefit to circumcision is ease in cleaning and avoiding the need to have the foreskin removed at a later date for medical reasons, but boys who are circumcised also have fewer urinary tract infections. Uncircumcised males are also more likely to contract sexually transmitted diseases later in life. Some dads just want their son circumcised so they'll "look the same."

Cleaning baby boys

Boys and girls really are different when it comes to diaper changing. When dealing with a baby boy, the worst part is projectile urination. You can easily avoid it if you remember to keep the penis covered at all times. A few good shots to the eye will reinforce your memory quickly.

Boys who have been circumcised (see Figure 10-1a), which means that the foreskin covering the tip of the penis has been removed, need extra TLC at first. You may need to wrap Vaseline-coated gauze around the tip for the first few days, depending on your practitioner's instructions. The gauze needs to be changed every time you change his diaper.

When you remove the gauze around the circumcision, you may be horrified to see that the skin is a yellowish color. This is normal healing for a mucus membrane. If the area is oozing or has pus or a foul odor, call your practitioner.

Uncircumcised boys are a little harder to clean, and the foreskin (see Figure 10-1b) needs to be kept loose. The foreskin doesn't retract, or pull back easily, before the age of 1 year or even longer. Up to this point, only the outside of the foreskin should be cleaned. When it can be retracted, gently push it back as far as it will go, which isn't be very far, and clean with only water. Return the foreskin to its normal position afterward. If the foreskin becomes red or swollen, have your medical practitioner take a look to make sure he doesn't have an infection.

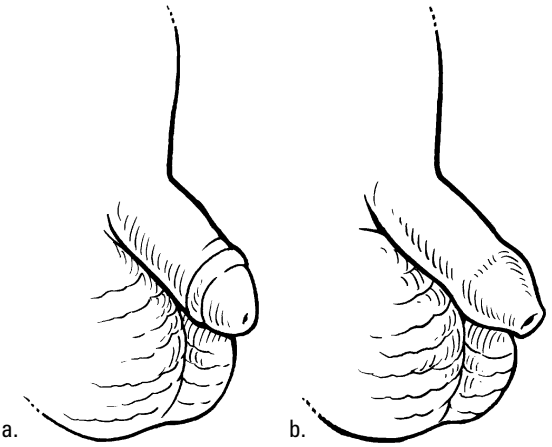


Figure 10-1: A circumcised penis (a) and an uncircumcised penis (b).

Cleaning baby girls

Baby girls aren't likely to spray the room when you remove their diaper, but they have their own set of problems. Keep these points in mind when changing a baby girl:

- Girls have lots of cracks and crevasses, and getting all of them clean is difficult. A runny, poopy diaper goes everywhere. Use moistened wipes or cotton balls to make sure you remove all the stool.
- Girls are more likely to have urinary tract infections because of the proximity of the anus and vagina to the urethra, so it's really important to make sure the whole area is clean.
- Always wipe from front to back. Doing so helps to avoid introducing fecal matter into the vaginal area, which can cause infections.
- Don't be too gentle. Make sure to thoroughly wipe the opening of the vagina or it can close up. If that happens you will have to apply a steroid cream to help reopen it, or, even worse, have it surgically reopened.

Bathing Basics

Few things strike fear into the hearts of inexperienced parents like the first bath. Take a squirmy baby, soap him all over to make him incredibly difficult to hold on to, and then put him in a tub of water. Sounds like a recipe for disaster, or at the very least, parental heart failure, but it doesn't have to be. Many hospitals now do a

"trial run" bath to make sure you won't drown the poor child right off the bat, but even the least experienced new dad can learn to give the bath. Remember these suggestions when getting ready for baby's first bath:

1. **Get your supplies ready first.**

   Nothing makes a bath more difficult than getting the water drawn, the baby undressed, and the towel laid out and realizing you forgot to get the soap, or the lotion, or the diaper. No, the baby doesn't wear the diaper into the bath — you need it ready the minute you take him out, though, especially if your baby's a boy, unless you want an eyeful of urine.

2. **Put the baby in a comfortable spot.**

   Undressing him on the toilet lid may seem like a good idea if you're bathing him in the sink, or on the counter if you're bathing him in a little baby bath, but those surfaces are cold and hard, even with a towel over them, and they may be riddled with germs. Get him ready on the changing table or bed; take off everything except the diaper (urine, remember?) and bring him into the bathroom wrapped in the towel.

3. **Hold the baby and fill the tub, or have your partner handle one of those jobs.**

   Bath water for the baby should be 90 to100 degrees F. You can monitor the temperature to make sure it isn't too hot or isn't getting too cold with cute little floating bath toys that have built-in thermometers. If you're using a sink, pad it by lining it with a towel. A towel also helps reduce the slipperiness of a baby bathtub.

4. **Before putting the baby into the bath, wet a washcloth and squirt the baby soap onto the washcloth.**

   This way you don't have to do it while you try to hold the baby in the water at the same time.

5. **Undo the diaper tabs, then whip off the diaper and put the baby in the water.**

   Don't give him time to do anything dastardly.

6. **Don't expect the baby to enjoy this new experience at first.**

   Yes, he spent 9 months in water, but he's forgotten already, and your inexperienced hands aren't supporting him as well as the womb did. Some baby tubs have a little sling or are curved to support the baby. Otherwise, support his

head and neck with your hand, or the crook of your arm, if you're well coordinated.

7. **Wash the baby with the soapy washcloth, starting at his head and working your way down.**

   Yes, just like you'd wash the wall, or the car. The genitalia should be the last part you wash. When you get to the bottom (literally), use a clean washcloth if it seems more hygienic to you.

8. **Rinse him off with a clean washcloth.**

9. **Lift him out of the water and wrap the towel around him.**

   A towel with a little hood help keep him warm and makes him look like an adorable elf. Don't admire him too long, because you need to get his diaper back on — quickly.

10. **Carry him to the changing surface, where the fresh diaper is already laid out. To keep him warm, keep the towel over the top half of his body while you put the diaper on.**

11. **Dry him off gently and dress him.**

    Babies have delicate skin, so don't rub too hard with the towel.

12. **Now collapse on the couch — you've earned it!**

Holding Your Baby

You're going to find yourself carrying the baby around quite a bit during the first few weeks. Babies who are colicky (cry a lot) are often more comfortable if you keep moving, and moving will help dispense your tension and anxiety when you're on hour two of a colic episode. Babies can be held in several ways, and yours may have a definite preference. Try these tried-and-true baby holds:

- **Cradle position:** Cradle the baby's head in the crook of your arm. Most people hold the baby on the left side, but go with what works for you.
- **Over the shoulder:** Some gassy babies feel better with pressure on their abdomen, so slinging them up onto to your shoulder may help get the gas out. However, spit-up-prone babies and vomiters also like this position, so have a burp cloth on your shoulder at all times.
- **Football hold:** The baby's head rests on your hand looking up, while her body lies on your arm, with her feet pointed at your elbow.

Whichever position you choose to hold your baby in, use it often! Nothing is better for dad and baby bonding than time spent in close proximity.

Cosleeping Pros and Cons

Cosleeping, or sleeping with the baby in your bed, goes in and out of vogue. Right now cosleeping is popular with many parents, although it comes with a twist in some cases: The baby may sleep in a little sidecar, or cosleeper, that attaches to your bed. You get the whole bed to yourself, but the baby is right nearby.

Traditional bassinets or small playpens or baby beds also work well, if you're not comfortable sharing the bed with the baby. If you're still debating about keeping the baby in your bed, or even in your room, consider the following advantages:

- **Cosleeping is convenient if your partner is breast-feeding.** Breast-feeding is much easier if you don't have to get out of bed to get the baby.
- **You hear the baby as soon as she starts stirring.** While this itself has pros and cons, the benefit is that she doesn't have a chance to work herself into a crying frenzy before a feeding.
- **It can give you a sense of closeness as a family.** To hear your baby's soft breathing is reassuring and also enjoyable.

Also consider the following disadvantages:

- **Very light sleepers, especially light sleepers with a baby who is also a light sleeper, may find the whole family awake most of the night.** If you're keeping the baby awake, or she's keeping you awake, you're all going to be excessively cranky.
- **You may be too worried about rolling over on the baby to enjoy cosleeping.** If you sleep very soundly, and the baby is right next to you, this can be a concern, but most parents are very aware of the baby's presence. If it worries you, a bassinet or other sleeping arrangement in the room may be better for you.
- **If one of you works odd shifts, you may find getting in or out of the room without waking the baby difficult.**
- **When you put the baby in your bed, you eventually have to put her out.** While your child may prefer to stay in your bed until she goes to college, you may want your bed back in a few years. Some children don't go quietly into the dark night and put up quite a fight about sleeping in their own rooms.

Remember that even if you don't want the baby in your room with you, baby monitors make it possible to hear the slightest stirring from another room.

Back to Sleep: Helping Baby Sleep Safely and Comfortably

Once upon a time, almost all babies slept on their stomachs. The babies preferred it, they had less gas, and if they spit up or vomited, they were less likely to choke. Then, in 1992, the American Academy of Pediatricians released new recommendations about placing babies on their backs rather than stomachs to sleep, claiming that babies were less likely to die of sudden infant death syndrome (SIDS) if they slept on their backs.

The "Back to Sleep" campaign went into full swing in 1994, heavily promoted by pediatricians. Within a few years, almost all babies were put to sleep on their backs, at least while they were in the hospital. Since the back sleeping movement was launched, the incidence of SIDS-related deaths has dropped by more than 50 percent, from 1.2 deaths per 1,000 live births in 1992 to 0.55 in 2006. Studies in 2006 showed that overall in the United States, 75 percent of babies slept on their backs.

A baby who is used to sleeping on his back but is placed prone (on his stomach) to sleep, possibly by a caregiver not familiar with the benefits of back sleeping, has an 18-fold increased risk of SIDS, according to the American Academy of Pediatricians (AAP).

Side positioning was originally considered a viable alternative to back sleeping, but more recent recommendations from the AAP are that side sleeping also increases the risk of SIDS, as well as the risk of the baby moving from a side to a prone position. To further reduce the risk of injury or death, keep soft fluffy blankets, pillows, and mattress pads out of the crib as well. A firm sleeping surface is best.

Coping if baby hates being on his back

Many babies truly hate sleeping on their backs. They don't sleep well, their parents don't sleep well, and everyone is miserable. What should you do if you and your baby are both desperate to get some sleep?

- **Tough it out.** This is really hard to do, but a good night's sleep is not worth the risk of SIDS.
- **Rock the baby to sleep first.** If she's asleep before you lay her down, she may stay asleep when you place her on her back.
- **Use a pacifier.** Even if you hate them, pacifiers really do soothe some babies. The American Academy of Pediatricians (AAP) recommends using one at bedtime because pacifier use also decreases the risk of SIDS.

Swaddling your little one

Some parents find their babies are calmer and sleep better when they're tightly wrapped in blankets so their arms and legs can't go flying off in every direction whenever they're startled. Nurses swaddle babies in the hospital for this reason (and because it makes them look adorable). Even the most fumble-fingered dad can do this at home, even though it won't look at all like the nurse's version at first. To swaddle, follow these instructions and also refer to Figure 10-2:

1. **Put the blanket on a flat surface like a diamond, with a point up.**
2. **Fold the pointy end at the top down about 6 inches.**
3. **Put the baby on the blanket, with his head just above the folded-down edge.**
4. **Pull one of the pointy ends on the side across the baby, covering his arms, and tuck it behind his back.**
5. **Bring up the bottom point to the baby's chin.**
6. **Repeat Step 4 using the remaining point of the blanket**

   Make it tight enough to make the baby feel secure, but not tight enough to cut off his circulation!

Realize that the baby is not going to lay perfectly still during this procedure. It will take you at least a few tries to get it right.

Preventing the flat head look

Babies now sleep on their backs and also spend hours with their heads back in swings, bouncy seats, and car seats. No wonder so many of them have flat heads. A flattened back or side part of the head, called plagiocephaly, can be more than just a cosmetic problem. Though 20 percent of infants today have flat heads, according to the AAP, all but 8 percent will round out naturally without treatment by 24 months.

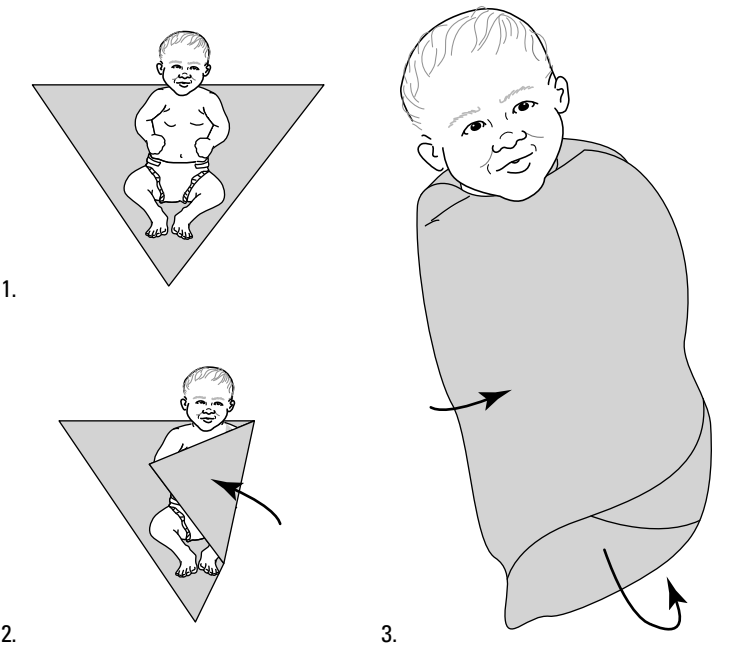


Figure 10-2: How to swaddle a baby.

You can help prevent plagiocephaly by following these suggestions:

- **Have tummy time:** Babies need to spend some time on their stomachs when they're awake to strengthen their neck muscles. This time also gives the back of the head a chance to round out!
- **Carry the baby:** Don't always plop the baby in a swing or bouncer when he's awake; carry him around with you so he gets to see more of the world and he doesn't put pressure on his head. Figure 10-3 shows you how to carry your baby in a carrier, if you're interested in doing so.
- **Change the room around:** If possible, move the crib from one side of the room to the other from time to time so the baby sleeps with his head turned a different way. Or leave the crib in place and turn the baby, moving him from one end of the crib to the other.

Plagiocephaly is treated by molding a custom helmet that exerts pressure on the baby's head and gradually changes the shape as the baby grows. The helmet is worn 23 hours out of the day and is adjusted as the baby's head begins to round out.

Deciphering cries

Every baby cries a little differently, and every baby has different cries for different occasions. Differentiating the "I'm hungry" cry from the "I have a gas bubble" or "I'm all alone and need company" cry takes practice, but eventually you'll be like the Amazing Kreskin, able to decipher your baby's every need from two rooms away.

And if you have no idea what the kid wants, even when you've had her home for a few months? Do what other parents do: Fake it and try everything until something works. Some parents resort to teaching sign language to babies who can't articulate yet so they'll have at least some notion of what she wants. Anything is worth a try.

Figure 10-3: A baby carrier lets your baby see more of the world and keep your hands free in the process.

Having your baby wear a helmet 23 hours a day for several months is understandably upsetting for parents. It's possible to make helmet wearing more fun — for you, not the baby — by painting the helmet or applying decals to cute it up. The babies don't seem to mind wearing them; having the plaster mold of their head done will probably annoy your child far more than the helmet will.

Soothing Baby Indigestion

All babies fuss from time to time, and many have a short fussy period every single day, usually around the time when you're the busiest and have the least patience for it. Although all screaming seems pretty much the same to you, fussiness can be caused by one end or the other of the gastrointestinal tract.

Crying with colic

Colic can send a parent around the bend in no time at all. Colic, defined by the Mayo Clinic as three hours of crying a day at least three days a week for three weeks or more in a well-fed, healthy baby, affects around 40 percent of infants. Colic generally starts between 3 and 6 weeks of age and ends by 3 months of age. They may seem like the longest three months of your life.

No one really knows what causes colic, but colicky babies often pull their legs up to their stomach and act as if they have a belly ache, so perhaps they do. Breast-fed and bottle-fed babies both get colic, and changing the formula rarely helps. Things that help calm a colicky baby include:

- **Car rides:** The motion of the car calms down many colicky babies. With the price of gas, this can be an expensive solution, but believe us, you'll try anything after the first two hours.
- **Vibration:** Vibrating chairs or swings calm some colicky babies. If you don't have either of these, you can do what many a desperate parent has tried: putting the infant seat on the dryer and turning it on. Whether it's the motion or the noise, something about it calms some babies. (Make sure to remain next to the baby to make sure she doesn't fall off of the dryer.)
- **Position changes:** Some babies like pressure on their abdomen, so letting her dangle over your arm while you walk around may work. Putting her over your knee, face down, and patting her back may work, too. See Figure 10-4 for help.
- **Decrease the stimulation:** Some babies can't handle any handling or stimulation when they're colicky and do better in a quiet, dark room.

Gas

Babies often need help to get gas out of their stomachs after they eat. Some babies burp it up spontaneously, but others need to be patted between the shoulder blades for a few minutes to get the gas out.

If the baby falls asleep at the end of a feeding without burping, don't put the baby down without getting a burp up. He'll give you just enough time to fall asleep or get involved with something before he wakes up with that piercing cry that means a bubble is stuck. Take a few extra minutes and get him to burp; you'll be glad you did.

Figure 10-4: Try this position if your baby is colicky.

Reflux

Although many babies spit up after feedings, gastrointestinal reflux disease (GERD) is a whole different entity. Gastrointestinal reflux (GER — not the same thing as GERD), or normal spitting, occurs in over half of all babies, but usually is worse between the ages of 1 and 4 months and disappears by 6 to 12 months.

Keeping the baby in an upright position for half an hour or so after feedings helps reduce GER, and then keeping her at a 30 degree angle for sleep may help. Some parents elevate one end of the crib to keep the baby's head higher than her feet.

Despite what you may be told, studies show that thickening the formula with cereal does not help, and it may worsen respiratory problems in children with GERD.

GER is annoying and potentially ruinous to your clothing and the baby's, but GERD is a more serious problem. Babies with GERD fail to gain weight, may have respiratory difficulties from milk aspiration, and may have feeding aversion, which is understandable since food so often brings them discomfort.

Keeping your cool during baby meltdowns

Babies sense stress, and an already stressed out, screaming baby will be made more unhappy by a stressed out, screaming parent. To help maintain control in difficult situations, try these ideas:

- **Leave the house:** You and your partner can take turns getting out of Dodge for a short time.
- **Close the door:** For periods of time when you can't leave the house but truly can't take it anymore, put the baby in his room and close the door for a few minutes.
- **Get help:** When a crying baby brings you to the brink, you may be shocked at how quickly your anger escalates. Anger management courses can help you tame an out-of-control temper. Learning to do it now rather than later is beneficial, because this child will be doing things to drive you crazy for the next 50 years. (No, parenthood isn't easier when your children are adults!)

Breast-fed babies are less likely to develop GER or GERD, because breast milk digests more easily and empties out of the stomach twice as fast as formula. Medications to reduce stomach acid or to keep stomach acid from entering the esophagus may be prescribed to treat GERD.

Scheduling Immunizations

Immunizations are a very hot topic today, and one that many parents have vehement opinions about. Although studies have not supported fears that immunizations are responsible for the increase in children diagnosed with some form of autism, a brain disorder that now affects 1 in 105 babies in the United States, many parents believe the increase in immunizations and increase in autism are tied together.

The number of injections a baby receives in her first year can seem overwhelming. Table 10-1 shows the average newborn schedule of immunizations (some of the series are continued after the first birthday):

Table 10-1 Average First-Year Immunization Schedule

Vaccine	*Before Leaving Hospital*	*2 Months*	*4 Months*	*6 Months*	*1 Year*
Hepatitis B	x	x		x	
Rotavirus		x	x	x	
Diphtheria/ Tetanus/Pertussis		x	x	x	
Haemophilus influenzae type B		x	x	x	x
Pneumococcal		x	x	x	x
Inactivated Poliovirus		x	x	x	
Influenza				x	
Measles/Mumps/ Rubella					x
Varicella					x
Hepatitis A					x

Skipping some shots?

Immunizations are so controversial in some circles today that you may consider giving the baby some but not all of the recommended vaccines, possibly skipping influenza, hepatitis, and chicken pox vaccines and splitting the measles-mumps-rubella injection into three separate shots. Talk seriously with your pediatrician about the advisability of this, and check with your local board of education, because some schools may require certain immunizations before your child is allowed to start school.

Spreading them out

Many parents compromise on the immunization question by spacing the immunizations over a longer time period than that recommended by the American Academy of Pediatricians. Taking more time may necessitate more visits to the pediatrician than are normally scheduled but can make it easier to determine which injection is causing a reaction if a problem occurs.

Pediatrician Robert Sears published an alternative vaccination schedule in his book *The Vaccine Book* (Little, Brown and Company). Be aware, however, that the American Academy of Pediatrics has vigorously protested his alternative schedule and continues to support the current guidelines. Discuss alternative schedules and the pros and cons thoroughly with your medical practitioner before making up your mind about vaccinations.

Marking the milestones

Baby books are a wonderful invention; it's a shame more parents don't use them throughout their child's infancy. Nearly every baby shower includes one as a gift, and most parents start out with great enthusiasm, recoding every pregnancy symptom, movement, and ultrasound. But when the actual baby arrives, time is precious, and the baby book often is neglected, although an occasional guilt trip may result in copious recording for a week or so.

Make every attempt to record your baby's milestones somewhere. You don't have to use a baby book; baby calendars, your own journal, or a blog can be used to keep track of your baby's first tooth, word, or step. You may think now that you could never forget such important milestones, but the sad truth is that you can, very easily. And if you have more than one child, trying to remember who had croup and who had chickenpox gets to be impossible. And when you have grandchildren, many years from now, you can prove to their parents how much more advanced the grandchildren are compared to them at the same age!

Chapter 11

Supporting the New Mom

In This Chapter

- Helping your partner by doing the dirty work
- Providing emotional assistance when her hormones are haywire
- Recognizing signs of postpartum problems
- Dealing with changes and establishing a new "normal"

A new baby is a celebrity, with every coo, smile, and gurgle met with a flash of the camera. A doting parent or grandparent is always ready to meet baby's every whim, and your protective nature makes you feel like you could uproot a mighty sequoia if it somehow threatened the well-being of your baby. Unfortunately, that limelight is taken away from the woman who just spent the better part of a year carrying that child and hours (or days!) in labor. She suddenly goes from living as an A-list celebrity to feeling like an out-of-work actress working for tips at the local diner.

This is your chance to step up and shine, new dad, by making sure your partner feels every bit as adored, pampered, and attended to as that new bundle of joy. This means taking care of tangible needs, like making sure the litter box is clean and dinner's on the table, and also less-tangible needs, like emotionally supporting your partner, limiting guests, and getting by on less sleep.

We know that the upheaval of a new baby can be a difficult adjustment for new dads, too, but rising to these challenges has long-term benefits for the health and happiness of your whole family. The following sections help guide you through the postpartum needs of your partner and teach you how to be a hero for the new mom in your life.

Handling Housework during Recovery

New moms and dad both experience the stress of adapting to a new little person who's still a stranger to you, but moms have the added burden of uncontrolled hormones and physical recovery from the delivery. Your partner's energy needs to be directed at keeping herself together right now, not worrying about the house — or you.

While your partner recovers, gets her hormones back together, and works into her new routine as a mom, she needs you to pick up the scut work around the house without being told what to do. You may not know exactly what that entails, but that's why we're here: to help you with all the things that need to be done. The following sections may look like a list of chores, but remember that a happy mom means a happy baby — and a happy next six months for your new family.

Getting the house in order

TV commercials make it appear that men are only good for making messes and that women derive joy from cleaning up after them, but in the real world, making sure the home is in tip-top shape is everyone's job. Except that now that your partner's limited to lifting nothing heavier than a baby for the next six weeks, cleaning has just become fully your responsibility.

You don't have time to clean every part of the house every day, so ask your partner point-blank what tasks are most important to her; then carry out her requests word for word — even if it seems irrational. For example, if she wants the bathroom cleaned every day, then grab your toilet brush and get scrubbing. She'll be spending a lot more time in there following labor due to postpartum bleeding, which can last anywhere from two to eight weeks, so a clean environment may help her relax and keep her from feeling embarrassed when visitors unexpectedly appear.

Speaking of visitors, well-wishers come bearing a lot of stuff, which means that clutter can get out of control very quickly. Because mom is trapped indoors with a baby who's feeding around the clock, feeling suffocated by balloons, flowers, and stuffed animals may only increase her anxiety. Make sure to find a new home for everything that comes into the house.

In addition, doing the dishes, vacuuming, and taking out the trash are some of the obvious tasks that need regular attention. The following sections guide you through some of the more unexpected tasks you're about to become intimately acquainted with.

Battling baby's bottomless laundry basket

Laundry may seem straightforward, but like all things related to babies, it's complicated. If you're already accustomed to the ins and outs of laundry, you'll have ample opportunity over the next few weeks to put these basic skills into action. But laundering baby's things is a bit different. We break down the important points for you here:

- **Wash brand-new infant clothes prior to first use to remove any chemicals or germs in the fabric.** As new clothes arrive, be sure to remove all price tags, stickers, and plastic tag holders.
- **To avoid exposing your baby to dyes and chemicals that can irritate his delicate skin, wash baby clothes in dye- and chemical-free detergent.** Generally, any detergents labeled as dye- and chemical-free are okay to use. Using organic is always best but can be quite pricey. Several detergents, such as Dreft, are designed specifically to wash baby clothes.
- **Use the delicate cycles on your washer and dryer.** Using the delicate cycle helps keep the materials used in baby clothing from shrinking, which they tend to do. And baby clothes are outgrown fast enough without adding shrinkage to the mix.
- **Be sure to treat stains — and you'll have stains — prior to washing.**

Couples opting to take the eco-friendly route of cloth diapers find the mounting laundry pile an even taller task. Follow these steps to take care of this particularly dirty laundry:

1. **Rinse the diapers.**

   Solid poops can be shaken off into the toilet and flushed. Consider installing a sprayer attachment on your toilet to help with loose stools and urine. It allows you to rinse the diapers and flush without having to dunk the diaper into the toilet.

2. **Pretreat cloth diapers by placing them in a pail, sprinkling stains with baking soda, and covering the pail to keep smells at bay for no more than three days.**

   Place an air freshener inside the pail to help control odors, too.

3. **Gather a load of no more than two dozen diapers, fastening all tabs on each diaper to keep them from sticking to each other.**
4. **Use a quarter to half the amount of laundry detergent you would for a normal load.**

   Using a normal amount can lead to detergent buildup in the fabric. Diapers are designed to absorb, after all, and they're not discriminating about it.
5. **Wash on a cold/cold cycle.**
6. **Wash a second time, using a hot/cold cycle to kill any remaining bacteria.**

Dealing with pet duty

Animals require a delicate transition when the baby arrives. To help reduce the shock of a new human roommate, prior to bringing baby home from the hospital, wash your pet's bed or favorite toys in baby laundry detergent to get her used to what baby will smell like. You can also prepare your pets by inviting over friends with babies so your animals adjust to the sounds of babies. Enroll your dogs in an obedience course to make sure they are well trained and will lie down on the floor next to you on command.

No matter how well trained or prepared your pets are, take care when introducing your baby. When baby comes through the door, be prepared to deal with any jumping, clawing, growling, or roughhousing your pet may want to engage in with both mom and baby. Keep animals separated from mom until she's healed enough to endure any unexpected pet reactions. When you trust that your pet won't react wildly, have the animal sit next to you while you hold the baby. Reward your pet with treats as you interact with the baby to begin making a positive connection between the two. Never hold your baby in your pet's face as this can cause a possibly dangerous reaction from the animal.

In addition to mediating interactions between your partner and rambunctious pets and baby and *all* pets, it's also your responsibility to complete all pet-related tasks. That means changing the kitty litter, taking the dog for walks, grooming, and playing. Making sure your pet's life stays as normal as possible eases everyone's transition. For example, if your dog enjoys playing catch, make sure to play catch with him as often as you did before so he doesn't make a negative association between the new baby and your lack of attention.

After contact with your pets, make sure to wash your hands with soap and water before handling the baby.

The weight game

Your partner may not be ready to get back into her pre-pregnancy jeans the moment she gets home from the hospital. Some women do lose a considerable amount of weight shortly after delivery, but some actually put on weight due to fluid retention. And as with all weight loss, unfortunately, losing pounds put on during and after pregnancy requires time and hard work.

Exercise helps the body recover from pregnancy (and has also been linked to decreased occurrence of depression), but even with exercise, it takes an average of two or three months before a woman gets back to her normal body weight. And even then, things will have changed. Stomachs are softer, body parts seemingly have shifted, stretch marks will have appeared, and she's likely to feel like a stranger in her own body.

You can help your partner improve her body image and fitness by reminding her how beautiful you think she is and planning activities that get you both moving together. A nice walk around the park or the neighborhood is always an enjoyable activity for the whole family, and following a normal childbirth, women can begin light walking a few days after returning home. If the gym is her scene, ask her if she'd like you to hire a personal trainer with knowledge of post-pregnancy fitness. If the yoga studio is her style, she may enjoy a mom-and-baby yoga class.

Whatever her desires, make sure she has been cleared by her OB-GYN prior to beginning any workout routine, and she'll likely be advised to stick with activities that she engaged in before having the baby. She needs to start small, and you need to make sure your partner is comfortable. Remind her to exercise at a slow pace with moderate effort, especially during the first weeks. If she experiences an increase in bleeding, shortness of breath, or extreme fatigue, have her wait a few days before trying again.

Most importantly, let any new exercise regimen be her idea. Suggesting that a new mom join a gym will put you squarely in the doghouse.

Becoming the errand boy

Grab the keys and get rolling, because driving duties are up to you for a while. Doctors recommend that women who have a vaginal birth don't drive for two weeks following delivery. That time increases to six weeks for a cesarean delivery.

Use the hours you spend driving to the grocery store and the post office (to mail thank-you notes, of course!) to recharge your batteries. Alone time is hard to come by these days.

Don't forget to extend an invitation to mom and baby, too. Many women will begin to feel trapped in the house, so as soon as your partner is up for it, begin including her in outings whenever she feels up to it. If she doesn't feel up for it or can't come along for the

ride, bring her back some flowers or another favorite treat to make her feel loved and cared for.

Taking care of meals

For the first few weeks following delivery, you need to manage the meals, because your partner is likely too physically drained — and too busy feeding baby — to think about cooking. Whether you're the guy who likes to take charge in the kitchen or the type who routinely forgets to add the cheese packet to macaroni and cheese, making sure you and your partner are well nourished is one of your most important roles.

Understanding what she needs

Breast-feeding women need to consume an additional 400 to 600 calories more than they would when eating a normal diet. That's because breast-feeding burns about as many calories as a 30-minute run. New moms need to eat energy-packed, nutritious foods. And with all the extra work you're doing on reduced sleep, you do too! Keep the following nutrition do's and don'ts in mind when grocery shopping and preparing meals:

- **Do** stock up on milk, yogurt, and other dairy products. Vitamin D and calcium are especially important for new moms. Some women are forced to eliminate dairy from their diets because it can cause excess gas and fussiness in the nursing baby. In order to get her the nutrients she otherwise would get from dairy, stock-up on plant-based milk substitutes, such as soy or almond milk, which have been fortified with vitamins.
- **Don't** bring home a lot of foods that are high in sugar, carbohydrates, and fat. Nothing is forbidden here, but don't go overboard. Not only is it bad for her waistline, but all the refined sugars, flours, and artificial fats are hard to digest and aren't ideal postpartum nutrition for baby or mom As hard as it is to deny a new mother anything, try to talk her out of those cravings for fried food.
- **Do** make sure she's getting enough water. If she's breast-feeding, she needs to drink at least 72 ounces of water each day to aid in milk production. If your tap water doesn't taste good, pick up a filtration pitcher or faucet attachment.
- **Don't** let her (or you!) drink too much alcohol. A glass of wine or a beer is okay, especially as a way for the new mom to clear her head and relax. But nursing moms should keep in mind that what goes in ends up in the breast milk, so moderation is essential. Non-nursing moms, and dads for that matter, still must be responsible caregivers, and alcohol lowers inhibitions and decreases sound judgment. Always drink very responsibly.

In addition to taking her nutritional requirements into account, make sure to ask her what sounds good before doing any grocery shopping. Just like during pregnancy, many women find certain foods unappetizing and/or nauseating following childbirth.

Putting food on the table

Since you're going to be getting less sleep and doing more work around the house, you may not be eager to strap on the apron three times a day. To make the task easier on yourself, cook meals that can be eaten multiple times or frozen for future consumption, such as easy-to-assemble casseroles or pots of soup. If time allows, this can be a great nesting activity with your partner prior to delivery, too.

Another great idea that only requires a little work on your end is to make a bunch of peanut butter sandwiches, put them back in the bread bag, and store the bag in the fridge, so that she can just grab one quickly. This would be especially helpful for a mom who's going to be home alone during the day when making good eating choices may be next to impossible with a baby whose needs come first.

Make sure mom has plenty of nutritious foods around that she can just grab and eat without either of you having to prep. Yogurt, nuts, fruit, and precut, precleaned raw veggies should be on hand as quick energy boosts that require no cooking.

When friends and family ask you what they can do to help, ask them to bring you a meal in a freezer-safe storage container in lieu of flowers. Having prepared homemade meals on-hand will help you avoid the temptation to order takeout or fast food, which is high in sodium and fat and not the most nutritious for mom and baby.

Calling in backup

Not every new dad has the luxury of taking ample time off work to attend to the needs of his partner, which means your partner may be facing a lot of alone time with baby at a very early stage.

Leaving a new mom alone while you're off at work isn't a good idea. Many women, especially those who delivered via cesarean section, need physical and emotional support during the daytime for several weeks following delivery.

Talk to your partner about the needs and desires she has while you're at work, then help her find the appropriate support from friends, family, and neighbors. Make chore lists for daytime helpers so your partner won't feel burdened by having to ask for help.

If financially viable, hire a cleaning service. It will be the best gift you can give to your partner . . . and yourself.

Following the birth of their grandchild, your parents and partner's parents may want to visit during this time in order to help, especially when you go back to work. Before agreeing to visits, however, make sure your partner wants them around. All of the advice and constant companionship from a parental figure may cause her more stress. She also may want a chance to go it alone without anyone's help.

If she does want them around, try to stagger the visits to provide a longer duration of coverage — and a little more sanity for you and your partner.

Supporting a Breast-Feeding Mom

Breast-feeding is a full-time job, especially in the first few months, and although it may be more fun and rewarding than changing poop-filled diapers, it's still a lot of responsibility. To the untrained eye, it may look like your partner is simply sitting in a rocking chair holding your baby, but she's actually working very hard to develop a complicated feeding relationship. This section shows you how you can help mom and baby be as successful as possible.

If you feel really lost on this subject, check out *Breastfeeding For Dummies* (Wiley) for more in-depth encouragement.

Making the decision to breast-feed

If your partner is physically capable of breast-feeding (some medical conditions prevent women from doing so), the decision is ultimately hers. It's her body, her time, and her commitment. Prior to the arrival of baby, discuss this topic so you both can research the benefits of breast-feeding and decide whether or not to do it and, if so, for how long.

According to the U.S. Department of Health and Human Services, breast-feeding is an important health choice, and it recommends that any amount of time a mother and baby can do so benefits both. Breast-feeding is a natural process, and the milk contains disease-fighting cells that help protect infants from germs, illness, and even SIDS (sudden infant death syndrome — turn to Chapter 12 for more info). Infant formula, while meeting the requirements of basic nutrition, does not include the human cells, hormones, or antibodies that fight disease.

For the new mother, breast-feeding is a wonderful bonding experience that has been shown to decrease the risk of postpartum depression and lessen its impact. It also causes more afterpains, which are spasms that help shrink the uterus back down to normal size. Producing milk also burns anywhere from 200 to 500 calories a day. Studies also show it reduces a woman's risk of breast cancer and increases her bone density after baby is weaned, reducing her chances of developing osteoporosis in the future.

The health benefits for baby and mom are good reasons to breast-feed, but be sure your partner considers the following details when making the decision:

- **Convenience:** Breast-feeding is much more convenient at home than bottle-feeding, but it can be awkward when you're out and about. Although many shopping centers, museums, and amusements parks have nursing stations, not all do, and your partner may not be comfortable nursing in public. That's why supplemental bottles were invented.
- **Comfort:** Some women are not comfortable with the idea of breast-feeding. Don't blame your partner. This discomfort may be due to a culture that makes breasts into sex objects rather than feeding machinery.
- **Ability:** Breast-feeding is not possible if breast reconstruction surgery that cuts the ducts has been done.
- **Schedule:** If your partner is going back to work in a few weeks, establishing nursing may seem like too much trouble. But nursing for even a short time is better than not nursing at all. Encourage her to try, for even a short time. Just don't be pushy about it.

The American Academy of Pediatrics recommends breast-feeding for the first year of a child's life, and the World Health Organization recommends breast-feeding for the first two years. However, the benefits of breast-feeding continue for as long as mother and baby do it, whether it be three days or three years. The more you support your partner in breast-feeding, the more unparalleled health benefits your baby will receive.

Whether you start off baby with formula or switch after a period of breast-feeding, do your research about the best, safest formula for your child. Many breast-fed babies resist the transition, so be patient. Then again, you're probably used to that by now.

Offering lactation support

LeBron James makes dunking a basketball look as simple as flushing a toilet, but that doesn't mean you can do it. If your partner chooses to breast-feed, keep in mind that it's not as easy as it looks, especially at first. Issues will arise, and although you can't be the one to solve those issues, your support is a major factor in her success. Be positive and upbeat, listen to your partner when she talks, and thank her profusely for making such a wise decision for both the baby's health and hers.

The most important role for dad is to stay informed about the process of breast-feeding. Many complications can arise, and the more you know about how to help your partner through those issues, the more likely mom and baby will be able to work through them. One of the most common reasons women have for ceasing breast-feeding is that it is uncomfortable or painful. Breast-feeding *should not hurt* after mom and baby establish the correct feeding positions and latches (how baby attaches his mouth to the nipple).

Some of the most common breast-feeding issues are

- **Sore nipples:** This problem is usually temporary during the first few days as mom adjusts to breast-feeding. For some women the pain increases, and the nipples become chapped or cracked. This is most commonly a result of a bad latch and can be treated by correcting the latch.
- **Pain from breast engorgement:** Engorgement occurs when the breasts fill up with milk, and can be eased by massage, milk expression, and warm compresses.
- **Clogged ducts:** This occurs when the breast has not been completely emptied and it becomes clogged, causing a small lump to form inside the breast. Heat packs, massage, and increased feeding from the clogged breast can treat it.
- **Mastitis:** Mastitis is a breast infection that a small percentage of breast-feeding women get. It can cause fevers, tiredness, and a hard lump in the breast. Treat with warm compresses, acetaminophen (Tylenol), and a trip to the doctor for a round of antibiotics.

Remember that it's the mother's decision to quit breast-feeding if she so chooses and should never be your suggestion. If lactation issues arise, don't tell her to throw in the towel and go buy some formula, no matter how frustrated or tearful she becomes. Listen to her concerns, help her find resources to correct problems and, ultimately, be supportive no matter what she decides.

Breast-feeding 911

If your partner is experiencing discomfort or suffering from a low supply, know where to go to get her the help she needs. Many hospitals employ lactation consultants and may also provide free breast-feeding support groups your wife can attend. Some lactation consultants also make home visits to help mom and baby work out their issues. Here are a few resources to contact when your partner needs guidance:

- The La Leche League International, phone 800-LA-LECHE; Web site `www.llli.org`.
- International Board of Lactation Consultant Examiners; phone 703-560-7330; Web site `www.iblce.org`.
- International Lactation Consultant Association; phone 919-861-5577; Web site `www.ilca.org`.
- Doulas of North America International, phone 888-788-DONA; Web site `www.dona.org`.

Whenever your partner decides for any reason to stop breast-feeding, thank her for the time she has invested in doing so and congratulate her for her achievements. You both should be proud of the hard, rewarding work you've done.

Including yourself in the process

Just because mom does the actual breast-feeding doesn't mean that you can't be involved, too. An important role for dad is to serve as mom's arms and legs while she breast-feeds, especially in the early stages while your partner's mobility is severely limited by a baby who eats at frequent intervals all day long. Let your partner know that you're happy to get her anything she needs and thank her for breast-feeding the baby. The more you can anticipate her needs, the better. Always have a drink and snack at hand, as well as the TV remote and something to read.

Many women feel frustrated by not being able to do things for themselves. Reassure her that baby's constant eating schedule is only temporary and that it won't be long before he eats less often and her mobility returns. Until then make sure to bring your partner everything she asks for without hesitation.

Sometimes fathers of breast-fed babies feel as though they're missing out on an important, unparalleled bonding opportunity. Remember that breast-feeding is about the well-being of your child,

and although you can't ever experience what your partner does, you can join in on the skin-on-skin bonding by letting baby rest on your bare chest. You can also occasionally give baby supplemental bottles of pumped milk. (See Chapter 10 for more on supplemental bottles.)

Dealing with Postcesarean Issues

Not only is the hospital stay longer for a cesarean section than that of a vaginal delivery — two to four days total — but the recovery time upon returning home is extended as well. A cesarean delivery is classified as a major surgery, which means that even if everything goes smoothly, you have to care for a woman who has been through nine months of pregnancy followed by a serious operation. You also will need to be on the lookout to make sure that no complications arise while your partner is recovering.

Helping with a normal recovery

Give your partner additional physical support for the first few weeks. She shouldn't engage in vigorous exercise or household chores or even climb a lot of steps. If you have to go back to work during the first two weeks postdelivery, find a family member or friend who can come to your home and provide all-day support for your partner.

Emotionally, it's important for the new mom to sit and bond with her baby following a cesarean procedure. Some women experience feelings of disappointment and can even struggle to bond with a newborn when unable to give birth vaginally. Most, however, have no trouble bonding after spending some time together.

If the operation was unexpected, many new dads and moms need some time to decompress following the stress of the situation. Following the birth, discuss the events leading up to the cesarean with your partner. Some new parents find it helpful to discuss the events with the obstetrician to help deal with any negative feelings they have about their birth procedure.

Pain management is important following a cesarean, and when not properly managed it can reduce the chances of successful breast-feeding and increase the chances of postpartum depression. Encourage your partner to ask her doctors about appropriate pain relief medication and how it will affect her breast milk.

Knowing when to call the doctor

Most women who deliver via cesarean recover quickly and without incident. However, watch out for these warning signs and contact a physician immediately if your partner

- Incurs a fever in excess of 100 degrees Fahrenheit
- Notices pus discharge from the incision
- Suffers a swollen, red, painful area in the leg or the breast, possibly accompanied by flu-like symptoms
- Complains of a painful headache that does not subside
- Experiences abrupt pain in the abdomen, including abnormal tenderness or burning
- Has a foul-smelling vaginal discharge
- Experiences an unusual amount of heavy bleeding that soaks a sanitary pad within an hour
- Feels abnormally anxious, panicky, and/or depressed

Riding the Ups and Downs of Hormones

If feeling physically normal while exhausted and still carrying a few pounds of extra baby weight wasn't hard enough for a new mom, along come the hormones to make it all even worse. As the body recovers from childbirth, several months are needed for a woman's hormone levels to completely even out. This section overviews the many changes your partner may experience and how to deal with them.

Thinking before speaking in the sensitive postpartum period

If you've ever put your foot in your mouth, then you know that you can accidentally hurt your partner's feelings via your own thoughtlessness. After delivery you need to be even more careful of what you say, because for most new dads, your partner's emotional sensitivity will feel like uncharted shark-infested waters.

Avoid using leading statements, such as "why don't you just" and "why didn't you" when your partner is upset. You don't have all of the answers, and she's not looking for answers, anyway. What she's likely seeking is a listening ear and an understanding hug.

The last thing you ever want to tell a tearful new mother when she confesses feelings of isolation is, "Why didn't you just go out today?" She likely has worked very hard all day taking care of herself and the baby, and by flippantly suggesting that she should have done more than she did can make her feel like a failure.

To show support, ask her questions that show you're listening, such as "What would make you feel better?" and "What can I do to help you?" If your partner responds with "I don't know" or "Nothing will help until the baby is older/sleeps more/cries less," then tell her you want to help in any way possible. If she has trouble expressing what she needs, you may find yourself becoming frustrated with your inability to fix the problem. Until she can express her needs, plan some time away for her that doesn't force her to make any decisions but instead pampers and caters to her needs and shows her how much you care.

When your partner is upset about something you said, keep in mind that hormones are at play, but don't suggest to her that hormones are the reason she's being sensitive. (That will go over about as well as telling her she's moody because "it's that time of the month.") The last thing you want to do is imply that her feelings aren't legitimate. Simply apologize for any and all offending statements and let her know that you understand where she's coming from.

Many new moms also become sensitive to anything involving hurt or neglected children, which can make TV programs, movies, and books potential minefields. To the best of your abilities, do research about the contents of your entertainment. If the movie you want to watch involves a child death, botched childbirth, kidnapping, or the destruction of Earth, put it on your queue for later viewing.

Shedding light on physical symptoms

Body-drenching night sweats are very common for new moms, and you can't do much to help except to set up a fan near the bed. Sudden hair loss is another physical effect of surging hormones. In the first few months following delivery, most women begin to notice a lot more hair coming out in the shower and on the hairbrush. Reassure your partner that this is normal and that it usually goes back to normal by nine months after delivery. If it doesn't, have her seek treatment from a dermatologist.

Supporting her baby blues

Happiness is only one of the complex emotions you and your partner will feel following baby's arrival. The most common and complicated issue for new mothers is the baby blues, feelings of exhaustion, insomnia, irritability, nervousness, panic, and that she will never be a good mother, which usually occurs during the first few weeks following delivery. Studies show that nearly 80 percent of women suffer feelings of sadness and loss postdelivery.

Experts believe that shifting hormone levels are partly to blame but that it's also a difficult for a woman who has been focused on giving birth for nine months to suddenly switch gears and focus on nurturing a newborn. Caring for a child stirs strong emotions and can make new parents feel an overwhelming sense of responsibility and fear, both of which are perfectly normal.

Talk openly with your partner about her feelings, as well as any sad feelings you may be experiencing. Keep reading to find out how to determine if her baby blues are something more serious that needs treatment.

Recognizing postpartum depression

While most new mothers experience some feelings of sadness that eventually pass, 10 to 15 percent of all new mothers suffer from depression during the first six months postdelivery, and depression requires some care and treatment. Distinguishing between the baby blues and postpartum depression is not as difficult as you may think, especially for you. Your partner may not be able to put her feelings into words or admit she's depressed, but you can be alert for signs of depression and have a discussion with her if you recognize any symptoms. Common symptoms include

- Lack of interest in caring for self or child
- Loss of appetite
- Relentless unhappiness
- Incapable of being happy while spending time with baby
- Sudden arrival of anxiety and panic attacks
- Hearing voices
- Disturbing thoughts about harming self or baby

If you believe your partner is depressed, tell her that you're concerned about her health, allow her to discuss her symptoms and how she's feeling, and let her know that what she's dealing with is a

serious medical condition. It doesn't mean she's a bad mother or a weak person. Good people can suffer from postpartum depression. Don't let her brush the issue aside by saying that it's just a matter of feeling sad and that she'll "snap out of it," because she won't.

A depressed new mom needs to be treated by a medical professional immediately, so work with your partner to schedule a session with her doctor. Counseling and antidepressants are very effective treatments.

Sleeping (Or Doing Without)

Surprise! It's a baby who doesn't sleep through the night. Depending on your newborn, you may be woken every hour on the hour for feedings and comforting. Or you may be one of the lucky parents catching hours and hours of uninterrupted sleep. Every baby is different, but one thing is constant: Sleep is a precious commodity for new parents.

Babies' sleeping habits change frequently, but the average newborn sleeps about eight hours during the day, waking up every hour or so to eat. They generally sleep another eight hours during the night, again waking frequently to eat. Newborn sleep cycles are shorter than those of adults, and they spend more time in light sleep than adults do, which accounts for the frequent disturbances.

The common rule of thumb is to sleep when your baby sleeps. A million chores may need to be done around the house, and you may enjoy an hour watching tennis in peace, but close your eyes instead. If you nap during the day when you have a chance, you'll be in much better shape to deal with a baby who's ready to party when you're ready for pillow time at night. You can take turns with your partner throughout the night, alternating who gets up each time or switching nights. Use a schedule that works for you both.

Many babies wake up for good before the sun has a chance to hit the horizon. If you're routinely jarred from sleep at an obscenely early hour, alternate days of getting up early with your partner so at least one of you can get some additional sleep. That way, when the early riser's energy wanes later in the day, the other partner can step up to help out.

A baby's internal sleep clock begins to mature between the ages of 6 and 9 weeks and starts to become constant between 3 and 5 months. By 10 months, the average baby's sleep cycle is constant, and he will go to bed and wake up at the same time every day. If you're still awake by that time and haven't become addicted to caffeine, congratulations. Your sleep cycle will start getting longer, too.

Ferber versus no-cry

Different schools of thought have varying theories about how to help a baby sleep through the night. Many parents opt to use the Ferber method, created by Dr. Richard Ferber. Commonly referred to as *Ferberizing* your baby, this is the classic cry-it-out system that offers limited comforting for a baby in an effort to teach him how to fall asleep by self-soothing. An increasing number of parents are beginning to use alternative no-cry methods that address an individual baby's sleep issues and offer parents tools to help babies put themselves to sleep without so many tears. Generally, a no-cry method encourages a slow, steady process to segue from cosleeping to crib sleeping that involves building a positive association with the crib for your baby instead of letting her cry until she falls asleep. Research all of your options and decide which method suits your parenting style.

Many babies begin sleeping through the night between 4 and 6 months. Then again, many babies begin sleeping through the night at 1 year of age. Both are normal. Consult your pediatrician if your baby's sleep pattern is unmanageable for you and your partner.

Coping with Company

Family and friends will be vying for any opportunity to get their hands on your baby. Being surrounded by love is important at this time, but mom, dad, and baby also need to get plenty of rest and to have sufficient time to bond as a family. And getting plenty of rest and private family time will help keep you from lashing out at your mother when she offers yet another "helpful pointer" about the proper way to fold bath towels.

Try not to schedule multiple visitors at a time, and limit the number of visits to two or three per day. Now is also the time in your life when it's okay to cancel or say no to visits. If Aunt Sarah is scheduled to drop by in the evening and your partner just needs to catch some shut-eye, put your partner's needs first. Reassure Aunt Sarah that she will get to see the baby in due time. If she's offended, she'll get over it the moment she holds your baby for the first time.

You and your partner should decide together when it's a good time to have people over and when you need some peace and quiet. However, she may feel guilty about saying no even when you know very well that having an empty house is in all of your best interests. Don't be afraid to turn people away without asking your partner so she doesn't always have to feel like the "bad guy."

As visitors cycle through your home, make sure they all wash their hands or use an alcohol-free hand sanitizer to avoid spreading germs. If someone is sick, it is your duty to keep him out of your home. Thank him for his support but let him know that exposing newborns to illness is dangerous.

Baby will be passed around a lot when company is visiting and often only handed back to the new mom for feedings. Make sure that your partner gets plenty of nonfeeding time with the baby to avoid having her feel like a dairy.

Dealing with grabby grandmas

Sharing isn't easy — especially for new grandmas. And as they will gladly tell you (again and again), someday you'll understand when you have a grandchild of your own. Until then, you need to manage everyone's needs for the next 20-plus years without offending anyone.

The best way to handle a too-hands-on grandma is to be honest and respectful. If you want to hold your baby and your mother or mother-in-law is reluctant to give up the wheel, reach for the baby and say something such as, "I just can't hold this little one enough. I've been waiting for this moment my whole life." There's nothing like a display of paternal love to remind a grabby grandma how important bonding is between parent and child.

Don't be passive-aggressive in your approach. Avoid asking questions like, "Mom, do you think I could hold the baby now?" You don't want to imply you think grandma is being overbearing, thoughtless, or disrespectful of your time.

If the problem persists, speak to the offending parent in private. Thank grandma for her love and support, and use only *I* statements (such as, "I have really been feeling the need to spend more time bonding with my baby right now, and even though it may not be what everyone would want, I really need this time") to convey how much you want to spend time with your baby.

Managing unsolicited advice

One of the first things to raise the ire of a new parent is a pushy, well-meaning advice giver. It makes parents feel like they're the heroes in a zombie movie who turn around and see a horde of the undead ready to rip then to shreds. Everyone seems to have opinions when it comes to how to care for your baby, and if you start paying attention to everyone, it will completely overwhelm you. So just run. Run far, far away and don't look back.

Whether the advice is on how to hold him, how to burp him, or even how to soothe him when he's on a crying jag, try to internalize the fact that most people are reaching out with advice because of the love they feel for your newborn. When advice comes across as criticism of your parenting skills, shrug it off. You and your partner know your baby's needs and preferences better than anyone else. Defer to your instincts. Every baby is different, and what works for one may cause another one fits of hysteria.

That being said, you may find some advice helpful, so be open to listening to what others who have parented before you have learned. Don't be afraid to reach out to others if you have questions, but never take someone's advice as gospel. Take the time to do your own homework and decide what works best for your family.

Don't feel the need to explain yourself, however. If your Uncle Robert thinks you're somehow failing your child by picking him up every time he cries, don't be afraid to push back. Say something like, "I guess the beauty of being a parent is getting to decide how you want to raise your own child."

Handling hurt feelings when you want to be alone

Inevitably at some point you'll need time to yourself. So will your partner. Baby love is all encompassing, but you can't let it overtake your individuality. Even though visitors have traveled from afar and people want to shower your new family with affection, you have to put on your own oxygen mask first, so to speak. Whether you're a runner or an avid video gamer, don't feel guilty about taking time to do what you need to relax.

Never under any circumstances utter the phrase, "I just need a break." Your partner will not like to hear that, because nobody deserves a break more than a new mom. Let her know that you really need to blow off some steam in order to continue being the best caregiver you can be. If she's angry, tell her you understand how she feels and offer her the same amount of time upon your return. Even the breast-feeding mom can enjoy a brief walk or a quick run to the store just to have some time to be on her own again.

Make sure to schedule time for your mental well-being, because it probably won't seem like a priority until you're raving like a madman because you just need a second of solitude. Keep a calendar and block out times in different colors for family time, dad time, mom time, and visiting hours.

If family or friends take offense when you say no to a visit or an invitation to attend a family function, don't change your mind to

save their feelings. You deserve time to bond as a family and time to unwind and just be yourself. Thank them for the offer, be honest about why you can't commit to that time, and plan a get-together for a later date that suits everyone's schedule.

Approaching Sex: It's Like Riding a Bicycle

Hang tight, fellas. It's gonna be a while. The earliest a woman can have sex is six weeks following delivery, and that's only after getting clearance from her doctor. Your hormones may be raging, but you need to remember that your partner's genitalia have been through the wringer, so to speak, and intercourse can severely jeopardize her healing process.

In addition to needing time for physical healing, most women won't be feeling all that sexy for a while. Hormones are the major culprits, but a lack of sleep, breast-feeding, and the difficulty of straddling the roles of mother and sexual being are also hurdles. As hard as it is to internalize, remind yourself that her lack of physical interest in you has nothing to do with her feelings toward you. Her absence of desire isn't personal; it's physical.

Some women find their sexual desires return by the time their doctor okays sex, but for many it can take between 6 and 12 months. Some new fathers also experience a diminished interest in sex when adjusting to the role of dad.

Even after your partner has healed and desire returns, she may experience discomfort when returning to a normal sex life. Be prepared to take it slow. You may need several attempts before you actually have sex to completion. Time will also be at a premium and baby just may wake up before you finish.

Time will also be at a premium as you work around baby's schedule, so as unromantic as it sounds, schedule sex with your partner and slowly ramp up to a frequency that works for both of you. With so much on your plates, it will give you both the security of knowing the "when" and the excitement of thinking about the "how."

Birth control also needs to be a talking point for you and your partner. Many people believe that breast-feeding women cannot get pregnant, but although breast-feeding does often delay a return to regular ovulation, some women do ovulate while nursing. Many breast-feeding women prefer not to go on birth control pills due to changes in milk supply, so condom usage is common for new parents returning to active sex lives. You can speak with a doctor to help you both determine a birth control option that fits your needs.

Part IV

A Dad's Guide to Worrying

In this part...

This part is designed to keep you from staying up all night worrying about all the things new dads worry about, from colic to college. We discuss possible complications and newborn concerns, and we devote a whole chapter to being a supportive partner, lest you forget the person who gave birth to your progeny. We also help you plan for your child's future financial security.

Chapter 12

Dealing with Difficult Issues after Delivery

In This Chapter

- Learning that your baby has problems
- Coping with serious postpartum issues
- Grieving together and separately
- Telling other people when your baby has problems

Not everyone goes home to perpetual roses and lollipops after their baby is born. In fact, hardly anyone does. But serious issues in baby or mom are rare, so when they occur, they can really knock you for a loop. In this chapter we discuss some of the serious complications that can arise after delivery and how to handle them. This is a chapter you can skip if you don't need it — and we hope you never will.

Coping with Serious Health Problems

Approximately 1 in 33 babies born in the United States has a congenital birth defect, according to the Centers for Disease Control. Developmental delays, serious illnesses, and sudden infant death syndrome are problems no one wants to contemplate when having a baby, but they can and do happen. The following sections give you an overview of the most common serious health problems.

Congenital defects

Congenital defects, defects that exist at birth (also simply called *birth defects*), are common. Some are minor issues that no one but the parents would ever notice; others are more serious. The most common birth defects include

- **Heart defects:** One in 100 to 200 babies born has a heart defect, which can range from mild to severe. Heart defects comprise one-quarter to one-third of all birth defects.
- **Down syndrome:** One in 800 babies is born with Down syndrome, which causes distinct physical features and mental retardation. The percentage is higher in older mothers and lower in those younger than 35.
- **Neural tube defects:** One in 1,000 infants has neural tube defects, which affect the brain and spinal column. They include spina bifida, an abnormal opening in the spine, and anencephaly, an absence of part of the brain.
- **Cleft lip and/or palate:** One in 700 to 1,000 babies has deformities of the lip and hard palate.

Sixty percent of the time, the reason for the birth defect is unknown. Inherited disorders, on the other hand, may be suspected ahead of time if a family history of a genetic disorder exists.

Some of the most common inherited genetic disorders include

- **Cystic fibrosis:** A disorder that causes thick secretions in the respiratory and gastrointestinal tract, cystic fibrosis is the most common inherited genetic disorder in Caucasians in the United States, affecting 1 in 3,000 babies. Both parents must carry the defective gene for a child to have the disease; it's estimated that 12 million people in the United States are carriers.
- **Sickle cell anemia:** An autosomal recessive disease causing deformities of the red blood cells, sickle cell anemia affects mostly people of African and Middle Eastern descent. Approximately 2 million African Americans carry the sickle cell gene.

Minor birth defects are much more common than serious defects. Eye, ear, and limb defects; extra digits; abnormal development of the intestines; and birthmarks may not be life threatening in most cases, but they can still be devastating for parents. Being concerned about birth defects, especially visible ones, is normal for parents.

Developmental delays

Many parents keep baby books that chronicle their baby's progress, and eagerly await each milestone: the first smile, the first step, the first word. When milestones aren't met when books say they should be, or when your friend's babies are meeting them but your baby isn't, doubt, concern, frustration, and a cold fear may begin to creep into your days.

Moms are usually the first ones to recognize a problem, so if your partner voices concerns, don't belittle them, even if the baby seems fine to you. Verbalizing fears about your baby's development takes a lot of courage.

When babies are very young, physical milestones are very important. Babies, after all, don't dazzle you with their small talk or charm you with their recitation of *The Iliad.* If they lift up their head, it's a big deal. Rolling over for the first time merits phone calls to relatives all over the country, and the first gurgle — the one that startles the baby almost as much as it does you — earns your undivided attention for the next hour as you try to catch a command performance on video.

When your baby isn't keeping up with the other babies on the block (whether in your mind or in fact), discuss it with your doctor, who may tell you that all babies are different and that you're making yourself crazy. Or he may nod and take notes, which is really frightening, because even when you know something's wrong, having someone else verify it makes it all too real.

If you suspect that your baby isn't meeting developmental milestones, take a deep breath and consider the following facts:

- **Babies really do develop at different rates.** Milestones happen at an average age, and an average is just that: 50 percent of babies achieve the goal at a younger age, and 50 percent don't meet it until they're past that age.
- **Babies all have different abilities.** Some are more physically oriented; others are more verbally inclined. Since physical milestones are all you have to go on at a young age, children who will shine verbally later may seem to be behind early on.

However, talk to your doctor if your baby doesn't meet the following milestones:

- Turns her head in the direction of a voice or sound shortly after birth
- Smiles spontaneously by 1 month
- Imitates speech sounds by 3 to 6 months
- Babbles by 4 to 8 months

If your baby does have developmental delays, she'll need your help to achieve normal milestones. Getting help early is the best thing you can do for her.

Illnesses

Infant illness can be *acute* (severe but brief) or *chronic* (long lasting or recurring). Both are terrifying, especially if your baby has to be hospitalized. A sick baby, especially a chronically sick baby, changes your family dynamic in major ways and can come become the unhealthy focus of the entire family. The following suggestions can help you deal with an illness in your infant, whether acute or chronic:

- **Absolutely, positively avoid any hint of the "blame game."** Even if anything either of you did caused the baby to get sick, it's over and done with, so pinning blame on someone will only make everyone feel worse. Babies can't be raised in a bubble, so getting sick is, unfortunately, a fact of life.
- **Don't let yourselves get overtired.** Especially if your partner delivered not too long ago, she really needs to get enough rest. Take turns staying at the hospital or being up with the baby at home, or one of you could get sick, too.
- **If your partner is breast-feeding, keep pumping.** Stress is hard on milk supply, and pumping isn't nearly as effective as a nursing baby for stimulating the supply, but encourage your partner to do her best. As long as she keeps it going in the interim, the supply will build up when the baby is nursing again.

SIDS

Sudden infant death syndrome, or SIDS, has decreased since pediatricians began recommending that babies sleep on their backs with the "Back to Sleep" campaign, but it's still the third most common cause of death for infants up to 1 year old. More than 7,000 babies in the United States succumb to SIDS each year.

Identifying the causes and debunking myths

The causes of SIDS still are not clear. However, doctors know that the following are *not* causes of SIDS:

- Suffocation
- Choking
- Vomiting
- Infections
- Immunizations

SIDS is considered to be multifactorial, meaning that it doesn't have just one cause. Several factors must all be present for SIDS to occur, including abnormalities in the brain, respiratory system, and possibly the heart.

Understanding what increases the risks

The following factors increase the likelihood of SIDS:

- The baby was born premature.
- The baby is male.
- The baby is of black, Native American, or Native Alaskan ethnicity.
- The baby is between 2 and 3 months of age
- The baby is overheated or overdressed. Too many clothes or an overly heated room may increase the risk of SIDS. SIDS occurs more often in cooler fall and winter weather when babies get bundled up.
- The baby has a sibling who died of SIDS.
- The baby was/is exposed to tobacco. SIDS rates are higher in babies whose moms smoked during pregnancy or who smoke around the baby.
- The mother used cocaine, heroin, or methadone during pregnancy.
- The baby recently had a respiratory infection.
- The baby sleeps on his stomach, especially if he's switched from back to stomach sleeping or is overheated and sleeping on his stomach.

Research also indicates that babies who are breast-fed and those who suck on pacifiers may have a lower risk of SIDS. Side sleeping may seem like a compromise if your baby hates being on his back, but back sleeping is still safer, and many side sleepers roll over onto their stomachs.

Placing a fan in the window, or even just opening a window, also has been shown to decrease the risk of SIDS in at least one study. SIDS deaths dropped more than 70 percent when a fan was placed in a window and dropped 36 percent when the window was opened. Better ventilation may decrease carbon dioxide buildup.

Watching Out for Postpartum Issues

Female hormones are a jumbled mess right after delivery, which is why women are so emotionally fragile after birth. Add sleep deprivation and insecurities about parenting ability, and it's amazing that your partner can function at all.

Mood swings and depression are normal for the first few weeks or even months after having a baby, but sometimes more serious problems can arise. One of your jobs is being aware of the signs of a serious problem and making sure your partner gets help if needed.

Getting through the "baby blues"

Nearly every new mom experiences the "baby blues," emotional mood swings and mild depression triggered by hormone changes after delivery. Symptoms of baby blues include

- Anxiety or feelings that she's not doing things "right"
- Crying for no reason — at least, for what seems like no reason to you
- Difficulty concentrating
- Irritability
- Mood swings
- Periods of sadness
- Trouble sleeping

Baby blues normally last just a few weeks after giving birth, so if symptoms last longer or seem more severe, get your partner to her medical practitioner for help. Many women don't recognize the severity of their own symptoms or don't have the emotional energy to deal with them.

Taking a look at postpartum depression

Postpartum depression, a more serious form of the typical "baby blues," occurs in up to 10 percent of women. Some of the symptoms of baby blues and postpartum depression overlap, but postpartum depression is more pronounced, lasts longer, and includes serious signs that need immediate medical evaluation.

Recognizing the symptoms

Women with postpartum depression may have the following symptoms:

- **Difficulty bonding with the baby:** This is a major red flag. If your partner pushes the baby off on you or says she's not a good mom or that the baby would be better off without her, get medical help.
- **Thoughts about harming herself or the baby:** She may not verbalize these thoughts, so they may be hard to recognize. She may want other people to handle the baby because of her fears that she will hurt him, accidentally or on purpose.
- **Guilt and shame over her negative thoughts:** Again, because she may not verbalize her thoughts, recognizing what's going on may be difficult. Statements like "I'm no good" or "Someone else would be a better mom to this baby" are warning signs.
- **Sleep difficulties:** She may not be able to sleep, or she may want to do nothing but sleep.
- **Disinterest in normal activities, including sex:** Seeing old friends, going out, even everyday activities like cleaning the house, doing laundry, and watching TV may all go out the window. While you may at first think she's just tired, a deeper reason may be at the root of her continued lack of interest in life that lasts for several months after delivery.
- **Loss of appetite:** Losing interest in eating is often an early sign of depression.
- **Anger and irritability:** Her anger may go far beyond a few swear words when she drops a quart of milk, and can be frightening.

Postpartum depression usually is not a short-lived disorder, so don't try and wait it out, thinking she'll get over it in a week or two. Postpartum depression can last up to a year, which can interfere with maternal-child bonding and seriously disrupt your family.

Children of moms with untreated depression also suffer the consequences, with a higher incidence of behavior problems, sleeping disorders, feeding problems, hyperactivity, and language delays.

Knowing who's more at risk

Any woman can have postpartum depression, but the chances of this developing increase if

- **She has a history of depression.**
- **She's recently undergone major life changes.** These changes can include a move, a death, job loss, illness, pregnancy complications, or trouble between the two of you.
- **She doesn't have a good support system.** Family and friends make a big difference in the life of a new mom. Postpartum depression makes it difficult to reach out to others, so a woman who doesn't have pushy friends and family who will check in on her even if she doesn't call them is very isolated.
- **The pregnancy was unplanned or unwanted.**

Treating the disease

Treatment for postpartum depression may include

- **Antidepressants:** Make sure the doctor knows if she's breast-feeding so he can prescribe an antidepressant safe for use by breast-feeding moms.
- **Hormone therapy:** Estrogen replacement to offset the rapid drop in estrogen after giving birth may be helpful for some women.
- **Counseling:** Talking things out with a professional is very helpful for some women.

Taking care of yourself

If your partner is suffering from postpartum depression, a large part of her normal chores and responsibilities may fall on you. If you're trying to hold down a job, make sure your partner's okay, make sure the baby's okay, and run the household on top of it all, you may start to feel a little stressed yourself.

While rushing in to take over a short-lived crisis is easy, a situation that drags on for months can take its toll on your mental and physical well-being. Take care of yourself by making sure you

- **Get enough sleep.** Sleep deprivation makes everything look worse. The very worst time to pore over your worries is the middle of the night; everything looks insurmountable at 3 a.m.
- **Eat right.** You'll feel better and be better able to handle situations if you're not eating junk food.
- **Call in the troops to help.** You may not have readily available family and friends, but if you do, enlist their aid. Send them to the store, or have them come over and clean. This is a fine line, because you don't want to give your partner the impression that she can't do all this stuff, even when she can't. If you

call in your mom to clean or cook, your partner may view it as a judgment against her abilities and a sign that you feel your mom is more capable than she is. Sometimes hiring help for household chores is a better idea.

- **Consider taking a leave of absence from work.** Some companies offer paid time off for dads or will let you use vacation or sick time. You can also use Family Medical Leave Act (FMLA) time for up to 12 weeks of time off, but this will probably be unpaid time, unless you work for an extremely generous company. Dipping into savings or borrowing from your 401(k) isn't ideal, but if it gets your family through a difficult time, it's worth it.

Acting fast to treat postpartum psychosis

Postpartum psychosis is an extremely dangerous psychiatric disorder that occurs in around 1 to 2 percent of women, usually in the first few weeks after giving birth. Women with bipolar disease or previous history of postpartum psychosis are more likely to develop the condition. Onset is sudden and includes the following symptoms:

- Paranoia
- Hallucinations
- Delusions
- Insomnia
- Irritability
- Restlessness
- Rapidly changing moods
- Bizarre thinking

Left untreated, postpartum psychosis can be lethal; the risk of suicide or infanticide is high. If your partner displays any of these symptoms, don't try to talk her out of it or persuade her to see her doctor. She almost certainly won't recognize her behavior as abnormal and in fact will probably consider you to be an adversary. Call 911 immediately.

Managing Grief

Grief is intense sorrow due to loss. The loss of the perfect child, the perfect partner, or perfect family can cause grief. The most important thing to remember about grief, no matter what the cause, is that it takes time to work through. Don't be hard on yourself or your partner when you're grieving, and don't expect you'll be in the same stages at the same time. Everyone works through grief differently.

Going through the stages of grief

Grief can be caused by many different scenarios, but the widely acknowledged five stages of grief, described by Elisabeth Kübler-Ross, include similar phases whatever the cause.

Whether you've found out that your baby has a long-term problem, your partner if suffering from serious postpartum illness, or your baby has to be hospitalized, expect to experience the five stages of grief:

1. **Denial:** The first stage of grief is often a feeling of "This can't be happening to us."
2. **Anger:** The second stage of grief is anger, often directed at God or other people.
3. **Bargaining:** Trying to make secret deals — "I'll donate our savings to this hospital if my baby's heart surgery saves him" — often with God (even if you don't believe in God!) is common in the bargaining stage.
4. **Depression:** When reality sets in and you realize that this is happening to you, fair or not, depression often follows.
5. **Acceptance:** Eventually you get through the other stages and settle down to dealing with what you have to deal with, but you may still go in and out of earlier grief stages at different times.

Stages may not follow this exact pattern, and not everyone goes through every stage. Yo-yoing back and forth between several stages is also common.

Grieving is important during the entire pregnancy process. Even if your baby is born without incident, you will be going through a lot of changes. Allow yourself and your partner to discuss the many things you're giving up in order to bring this child into the world.

Even something as silly as giving up your daily latte in order to buy diapers can become a source of resentment over time. As a general rule, talk openly and honestly about the changes that affect you and support each other.

And cut yourself a break — parenting isn't easy, and it's perfectly natural to miss having nights out with friends or even being able to eat an entire meal before it gets cold. Grieving the little things doesn't mean you don't love your baby — it means you're dealing with change in a healthy manner.

Why, why, why? Getting past the question

When grieving, getting bogged down in why a particular thing has happened to your partner or child is easy to do. However, it's not particularly good for you, especially if there's no way of deciphering exactly why something happened and most of your thoughts are purely speculative.

Unless knowing the reason why your problem happened can prevent a recurrence or change a situation, asking "why" doesn't help. Wanting a reason is a way of imposing control on a situation, but it doesn't help you move forward in helping your child.

Grieving together and separately

Everyone needs time to grieve a loss in their own way. Grieve together with your partner, certainly, but take time to grieve separately as well. Don't feel bad about needing to be alone with your thoughts sometimes. At the same time, the following tips can help you and your partner get through your grief, both together and on your own:

- **Stay physically close.** It helps you feel less alone, keeps you centered on still being a couple, and helps keep your relationship going in a situation that could easily break it apart. Even if you don't feel like it, make the effort to hold hands, cuddle on the couch watching TV, and have sex regularly.
- **Expect to be discouraged at times.** Everyone has moments when things look much worse than they really are, usually because they're tired, hungry, or just plain stressed. Identify it for what it is: temporary discouragement, not a new permanent negative outlook on life.

- **Don't get upset with your partner.** One day you or your partner may be raging at the world, and the next day the other one may take a turn. Listen to each other without taking things personally, trying to make it all better, or reproving them for their feelings.
- **Arm yourself with knowledge.** Knowledge really is power. Especially if your baby has a genetic or long-term condition, learning all you can about it helps you be your baby's best advocate and can help you and your partner feel like you're doing something productive in a frustratingly out-of-control situation.
- **Keep a journal, if the thought appeals to you.** Journals are not only good for privately venting feelings and fears that you and your partner don't want to share with each other; they're also good for looking back later and realizing how far you really have come.
- **Find a support group.** If you're coming to terms with a birth defect, your child or partner is ill, or you're dealing with a loss, talking to other parents dealing with the same thing can be a lifesaver. When relevant, it can also be a really good source of information on specialists, educational programs, and other outside help.
- **Get help for yourself.** If you find yourself mentally overwhelmed, seek counseling, either with your partner or alone. Often just being able to talk through a situation with a person not involved helps you sort things out.
- **Tell people when you're not up to something.** Another baby's christening, a big family party, or a holiday celebration may all be beyond your or your partner's ability to handle at first. Don't be afraid to say no to things that you feel would strip you raw right now. People who love you will understand, even if they're disappointed.

Determining when grief has gone on too long

Grieving can take a long time. But sometimes grief takes on a life of its own, and a situation called *complicated grief* can become permanently entrenched in your or your partner's life. While everyone has times when the sadness of circumstances becomes overwhelming, normally these feelings don't affect every aspect of life after the first few weeks or months. Complicated grief may be taking over your life or your partner's after a period of time if

- You still feel numb and detached.
- You're preoccupied and bitter about what's happened.
- You can't perform normal tasks, go to work, or participate in normal social functions.
- You feel life has lost its meaning.
- You're unusually angry, irritable, or agitated most of the time.
- You make rash decisions or do things you normally wouldn't do, such as drinking too much.

When grief becomes complicated, it becomes self-perpetuating. This is a time for intervention, either with medication or therapy. Talk to a grief counselor, psychologist, psychiatrist or other mental health personnel about your feelings and symptoms. Antidepressants have been found to help in some cases.

Talking to Other People about Your Child

Accepting a child's health problems is challenging enough for parents, and an emotionally sensitive situation is made even more difficult by the fact that eventually you need to inform other people of the problem. In time you may become accustomed to the comments of well-meaning but blundering family members and rude strangers, but at first you will likely be uncomfortable and upset. The following sections give you guidelines for getting through these situations.

Telling other people

Telling other people that your child has a problem can be gut wrenching; verbalizing to other people can be almost like hearing it for the first time yourself. When you tell other people your child has a problem, try the following tips:

- **Keep it simple.** Especially if your child has an ongoing medical problem, giving out information a little at a time may make it easier for others to digest.
- **Keep it positive.** Maybe your child isn't going to be able to be all you ever hoped for him. Actually, no child ever can! Remember that your child will be able to have a happy life, no matter what his disability, and you can enjoy him no matter what his issues. That positive outlook will express itself in your message.

- **Keep it straightforward.** You may be tempted to sugarcoat a situation when explaining it to others, but there's no reason to give them hope that a child will grow to be something he won't. Be honest about the situation from the beginning.

Handling insensitive remarks

Unfortunately, people do notice when a child has a birth defect or development delay and sometimes your hear them whispering to each other or pointing at your child. As devastating as this is, use it as a teaching experience if you can. If your child has a visible birth defect, comments *are* going to come your way — and your child will hear and understand those comments as she gets older.

Openly discussing your child's disability as something not to be hidden or ashamed of sets a positive example for your child. This doesn't mean that you have to freely discuss your child with every obnoxious person who asks pointed questions. But addressing questions with an open, accepting, positive attitude tells your child — and everyone else — that he's a great kid and that you're happy with him just the way he is.

Sometimes you won't have the patience to deal with questions, and you don't have to educate every person who crosses your path. But when your mood allows it, try the following suggestions when confronted with insensitive remarks:

- **Answer a small child's questions.** Children, having no discretion at all, often ask their parents about people with visible problems at the top of their lungs. Introduce yourself and use this opportunity to teach others about your child's disability.
- **Address an adult's comments in a nonjudgmental way, if you're up to it.** Most insensitive remarks are made out of ignorance, not malice, and even if they were made out of malice, addressing them politely can take the wind of a person's puffed sails and, with any luck at all, shame them into better behavior in the future.
- **When your own relatives are saying inappropriate things, address it firmly and in a non-negotiable way.** Offer to teach them anything they'd like to know, but let them know in no uncertain terms that this is your child and certain comments will not be tolerated.

Chapter 13

Daddy 911: Survival Tips for Bumps, Lumps, and Scary Moments

In This Chapter

- Surviving the illnesses and accidents
- Staying cool and handling emergencies
- Giving medicine, taking temperatures, and monitoring diapers
- Helping your child through teething
- Taking a look at reactions to vaccines, medications, and food

Nothing in fatherhood gets your adrenaline flowing like a "thump" from the other room, followed by a scream, or worse, by silence. Nothing, that is, except endless vomiting, a seizing child, or a fender bender with baby in the car.

Fatherhood is full of frightening moments, but most of the time, babies survive parental ineptitude and concern. No one gets through babyhood and early childhood without a few accidents, sicknesses, and spills and thrills along the way. If your child never has a bruise or bump, you're probably protecting him too much, and a child who never gets sick never develops a good immune system. So take heart when dealing with heart-stopping situations: They're an inevitable part of parenthood. In this chapter we review the most common sources of parental anxiety, tell you what to do when they occur, and reassure you that, 99 times out of 100, baby — and you — will be just fine.

Handling Inevitable Illnesses

Most babies are now vaccinated against the most common illnesses, but plenty of illnesses can still infect your baby. And no

matter how hard you try to protect your baby from illness-causing germs, you can't protect him from them all — and that's okay. Although hand washing, careful food handling, and cleanliness do help reduce germs, some germs are necessary. In fact, recent studies indicate that people who keep the bacteria around them at too much of a minimum are more likely to get sick than people who share their abode with a few stray germs. Go figure.

You can be sure that your baby will catch something in his first year, no matter how carefully you clean the shopping cart handles. In the following sections we tell you the symptoms, causes, and treatments of common illnesses so you'll feel prepared when the inevitable happens.

Nursing baby through common childhood diseases

Babies have immunity to many illnesses for their first six months because of antibodies passed on during pregnancy, but after six months, it's open season for germs. Following is a rundown on the most likely candidates for first illness to infect the baby.

Common colds

The common cold is so common that it comes in more than 100 varieties, which is why having a cold this month doesn't mean you won't get another one next month. And because your baby has never had any of them, she's likely to have at least one case of the sniffles in the first year. In fact, the Mayo clinic says that the average baby has eight to ten colds in the first two years of life, and each one lasts seven to ten days, no matter how many decongestants you buy. You may want to consider buying stock in facial tissue.

For most babies, colds aren't serious, although they are messy. Typical symptoms of a cold include:

- Runny nose, which may start with clear, thin secretions that turn thicker and yellow or green
- Sneezing
- Coughing
- Decreased appetite (young babies may find it hard to nurse or drink from a bottle because of nasal stuffiness)
- Low-grade fever up to 100 degrees
- Irritability

Babies under the age of 3 months should not be given decongestants at all, and infants younger than 6 months should be given them only if congestion interferes with breathing or sleeping. Infant acetaminophen or ibuprofen are fine to help the baby feel better.

Although colds aren't usually serious, babies younger than 3 months old who develop cold symptoms need to visit a medical practitioner. Babies that young are more likely to develop pneumonia or other complications from a cold.

Ear infections

Between 5 and 15 percent of babies with colds develop an ear infection, which just prolongs the misery. Contrary to popular opinion, tugging on the ears doesn't always indicate an ear infection, although it can. Other ear infection symptoms include:

- Irritability
- Head shaking
- Refusal to nurse or take a bottle
- Mild fever
- Trouble sleeping

Breast-feeding when mom is sick

Moms aren't allowed to get sick — it's in the code of parenthood. But if your partner does get sick while breast-feeding, you both may wonder about the wisdom of continuing to nurse.

If she's already sick, the baby's already been exposed to the germs before the sickness became evident, so there's no reason to avoid the baby. Very few illnesses require her to stop breast-feeding. In fact, moms who develop colds and other common illnesses develop antibodies that they pass on through the breast milk, so nursing when sick may actually help the baby. Toxins such as E. coli, salmonella, botulism, and other gastrointestinal bugs stay in the GI tract and don't affect the milk, so breast-feeding is safe.

Your partner should check with the baby's doctor if she's taking heavy-duty cold medication that has a sedative effect, and she should avoid cough syrups with alcohol contents over 20 percent. Nasal sprays for sinus congestion can dry up her milk, so use sparingly.

When your partner's sick, she's likely to require higher than usual amounts of fluid to stay hydrated — and a double dose of TLC to keep her going through nighttime nursing sessions. Getting up yourself and giving a bottle of pumped breast milk for a night or two so she can sleep will buy you bonus points as a helpful dad.

The thinking on treating ear infections has changed during the last few years; ear infections may not require antibiotic treatment, because more than eight out of ten heal without treatment. Some doctors treat, and others wait, depending on the severity of the infection and the symptoms. Pain relievers help with discomfort.

Respiratory syncytial virus (RSV)

Respiratory syncytial virus (RSV) is a lower respiratory illness that infects most children at least once before age 2. Symptoms include lethargy, poor feeding, cough, difficulty breathing, and fever. While most cases are mild, severe illness requiring hospitalization can occur in small babies and premature or otherwise compromised infants.

For less severe cases, which occur far more frequently, acetaminophen or ibuprofen help with discomfort. Like most viruses, this one needs to run its course.

Vomiting

Small children and babies vomit more easily than adults when they're ill. Vomiting once at the beginning of an illness is common and requires no special treatment, but repeated vomiting requires medical evaluation because of the risk of dehydration.

Signs of serious dehydration require medical treatment. A sunken fontanel, the soft spot on the top of an infant's head, extreme lethargy, sunken eye, or sunken skin that remains raised after you pinch it deserve an immediate call to the baby's doctor.

Pediatricians often recommend giving vomiting children younger than 6 months an oral balanced-electrolyte solution such as Pedialyte in place of formula, starting with a few teaspoons or half an ounce every 15 minutes or so. Don't give plain water to any child younger than age 1 unless your pediatrician specifically recommends it. A medication syringe often works better than a spoon for this if your baby refuses to drink. Gradually increase the amount you give each time if the baby isn't vomiting it back up.

Don't give a volume more than you normally would: for example, if you normally give 4 ounces of formula every four hours, don't exceed that amount.

If no vomiting occurs after 12 hours, slowly start to reintroduce formula, but stop if vomiting occurs again. Breast-fed babies should continue to nurse, because breast milk is more digestible than anything on the planet. However, if vomiting continues, call your doctor.

Some medical personnel recommend following the BRAT (bananas, rice, applesauce, and toast) diet during and after a vomiting illness for children older than 1 year, after they haven't vomited for eight hours or so, because these foods are easily digested. Go slowly with foods and don't introduce any new foods until all vomiting and stomach upset have passed.

Babies who suddenly start vomiting after every feeding even though they appear healthy and still have an appetite may have *pyloric stenosis,* a narrowing between the stomach and small intestine. Pyloric stenosis requires surgery but has no aftereffects; when it's fixed, it's fixed.

Wheezing

Wheezing often follows a cold and doesn't always mean a baby is going to have asthma. Children younger than age 2 who wheeze with respiratory infections are no more likely to develop asthma than children who don't wheeze, according to a study published in 2002 in the *American Journal of Respiratory and Critical Care Medicine.* Children who start wheezing at an older age are more likely to develop asthma.

Wheezing can be scary for parents, and may require prescription bronchodilators that are breathed in as a mist, using a nebulizer, to open the narrowed airways and make it easier for the baby to breathe. Wheezing always requires a call to the pediatrician, especially if the baby doesn't have a cold or cold symptoms. An object stuck in the throat or more serious medical conditions can also cause wheezing. Some children wheeze with every upper respiratory treatment and may need nebulizer treatments whenever they have bad colds.

A child who is limp and exhausted, who has a bluish tinge around the lips, or who is struggling to breathe needs immediate medical attention.

Infectious diseases

Many infectious diseases of old (30 years ago!) have been eradicated, or nearly so, due to vaccines (see the later section "Reacting to Medicines and Vaccines"). However, vaccines haven't been developed for everything, and sometimes a baby is exposed to an infectious disease before she gets the vaccine. Chicken pox, measles, mumps, and rubella (German measles) vaccines, for example, aren't given until age 1, and roseola, a common infectious disease in infants, has no vaccine.

Being viruses, most common childhood diseases have no specific treatment beyond treating the symptoms and keeping

the child comfortable. Aspirin should never be given to treat fever or discomfort, due to the possibility of Reye's syndrome. Acetaminophen or ibuprofen are fine if your child is uncomfortable; follow your pediatrician's instructions on dosing.

Many infectious diseases are accompanied by rashes, so any time your child has a rash and fever, call your medical practitioner for advice. He may want to see your child, but then again, in some cases, he may not want you bringing your infectious child into the waiting room! If the disease is highly contagious and fairly evident from the type of rash, such as chicken pox, he may give instructions over the phone without seeing the child. Following are some common infectious diseases with rashes:

- **Roseola:** Roseola has few complications but often results in frantic calls to medical personnel because the first symptom, which lasts for several days, is a high fever. Around day four the fever breaks and a rash appears. A telltale sign of roseola is that even with a fever as high as 104 degrees, the child doesn't appear ill. Roseola has no treatment and generally doesn't cause a great deal of discomfort.
- **Chicken pox:** Chicken pox is unmistakable: small red spots that form blisters that break and crust. A mild temperature and respiratory symptoms often accompany chicken pox. In rare cases, chicken pox can cause encephalitis, brain inflammation that can have long-term consequences. There's no way to shorten the duration of the disease, but cool baths and anti-itch lotions help with discomfort.
- **Hand, foot, and mouth disease:** Although this sounds like some ghastly disease only ranch hands would catch, hand, foot, and mouth disease is a common virus that causes blisters on the — yes, you guessed it — hands and feet and in the mouth. Mild fever can also occur, and the mouth sores can make it hard for a child to eat.
- **Measles:** Also called rubeola, measles was once a common disease. From 2000 to 2007, an average of only 63 cases occurred each year in the United States, but in the first half of 2008, 131 cases were reported, with most cases not vaccinated or with unknown vaccination status. Measles rarely occurs before age 6 months, due to maternal immunity being passed to the fetus. Children with measles usually appear quite ill and have a rash and high fever.
- **Rubella:** Rubella, sometimes called German measles, is a mild infection that causes a rash. While not serious for infected children, rubella poses serious risks for pregnant women, causing a number of birth defects as well as pregnancy loss. Rubella has become rare in the United States due to vaccination.

- **Mumps:** Mumps causes pain and swelling in the parotid glands, resulting in the classic "chipmunk" appearance. Mumps, like measles and rubella, has become rare in developed countries with the mumps vaccine. Mumps can cause painful testicular infection in males and affects sterility less than previously believed.

Staying alert for scarier diseases

Some major-league bacteria and viruses can infect infants, but the signs are usually pretty obvious: Your baby looks and acts sick, refuses to eat, cries, and sleeps too little or too much. Rest assured that if your baby is seriously ill, you'll recognize the signs. In the following sections we tell you what to watch for.

Meningitis

Meningitis, an inflammation of the tissues that cover the brain, can require hospitalization. Meningitis can be bacterial or viral and is caused by a number of organisms. Vaccination for *Haemophilus influenzae* type B, also known as Hib, reduces the chance of meningitis. Symptoms include fever, irritability, poor feeding, rash, seizures, a high-pitched cry, and stiff neck. In infants, the soft spot at the top of the head, the fontanel, may be bulging rather than flat. Signs of meningitis need immediate treatment to prevent complications.

Diarrhea

Although diarrhea may seem like more of a nuisance than a serious disease, severe diarrhea can cause life-threatening dehydration in an infant within a day or two. Diarrhea accompanied by fever, vomiting, or refusal to drink fluids needs immediate treatment. Diarrhea is most often caused by bacterial or viral illnesses including food poisoning.

The following symptoms indicate serious dehydration that needs a doctor's treatment:

- Extreme lethargy
- Sunken fontanel (the soft spot on top of baby's head)
- Sunken eyes
- Sunken skin that remains raised after you pinch it

Loose, frequent stools aren't always diarrhea; see the section "Deciphering Diaper Contents" in this chapter for ways to distinguish diarrhea from normal stool.

Protecting Baby from Common Accidents and What to Do When They Happen

You may not think newborns have a lot of accidents, since they're not all that mobile, but they do. In this section we go over the most likely scenarios and tell you how to handle them.

Taking care of baby after a fall

Even a newborn can scoot himself enough to fall off the changing table or bed, which is why you're not supposed to leave a baby unattended, without your hand on him, for even a second. Babies usually bounce pretty well and rarely break bones in a fall, but the parental guilt may be enough to put you in a rest home for a week.

Even worse is the "I was holding the baby on the couch and the next thing I knew there was a thump" fall. Most common in the first sleep-deprived weeks of parenthood, the "I dropped the baby" fall devastates guilty parents. Avoid the guilt by not lying down on the couch holding the baby — and don't sit up holding her if you're feeling really sleepy, either.

Parents rarely drop babies when they're walking, but a trip on the sidewalk or over a misplaced toy can send you and baby sprawling. Whenever the baby goes to ground, watch for these signs that a medical evaluation is in order:

- **Prolonged crying:** Every baby cries after a fall, if for no other reason than that landing on the ground is startling. Besides, you're crying, so baby thinks she should be, too. However, crying that lasts more than a few minutes may indicate an injury that should be checked out.
- **No crying:** Obviously, if your baby is completely unresponsive after a fall, call 911 immediately. Give him a minute, though; he may be too stunned to cry for a few seconds.
- **Repeated vomiting:** A baby who falls with a full stomach may spit up, but repeated vomiting can indicate a head injury.
- **Sleepiness:** This is one of the trickiest judgment calls of parenthood: What do you do when the baby falls right before bedtime? Keeping a tired baby awake is nearly impossible, and you shouldn't wake him up every few minutes just to make sure he's still responsive. Watch him for an hour and

keep him awake if possible, but don't stress if it's not. If it's naptime or the middle of the night, let him sleep, but assess his breathing and color for any changes every few hours and watch to make sure he's moving normally in his sleep. Breathing that becomes very heavy or deep may indicate a problem.

- **Inability to move a body part:** Babies bones are still made of mostly cartilage, which bends easily, so she's unlikely to break a bone in a fall. If a mobile baby refuses to crawl or use an extremity, have it checked out.
- **Gaping cuts:** If he falls on a metal object and comes up bleeding, see if the wound's edges are close together or gaping. Gaping wounds usually need stitches, glue (no, this is not a do-it-yourself project!), or butterfly bandages. Take your baby to a doctor or hospital.
- **Huge bruises:** Foreheads are famous for developing immense bruises after a bump. Bruises alone aren't concerning, unless they're accompanied by other signs, such as sleepiness, or if they keep growing. Bruises that bleed excessively can be a sign of other diseases, such as hemophilia, and need to be evaluated.

Staying safe in the car

Car accidents are a fact of life, and you can't always prevent other drivers from driving badly or from running into your rear end at a stop light. This is why a properly fitted, age-appropriate, approved car seat is absolutely essential.

A newborn should never, never, never be held in a moving vehicle. Not in the front seat, the back seat, or anywhere else. Numerous studies have proven you cannot hold on to an infant in an accident; the baby will fly out of your arms and straight out the front or side window into the street, or will be tossed around the car like a rag doll.

Yes, this warning is meant to create a vivid picture that will scare you into never riding with your child in your arms. Babies die this way every year because they were taken out of the car seat to be fed or soothed for a moment. A moment is all it takes.

Following is essential car-safety information for your baby:

- **Put newborns and small infants in a car seat designed for their weight.** Never put a newborn in a seat designed for an older child, or vice versa.

- **Never put infants and small children in the front seat, even if they're in an approved car seat.** The front seat is much more dangerous for your child if you're in an accident. Getting them in and out of the car is easier in the front seat, but put them in the back. Please.
- **Use rear-facing car seats for infants up to at least 12 months and 20 pounds at a minimum.** Riding facing backwards is safer in the event of a crash, and pediatricians now recommend keeping children rear facing to the weight limits of the seat they're in. Children do not mind riding backwards, even up to age 2 or longer, and you can place a mirror so you can see them.
- **Don't use a car seat beyond its expiration date.** Yes, car seats have expiration dates, usually on a sticker on the side of the seat. The plastic can degrade over time, making the seat unstable in a crash.
- **Don't reuse a car seat that has been in an accident**. The car seat may have been weakened or damaged in the accident and may not perform as expected if you have another accident. It's worth the extra money to get a new one
- **Don't borrow a car seat unless you know the expiration date and know it's never been in an accident.** Don't take chances on a car seat that may be damaged in any way, even if it looks fine.
- **Read the instructions so you install the seat correctly.** A huge percentage of car seats are found to be incorrectly installed when checked at car seat clinics.
- **Don't carry dangerous loose items in the car, like shovels.** They become missiles in an accident.
- **Always wear your own seatbelt!** It sets a good example and helps you maintain control of the car in an accident, not to mention keeps you from flying around the car, possibly landing on the baby.

If you are in an accident, check the baby carefully for bruises and cuts, especially if the car seat is dented or banged up at all. Remove the car seat from the car with the baby in it if you can so you can check for signs of injury without causing more injury to the neck or back.

Be assured that if your child is in a safe car seat, the chances of his getting injured in an accident are low. If you don't think you can afford a car seat, talk to your medical provider or health department; some organizations offer help with money for car seats.

Managing Medical Crises at Home

Staying calm while talking about what to do in an accident is much easier than staying calm if your child actually gets hurt. In the next section we give you hints on how to stay calm and effective if your child needs help.

Don't panic! Don't panic!

Panic is inevitable when your child is injured, but try not to show it, because even babies can sense your alarm and respond to it with a few alarms of their own. Try to remember the following guidelines when your child crashes into the coffee table or experiences some other medical crisis:

- At first glance, it always looks like more blood than it actually is. Because blood is red, you notice it immediately. The injury probably isn't as bad as it first looks.
- Head and face wounds can bleed copiously because of the large number of blood vessels there. Clean up the area, and you may find just a tiny cut or scrape.
- Spurting blood can indicate a cut artery. Hold firm pressure over the wound with something clean. This injury requires medical attention, because arteries, unlike veins, do not stop spurting on their own quickly enough to prevent significant blood loss. Call 911.
- Any injury to the eye should be seen by an ophthalmologist. If your child has something stuck in his eye, don't pull it out; you may make things worse. Call 911.
- If you suspect a neck injury, don't move your child. Call 911 for help.

Calling the doctor

In an emergency, thinking clearly is very difficult. Sometimes you may even have trouble remembering your doctor's name, much less his phone number. To save yourself from fumbling through the phone book when you want to call your doctor, post the following information on your refrigerator in bold print so it's visible not only to you, but to the baby sitter, relative, friends, or anyone else who may be watching the baby:

- **Your baby's doctor's name and phone number:** Even you probably won't remember this information in an emergency.
- **Your baby's full name and date of birth:** Yes, we're sure you'll remember your baby's name. But today, with hyphenated last names and moms who keep their maiden names, don't be so sure your sitter knows your baby's last name! And it's a pretty safe bet she doesn't know his date of birth, unless she's closely related to you.
- **Your address:** Believe it or not, people tend to go blank on this kind of information in an emergency. You may not forget where you live, but your mother-in-law may.
- **Your phone number:** Ditto the above. Everyone's on speed dial now; your mother may not even know your phone number!

Taking the precaution of writing down important information may seem a little silly until you're actually in an emergency and can't seem to remember your own name, much less the baby's birth date.

When you get the doctor or emergency personnel on the phone, speak clearly and slowly enough so she can understand you the first time and not waste time asking you to repeat yourself.

If you have the presence of mind to do so, jot down a few notes about exactly what happened, because, believe it or not, the actual details get very jumbled in a crisis, which is why eyewitness stories never jibe.

Open Wide, Baby! Administering Medicine

Getting a baby to take medicine isn't as easy as it seems. Even small babies seem to have an uncanny sense that you've spiked their evening bottle with medicine, and if your partner is breastfeeding, spiking the boob with baby Motrin just isn't going to work.

When drawing up a dose of medication, remember that a kitchen teaspoon is not always a teaspoon; it can range from half a teaspoon to two or more. One U.S. teaspoon equals 5 milliliters or cubic centimeters, usually abbreviated to cc. Milliliters, known as ml, and cc are the same thing. So if the dose for your child's age is half a teaspoon, it's 2.5 ml or cc. To measure these miniscule amounts, you need a specially marked syringe, which pharmacies often provide with medication. If yours doesn't, beg for one.

Since a wrestling match will end up with far more medication on your shirt and on the floor than in the baby, try the following tips when you really need your baby to take medicine:

- **Mix the medicine with a small amount of a sweet-tasting food like baby applesauce.** Unfortunately, even small amounts of medications often change the flavor of the food, so don't put a tiny bit of medicine into a large amount of food hoping to dilute the taste enough so that baby will eat it. Chances are, he won't eat all the food, and you won't know how much medicine he actually got. Mix the medication into just a few bits of food he likes, and you may have a fighting chance of getting it into the baby.
- **If you mix medication into formula, don't spike the whole bottle, because this will be the first time in your baby's entire life that he doesn't chug down an entire 6 ounces of formula.** Mix it into 1 ounce, so he finishes it before he realizes there's something rotten in Denmark.
- **Use a syringe to squirt the medicine into the baby's mouth.** Insert the syringe gently into the corner of her mouth; don't try to force her mouth wide open, unless you want to wear cherry-flavored Tylenol for the rest of the day. Push the syringe plunger down slowly but steadily, gently holding her lips closed, and hope for the best.
- **Some medications can be given in rectal suppositories.** This may not sound like a really great solution, but inserting a suppository into the rectum is easier sometimes than getting medicine into a recalcitrant mouth. Just don't put a suppository into the child's mouth.
- **If your child is not an infant, firmly tell him he has to take his medicine.** You may not believe this now, but kids often know when you really mean business, and they comply. It's a miracle when it happens.

Taking a Baby's Temperature

Taking a baby's temperature is much easier now than it was a few years ago. You no longer have to stick a rigid glass thermometer into a flailing child's behind and hold it there for three minutes — in fact, there are very good reasons not to! You can measure temperatures even in tiny babies much easier today.

Choosing a thermometer

When standing in the big-box baby store looking for items to add to your baby registry, the sheer number of thermometer types may stagger you. Talking to friends who have babies may not clarify the thermometer choices, because everyone seems to have a favorite method, and hardly anyone agrees with anyone else. Following is a list of different types of thermometers and their pros and cons:

- **Digital rectal thermometers:** These are the gold standard for temperature taking, especially for infants younger than 3 months. Rectal thermometers measure internal temperature, the most accurate way to determine a child's temperature, and they have a flexible tip that gives if your child squirms. They're accurate and easy to use on some babies, although others hate them.
- **Digital oral thermometers:** These aren't practical or accurate until your child is 3 or 4 years old, because they can't hold them properly under their tongue and may bite and break them.
- **Axillary thermometer:** You can use a digital rectal or oral thermometer under the arm as an axillary thermometer, but this method gives the least accurate reading and normally registers as much as 2 degrees lower than a rectal temperature.
- **Tympanic thermometers:** These thermometers, shown in Figure 13-1a, are used in the ear canal and aren't appropriate for use in children younger than age 3 months because their ear canals are too small to properly insert the cone-shaped tip. They also may not be accurate for temperatures higher than 102.
- **Forehead thermometers:** These register temperature as you roll the tip across the forehead, but they're not very precise.
- **Pacifier thermometers:** If your baby will suck a pacifier for three minutes, a pacifier with a built-in oral thermometer (see Figure 13-1b) may be the way to go.

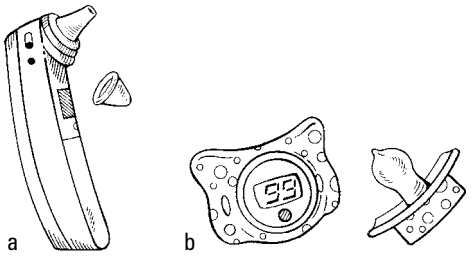


Figure 13-1: A tympanic ear thermometer (a) and pacifier thermometer (b).

Taking a rectal temperature

Taking a rectal temperature is much easier if the baby is lying face down. Inserting the thermometer while the baby is on his back is possible, but you'll have much more difficult keeping him from flailing around and possibly hurting himself. To take a rectal temperature, follow these steps and also check out Figure 13-2:

1. **Put a little Vaseline or other lubricant on the thermometer to make it less uncomfortable to insert.**
2. **Place the baby over your lap, with his head slightly down over your thigh.**

   This brings his rear end up slightly, making the anus, the opening to the rectum, easier to find.
3. **Locate the anal opening visually before you start prodding around with the thermometer tip.**
4. **Hold the thermometer the entire time that it's in the baby's bottom, to avoid injury.**

Taking baby's temperature with a rectal thermometer

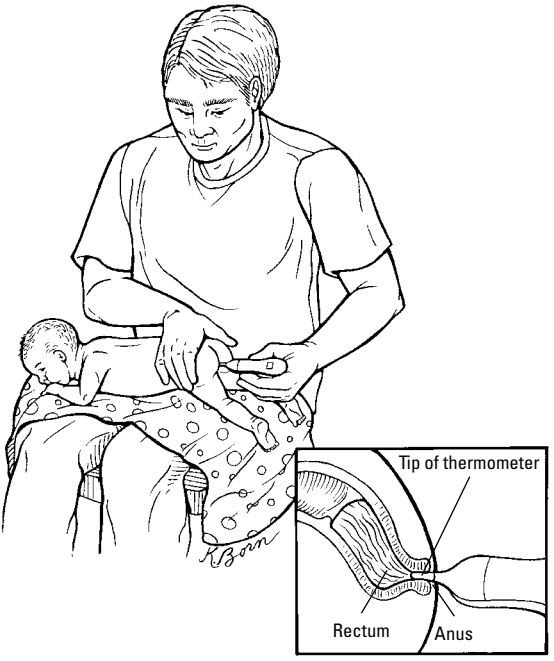


Figure 13-2: Taking a baby's rectal temperature.

If you still have an old mercury thermometer lying around the house, get rid of it. Don't just throw it in the trash. The Environmental Protection Agency recommends taking it to a hazardous waste dump, and throwing them in the trash is actually illegal in some states.

Recognizing fevers

So when is a fever a fever? It can be hard to know, especially when you're juggling half a dozen methods of temperature taking in an attempt to get an accurate reading. The following guidelines explain what your medical practitioner means when he talks about a fever:

- **In an infant up to age 3 months, a rectal temperature of 100.4 (or oral pacifier temperature of 99.5) or higher needs immediate evaluation.** Small babies don't normally run fevers, so even these seemingly low temperatures need attention.
- **Between ages 3 months and 3 years, a rectal fever of 102 or higher should be reported to your medical practitioner.** Although fever is important, the way your child is behaving is equally important. A child who is still eating, drinking, and playing happily with a high fever is less concerning than a lethargic child with a lower fever.
- **An axillary temperature of 99 or higher may be a fever.** Confirm the exact reading rectally, if at all possible.
- **Ear temperatures are roughly equivalent to rectal temperatures.** If you're sure the tip is properly inserted into the ear, call your doctor for a temperature of 100.4 for infants and 102 for ages 3 months to 3 years.

Febrile seizures

Febrile seizures, or convulsions, are extremely scary for parents, although the child probably won't remember it. Most febrile seizures occur when the temperature rises suddenly, but the exact degree of fever isn't the determining factor of whether a child has a febrile seizure. Around 3 to 5 percent of children experience febrile seizures, usually between the ages of 5 months and 5 years.

Don't try to do anything while your child is having a seizure, other than trying to cool her off by sponging her down with cool water. Don't put anything into her mouth or try to restrain her; more damage is done by these attempts to prevent damage.

Move any hard or sharp objects away from the child during a seizure to prevent injury. Remember to move the objects away from the child; don't try to move the child away from the objects.

Most febrile seizures last only a few minutes, but your child may be limp and lethargic afterward. Follow up with medical personnel immediately after a seizure; your doctor may want you to bring the baby in immediately or may be okay with a visit the next day to determine the cause of the fever. Be guided by his advice. Most parents who have just experienced an infant seizure want the reassurance of a visit.

If your child's seizure lasts 15 minutes or more, she starts to turn blue, or she remains unresponsive after a seizure, call 911 immediately.

Treating a fever

Fevers of 100.2 or less don't always need treatment. Fever is the body's way of fighting off infection, so giving your child medication at the first sign of a fever doesn't help her immune system to develop. Aspirin is no longer recommended for children, due to the possibility of developing Reye's syndrome. Infants can be given children's Tylenol or ibuprofen in recommended doses.

Deciphering Diaper Contents

Some parents are inordinately interested in their offspring's waste products (mostly parents who were raised to be inordinately obsessed with their own). But even parents who are pretty casual about the contents of a diaper can sometimes be concerned about what appears there.

Knowing what's normal

Breast-fed babies normally have frequent stools that are often looser than those of bottle-fed babies. Breast-fed babies' stools are often yellow and seedy, whereas bottle-fed babies' stools may be tan and firmer.

Babies frequently poop after every feeding in the first month or so, and then slow down production. Some babies may only "produce" every few days, which is fine as long as the stool is soft. At the same time, they may begin to squirm, cry, grunt, and make faces when pooping, worrying parents that they're having a hard time passing stools. What they're actually doing is becoming aware of their own bodily sensations.

However, if stool is hard, comes out in pellets, or if the baby doesn't go for several days, call the pediatrician for advice.

Checking out color changes

Stool is usually yellowish or tan in babies who are exclusively breast-fed and/or formula-fed. When unusual-colored poop makes an appearance, parents are understandably concerned. Changes in stool color can be perfectly normal or a sign of a problem, so keep the following information in mind when deciding whether to call the pediatrician:

- If your baby is on iron-fortified formula, she may have green or dark stools.
- Green stools can indicate an imbalance of foremilk, the first milk released, and hindmilk, which has a higher fat content. Too much foremilk and not enough hindmilk can produce green stools and upset the stomach. Allowing the baby to nurse long enough on one side — ten minutes or longer — to get a good dose of hindmilk corrects the problem.
- If blood is on the outside of the stool, the baby may have a small fissure and may need a stool softener, but ask the pediatrician. Make sure the baby doesn't have a diaper rash that's causing the blood.
- Bloody, mucousy stools need immediate attention, as they can indicate intestinal problems.
- Dark, tarry stools can indicate intestinal bleeding and should be evaluated.

Teething Symptoms and Remedies

Parents peer into their infant's mouths looking for teeth like gold miners sifting through the silt for nuggets of gold. When it comes to teeth, the best thing you can do is relax. All children, with very few exceptions, get teeth eventually, and prying your kid's mouth open to search for a pearly white doesn't make them come in any faster.

Keeping in mind that these guidelines have many exceptions, you generally can expect teeth to appear in this order and at these times:

- The first tooth appears between 4 and 7 months.
- The two lower middle teeth usually come in first.

- The two upper middle teeth follow next.
- The back teeth are the last to come, usually around age 2; you probably won't be all that excited by new teeth by then and may not even notice.
- By age 3, your child will have 20 teeth, 10 on each level.

After you get over the thrill of finding a new tooth, you may be consumed with ways to ease the discomfort of teething. Although alcohol, an old-fashioned remedy for easing the pain of teething, should not be applied to baby's gums, it may help to apply it to *yours.* You can decrease teething discomfort in your baby with:

- Pain medication such as Tylenol or ibuprofen
- Teething gels applied to the gums
- Chilled teething rings or other items for baby to bite down on

Teething tablets are popular over-the-counter mixtures of homeopathic medications but should always be cleared by your baby's doctor before using them. Teething does not normally cause a fever higher than 100 degrees, so a fever still needs investigation, even if your baby is breaking in a full set of choppers all at once. (Not likely, by the way — teeth tend to trickle in in groups of no more than two at a time.) Teething can cause:

- Drooling
- Irritability
- Swollen gums
- Difficulty sleeping
- Difficulty nursing or taking a bottle
- Biting on everything within reach

Whether or not teething causes diarrhea, vomiting, and rashes other than the rashes associated with constant drooling is debatable. Kids can get sick while teething, so don't assume that teething is responsible for sudden signs of illness.

Reacting to Medicines and Vaccines

Giving a child any type of foreign substance can trigger allergic or hypersensitivity reaction. New foods are actually the biggest culprit, but medications and vaccinations can also cause reactions.

Vaccination reactions — yours and your baby's

Many parents have concerns about the number of vaccinations given to infants and worry about which ones their child should have, when to give them, and possible consequences of vaccinations. Remember that vaccines are given to prevent *serious* illness; they're not given to prevent diseases that aren't potentially harmful for your child.

Giving two or three injections at one visit, especially when each one contains more than one vaccine, is concerning to many parents. But the American Academy of Pediatrics stands by the current vaccination schedule recommendations (which you can find in Chapter 10) and states that giving a number of injections at one time does not overwhelm the immune system, as some opponents suggest. They state that children are exposed to 2,000 to 6,000 antigens every day, as opposed to the 150 antigens introduced in vaccines during the entire vaccination schedule.

While there's no proof that vaccines are responsible for the increase in autism and similar issues, vaccines can cause complications in some children. Typical symptoms include fever, pain at the injection site, redness, or rash. Approximately 3 out of 10,000 children have febrile seizures (see the section "Recognizing fevers" for more on febrile seizures) after getting the measles-mumps-rubella (MMR) vaccine, the Merck Manual reports.

The debate about how to spread out vaccines and which ones are really necessary could fill books — and undoubtedly has — and every couple has their own feelings about vaccines. The most important thing in deciding on how, when, and what to vaccinate is to find a medical practitioner whose opinion you trust, discuss the pros and cons, and follow her recommendations.

Because many children do run fevers after vaccinations, premedicating your child with Tylenol or ibuprofen before the doctor visit can prevent a few hours of misery after the injection. Usually fever is a short-term reaction, so if your child is still feverish and miserable the next day, let the doctor know.

Some children develop a rash after vaccinations. Again, if it lasts more than a day, ask the doctor about it.

Medications that cause reactions

Any medication can cause allergic reactions, but some are more likely to cause a reaction than others. Antibiotics are more likely to

cause an adverse reaction than other medications. Typical offenders include:

- Penicillin or any of the same family, such as amoxicillin or ampicillin (Penicillin causes more allergic reactions than any other antibiotic.)
- Sulfa medications
- Cephalosporins

Drug allergies can cause a variety of skin reactions, including

- Rashes
- Hives, small welts that move around from one area to another
- Erythema multiforme, a moving bull's-eye-patterned rash with a fever, joint pains, itching, and a overall sick feeling, as well as painful eyes and sore mouth.

Notify your child's doctor if any reaction occurs after taking any medication. Children's diphenhydramine helps control itching and swelling in most cases, but follow your pediatrician's advice. Severe reactions may require steroids.

Dealing with Food Allergies

Food allergies affect around 1 in 18 babies before age 3. As with many facets of baby raising, the thinking on solid food introduction and allergies has completely changed since you were a baby, a fact that can result in heated discussions between you and your parents.

Introducing new foods

At one time, introducing solids early was all the rage in parenting, as if having your 2-month-old chow down pureed carrots merited some sort of parenting prize. Today, pediatricians recommend waiting until a baby is 4 to 6 months old to introduce new foods to reduce the chance of developing food allergies, especially the five most common food allergens, which are:

- Cow's milk
- Eggs
- Peanuts
- Soy
- Wheat

An almost unbelievable 90 percent of food allergies are caused by one of the big five, which is why the American Academy of Pediatricians recommends introducing new foods one at a time. Age at the time of introduction is no longer considered a factor in whether a child develops allergies after age six months.

Recognizing allergic reactions

Parents who have allergies themselves may be looking for signs of allergies in their children, and allergic tendencies do run in families. Some common reactions, like reddened cheeks after eating tomatoes or citrus fruits, aren't allergies, and lactose intolerance, caused by a missing enzyme that breaks down milk products, also isn't an allergy. Irritability, skin rashes, and intestinal upsets are the most common signs of food allergy in infants.

Colic, skin rashes, and stomach upsets such as loose stools are the most common signs of food allergy, but severe anaphylactic reactions with difficulty breathing, hives, and loss of consciousness can also occur, often within minutes of eating the offending food. Get medical help immediately if this occurs.

Having previously eaten a food without a reaction is no guarantee that an allergic reaction won't occur; reactions don't occur the first time a person is exposed to a substance. Always call your baby's doctor if a significant reaction occurs and follow his recommendations on treatment.

Preventing allergic reactions

The best prevention for allergy development is exclusive breast-feeding for at least the first 4 to 6 months of life. Some evidence exists for prevention of wheezing in infancy and early childhood by exclusive breast-feeding for the first 3 months of life. There's no proof that use of soy formulas prevents allergies compared to cow's-milk-based formulas; in fact, many children with cow's-milk allergies are also allergic to soy.

Cook fruits and vegetables for your infant rather than serving them raw, because cooking appears to decrease the risk of allergic reactions. Processed foods, including junior baby foods, contain a number of ingredients, which makes it hard to tell what an infant is reacting to if he develops an allergic reaction.

If your child has severe allergies, your pediatrician may recommend carrying an auto-injector containing epinephrine in case of serious allergic reaction. Fortunately, around 20 percent of children outgrow allergies to foods by the time they hit school age.

Chapter 14

Time and Money: The High Cost of Having a Baby

In This Chapter

- Balancing work and life with baby
- Going back to work, or deciding not to
- Preparing for unexpected baby expenses
- Spending your money wisely

Even before baby arrived you probably never felt like you had enough time in the day or money in the bank for everything you wanted to do. Money concerns aren't a new worry in the lives of most new parents, but with diapers, baby wipes, and the cutest clothing you've ever seen in your life added to your weekly expenses, even financially sound parents can quickly begin to feel strapped for cash.

The only thing in shorter supply than money may be your time. Sometimes just finding the time to shower in the morning may feel like a major accomplishment, but keeping your life and self in order is important for your entire family. Adjusting to a new life in which baby comes first is a challenge, and even the most organized parents will find that tasks that used to require minimal effort are now a major undertaking. In this chapter we take a look at how to juggle your new responsibilities with your old ones — with a little fun mixed in to boot.

Creating a New Work/Life Balance with Baby

Unfortunately, bliss doesn't pay the bills, which means that unless you're embarking on a new journey as a stay-at-home dad or you

win the lottery while on paternity leave, you will find yourself back in the throes of work in what feels like the blink of an eye. Don't be surprised if for the first few days you find yourself disinterested, distracted, or bored on the job, especially if your partner is still at home. In the beginning your mind will be more focused on the amazing event you've just experienced, and the fatigue your brain may be feeling as a result of less sleep won't help any.

When you're working full time again, winding down after a hard day won't be as easy as it once was now that you have to help with baby's bath time, night feedings, diaper changes, and endless chores. Congratulations — you now have another full-time job awaiting you when you get home.

Striking an ideal work/life balance is a major challenge for all parents, and it takes a lot of negotiating, planning, and sacrifice. From work to home to play, everything becomes a little more complicated to juggle. In the following sections we help you make the best of a very full plate.

Taking time off with paternity leave

Not so very long ago, new dads were expected back on the job the day after welcoming a baby into the world. And although we're still a long way from equal time off for both mother and father, strides have been made to allow new dads time to bond with their new family.

Looking at possible time-off options

When planning your time off, consider the following options that may or may not apply to your employment situation:

- **Parental leave:** A benefit offered by many companies, parental leave is time off that may be paid, unpaid, or a combination of both. Companies usually require that you be employed there at least 12 months in order to qualify. Parental leave usually applies to maternal, paternal, and adoption leave, and policies vary by company. Speak with your human resources manager to find out your company's policy — or lack thereof.
- **Family medical leave:** In the United States, the Family Medical Leave Act of 1993 requires companies that employ more than 50 people to allow up to 12 weeks of unpaid leave in a given year for certain medical reasons, including caring for a new child.
- **Vacation time:** Is there a better way to use your vacation time than to bond with your new baby? If you don't qualify for any of the above time-off options, or the parental leave offered by

your company is insufficient for your needs and wants, most companies allow you to use vacation days at the end of the leave in order to extend your time off. If your company allows you to use vacation days for emergencies and illnesses, be sure to save a few days in case you don't have enough sick time to get you through the rest of the year.

- **Sick time:** Some companies permit you to use sick time as part of your leave. Using sick time can be especially beneficial to hourly workers and unsalaried employees who don't accrue time-off benefits at a rapid pace or may not be eligible for all of a company's benefits, as well as for employees who haven't worked for their company long enough.

Just remember not to use it all — babies tend to come down with all sorts of bugs. And with all of the extra responsibilities and late nights involved in parenting, you may find yourself in dire need of a sick day for your own use. Instead of using all your sick time, inquire about the possibility of using unpaid time off so you can save those sick days for when you really need them. Your boss will probably be more willing to give you unpaid time off for baby's arrival than for your stuffy nose.

- **Flextime:** Perhaps your company really needs you back ASAP. Talk with your boss and HR representative about temporarily working flexible hours or even part time from home. You may be expected to meet daily and weekly goals and complete all of your work, but the non-nine-to-five schedule can be helpful for numerous reasons, especially if baby or mom has health concerns that require extra care or help.

Discussing your leave options

Before meeting with your employers to find out what arrangements for leave you can make, speak with other recent fathers in your company about their experiences to get a better idea of what to expect. Their information can provide you an opportunity to craft a plan that meets your needs and adheres to your company's policies. Some great questions to ask other fathers are:

- What was the company's paternity leave policy at the time you became a new dad?
- How did your boss react to your paternity leave inquiry?
- How much time off did they grant you? How much of it was paid?
- Did you use the Family Medical Leave Act, and if so, what was your boss' reaction?
- How did you structure your paternity leave?
- Did you ask about using flextime before or after baby's arrival? If so, what was their response?

- How much responsibility did you have to take for covering your job in your absence?
- What is the one thing you wish you would have done differently in arranging your time off?

When meeting with your boss and/or HR representative, make sure to take notes of everything that is said and get any policy-related statements in writing. In addition to asking about some of the issues in the questions above, be sure to ask about the company's policy regarding additional time off in case of complications with mom or baby. Also find out if the leave will cause delays in future raises and how you will pay your share of health insurance if you're taking unpaid leave.

Getting all your paperwork in order

Be sure to get the necessary time-off paperwork in order prior to heading to the hospital. Don't get defensive if your employer requires a doctor's note regarding your leave — nobody is questioning the fact that you're a new parent, but rules must be followed.

Keep a folder with all of the paperwork and forms you need to secure your time off. Following are some of the forms and papers to have on hand:

- **Family and Medical Leave Act application.** Your HR office can give you a copy.
- **State-sponsored family-leave applications.** You need these forms only if your state's regulations differ from federal.
- **Medical time-off verification forms.** Include any forms your family doctor or pediatrician needs to fill out for your HR department.
- **Your company's family-leave policy.**
- **Copies of all e-mail and letters sent to or received from your boss or HR department regarding your time off.**
- **Vacation time request.** This form needs to be approved and signed by your boss and/or HR representative.

Managing sick time when you're back at work

When both parents head back to work, sick time suddenly becomes a hot commodity. Between baby's multitude of doctor appointments, vaccination reactions, fevers, and diarrhea, as well

as your sitter's unexpected life moments, you will be required to leave work more frequently than you used to do pre-baby.

Check with your employer several weeks prior to the beginning of your leave to find out if flextime or work-at-home days are allowed in case of child illness or childcare gaps. If they aren't, stay honest. Don't start coughing and sneezing or fabricate some family emergency as a front to mask the real reason you have to leave.

Ask for a performance evaluation a month or so after returning from paternity leave. If you're be experiencing bouts of insecurity and anxiety about how you're perceived and performing on the job now that you're a dad, or feel intimated or scared about asking for days off because of the new baby, a performance review gives you an opportunity to address any minor issues that have arisen before they become full-fledged annoyances for your boss. Be sure to let your boss know that you're aware that your schedule is trickier than normal, and that you appreciate her/his flexibility as you adjust to a new schedule. Letting your boss know that you're open to criticism and want to fix any problems will make you look like the responsible new parent you have become.

Dealing with after-work expectations

Depending on the business you're in, you may be used to participating in after-work activities and commitments. However, after baby arrives, it quickly becomes clear that you no longer have the ability to attend happy hour three nights a week. Although nobody wants to be seen as the new dad who suddenly says no to everything and isn't the same fun, karaoke-loving guy he used to be, a certain amount of reality will dictate your ability to party instead of heading straight home to take care of business and spend time with your family.

Evaluate any after-work requests with the following guidelines to help you determine the appropriate way to handle them:

- **Mandatory engagements:** Sometimes meetings run late, business dinners take priority, and your boss asks you to work overtime on a very important project. Always say yes to anything that's important to the function and maintenance of your job, and work with your partner to find help for her at home if needed.
- **Occasionally important dates:** A beer isn't always just a beer. Sometimes going to a bar after work is an important networking opportunity or even where important business decisions and advancement opportunities are made. Try not to commit to quasi-important after-work requests more than a few times

each month unless you can arrange for (and afford) childcare during that time.

- **Optional events:** Sometimes a beer *is* just a beer — and there's nothing wrong with that, as long as you keep in mind that you can say yes only so many times without annoying your partner and it's best to save those for when it really counts. If you perceive an after-work event to be merely for sport, pass unless you need a mental-health night out. Just remember that every time you say yes, you're giving your partner the opportunity to say yes to an activity of her own down the road. It doesn't take too many commitments to severely diminish that all-important family time.

Be proactive in scheduling out-of-the-office social events over lunch. If you take the lead, you will have control over when they're held and won't feel the need to justify your inability to commit to activities after work.

If a co-worker challenges your decisions to not attend after-work events that you perceive to be nothing more than social calls, don't feel the need to defend your decision. Let him or her know that you spend eight hours a day with your co-workers and you like to spend the rest with your family.

Reprioritizing your commitments

With so much on your plate, you may wonder when you'll have time to hit the gym, go to the movies, take your partner on a date, volunteer at the local farmer's market, or engage in any of the myriad activities you enjoy doing. The bad news is that there isn't time in the day/week/month to do everything you've always done on top of caring for baby. The good news is that you'll still have time to have fun despite your overfull schedule.

Make sure to keep yourself high on the list of priorities, because you can't manage work, family, and your social life if you're run down, sick, or depressed. If you try to do it all, you won't do anything very well because you'll be spread too thin. To have more energy and stave off illness, take your vitamins, get as much sleep as possible, eat healthy foods, and continue to make exercise a priority.

Just as you wouldn't skip a doctor appointment or just not show up at work one day, you have to schedule your personal commitments as well. Whether that's a stroll through the park with your family, sex with your wife, or time to sit and watch a tennis match on TV, don't make your personal time optional, or the balance between work and life can easily become off kilter.

How do you make the work/life balance stay in balance? Keep a calendar and write down everything, even blocking out time you set aside for fun. Try as best as you can to separate your commitments by focusing on work at work, family during family time, and you during your scheduled personal time. You can't make the most of your time if you're mentally juggling too many tasks and people.

Figuring out what's most important to you

Because thinking about everything you need and want to do at the same time is impossible, make a list of all of your commitments and activities. You list may include the following activities:

- Spending time with your family
- Working overtime
- Exercising
- Socializing with friends
- Engaging in hobbies, such as fixing cars or reading
- Traveling
- Maintaining a healthy relationship with your partner
- Doing community service
- Participating in clubs, groups, and intramural sports

When you complete your list, ask yourself, "If I could only give my attention to one thing in life, what would that be?" After you pick the most important thing in your life, choose the next four so you've designated your top five priorities. As your child grows and your life changes, frequently revisit this priority list. What's important to you now may not be as important four months from now.

Figuring out what can go, at least for now

After you set your priorities, drop any unnecessary activities from your to-do list — at least the ones that require a major time commitment. Sure, a twice-weekly euchre league may be a fun getaway, but is it really vital to your well-being and that of your family? How much TV can you cut out of your week and still feel entertained? Any activity that eats up copious amounts of your time without much reward should be removed from your regular routine.

Work with your partner, as well as baby sitters and family members, to help you adhere to your priority list. Couples often tag-team to great effect: Mom watches baby while dad attends guitar lessons, and dad watches baby while mom goes to yoga. And when your friends and family members offer to baby-sit, try not to always use that time for errands. Instead, take your partner out for a night — or an afternoon, which is sometimes easier with babies — on the town.

Readjusting When and If Mom Goes Back to Work

Not every mother (or father, for that matter!) decides to go back to work. Others have to do so for financial reasons even when their hearts and tear ducts tell them otherwise. And some mothers and fathers are excited to get back to the daily routine and job they love. Everyone's experience is different, but regardless of what choice you and your partner make, the transition is challenging.

Making going back to work easier on mom

Mom gets far more time off work after baby is born than you will (usually 6 to 12 weeks), which only makes the going-back process more difficult and emotional for her. There may be tears, running mascara, threats of quitting her job — lots of them — and it's your job (on top of everything else!) to support her through this difficult transition.

Mom's innate protective instincts will be at an all-time high the moment she's forced to put her 3-month-old baby into full-time daycare for 40-plus hours every week. When you went back to work, you had the benefit of transitioning back when baby was at home with the only other person you trust as much as yourself to care for your child. Under most circumstances, mom doesn't get that luxury, and taking the leap back into business-as-usual won't be easy for her.

Try these techniques to ease your partner's return to the workplace:

- **Practice in advance:** Getting out the door won't ever be the same again, and the last thing you want is a panicked, rushed mom on her first day back. Much like you did with the trial run to the hospital before baby's birth, take the time go through a trial run for mom's first day back to work. It will benefit you, too, since you'll be involved in the process of getting baby fed and clothed and delivered to the sitter *and* still making it to work on time.
- **Provide mommy alone time:** It's not so unusual for new moms to cling to their newborns, and in some cases, going back to work is your partner's first separation experience after giving birth. Start slowly by giving your partner blocks of time to be alone on the weekends or evenings during which she can practice doing things without baby around.

- **Get comfortable with childcare:** Trusting someone else to care for your fragile baby isn't easy, but the sooner you start, the easier it will be when that care becomes more frequent. Start letting friends and family take short shifts watching the baby, and even ask your future childcare provider to take on a shift before your partner goes back to work. Also, feel free to ask your provider for time to observe his or her interaction with your child on-site.
- **Stagger the return:** Going from full-time mom to full-time employee overnight can be a major shock to the system. Have your partner talk to her employer about the possibility of a staggered return. If the first week back she only works one day, and then the following week she works three, and so on, the transition will be much smoother.
- **Plan ahead for morning:** Mornings are tough for everyone, so don't leave anything other than showering and getting dressed for the a.m. because you now have to factor in getting baby ready for the day and travel time to the sitter. Take time the night before to make lunches, pick out clothing, pack baby's diaper bag, and so on to create a calmer mood in the morning.

If your partner is threatening to quit her job the first day back, don't panic and certainly don't try to change her mind. The best thing to do is listen to her concerns and give her all the bonding time she needs with baby upon returning home from work. Tell her to take it day by day, and that at the end of every week you will reevaluate the situation. There's nothing wrong with her making the decision to stay home, but making the decision when her emotions are heightened isn't a good idea.

Following are some thoughtful ways to improve your partner's emotional state during the transition back to work:

- **Digitize baby:** Buy your partner a digital picture frame for her desk at work, or even a pocket-sized device if she works in a nonoffice environment. Add new pictures every day to give your partner a daily visual jolt of baby, which will help her feel more connected.
- **Free nights for bonding:** Though you won't want to shoulder the chore burden all by yourself forever, consider giving your wife a get-out-of-jail-free card during her first week back. Allow her to spend every waking moment with baby to give her the opportunity to reconnect with her child and not feel like she's missing out on everything.

- **Shower her with gifts and praise:** You don't have to go overboard, but some flowers on her first day back may go a long way toward making her smile, at least for a second, during that first week back. Be sure to tell her how well she's doing at adjusting to the changes and that you think she's a wonderful mother.
- **Don't try to fix it:** Let her cry and validate her experience, even if you don't understand why it's so hard. Mothers give birth to the babies, and as deep as the bond between fathers and kids can run, it's still different for mom. Call her throughout the day to check in and let her know that what she's experiencing is normal.

Deciding to be a stay-at-home parent

Making the decision to be a stay-at-home parent can be the fulfillment of a lifelong dream for some parents and a total surprise to others. If you and your partner make the decision that one of you will stay at home to care for the baby, thus begins another exciting, challenging chapter in your new parenthood experience. However, it isn't a decision that should be taken lightly. If you've been used to income from both yourself and your partner, losing half that income will make a profound difference in your lives, and you and your partner need to carefully consider whether or not you can make it work.

Considering whether your partner can stay home

Some women know in advance that they don't want to go back to work after having a baby, and some come to that decision after baby arrives. If you can make it work financially and your partner is refusing to budge, do your best to make arrangements for her to stay at home that work for both of you. She may have loved her job before and you thought the routine you'd established as a family was working fine, but while you don't always need to understand why your partner feels the way she does, it is vital that you respect her right to feel that way.

Take plenty of time to talk it over and make sure staying home is really a feasible option. When choosing to stay at home, many costs beyond salary must be considered. If your insurance coverage comes from your partner's employer and she decides to stay home, you will have to opt-in to your company's plan, which will reduce the size of your check. Also, most companies have an open season at the beginning of each year during which you can enroll for insurance. If the decision is made outside of the open-season

period, you will either be without insurance or forced to pay for private insurance until that time arrives.

Looking at options when you can't afford to lose the income

Sometimes the desire to stay home won't subside, and you and your partner may be at odds as to what is best for your family. If your financial situation doesn't allow for your household income to be reduced by tens of thousands of dollars annually, stand your ground. Be understanding to her concerns and desires, but don't put your livelihoods at risk in order to make her happy. Most importantly, don't rule it out forever. Make a savings plan that you both can work toward in order to achieve her goal of staying at home. Encourage your partner to seek out work-at-home opportunities. Work with your partner to create a tangible goal that will keep your finances in the green and eventually allow your partner to stay home.

Sometimes both parents want to quit their jobs to stay home and care for the child. Unless you and your partner are independently wealthy, this won't be an option. As unfortunate as it is, the decision will probably come down to money. If you can only afford for one person to stay home, the logical choice is for the person with the larger salary to continue working. It's possible, however, that the person who makes more money is working long hours and traveling frequently. Sometimes the decision is better made from a work/life balance standpoint rather than salary. In this case, lifestyle changes have to make up for the loss of salary, but it can be done.

Some companies are adapting to the push for flexibility by allowing new parents the opportunity to spend some or all of their work hours at home. This arrangement can ease your partner's pain if she really wants to stay at home with baby but you can't afford to lose her income. However, working at home doesn't eliminate the need for childcare; you still need someone in the home to help while your partner gets work done, unless your partner is willing to work nights and weekends while you take over childcare duties. Even then, having baby sitters at the ready is a must for busy times, meetings, and phone conferences.

If you and your partner can both work from home, you may be able to stagger your work hours so that you take turns caring for the baby. These kinds of alternate work arrangements can vary widely; your company may have guidelines in place for such arrangements, or you may have to renegotiate your own plan. Ask your boss or human resources manager about this option if you're interested.

Helping mom adjust if she doesn't go back to work

The adjustment to being a stay-at-home mom can be just as challenging as heading back to work, only in different ways. As wonderful as it is to have the opportunity to raise your own child during the day, it can be an isolating experience. Some women will find themselves a bit stir-crazy from all of the indoor time and begin to crave adult interaction.

Here are some ways to help your partner transition to staying at home:

- **Repeat after us: Raising a child is a job.** Sure, staying at home may seem at times like a dream gig — access to the TV all day, no more commuting — but resist the thought that she's got it made. As you know full well by now, taking care of a baby is exhausting. Babies require full-time attention and are the most demanding bosses on earth.
- **Remember that her office is your home.** If your partner suddenly has higher standards for the cleanliness and tidiness of your home, help her keep it that way. She's now in the house all day, every day, and as strange as it may sound, you need to treat your home as her office, too.
- **Encourage hobbies.** Mental boredom is inevitable, no matter how much you love your child. Stacking blocks, reading books, and taking long walks can be fun, but urge your partner to take up a hobby that's just for her that works her mind and gives her something to focus on other than baby.
- **Give her personal time.** When you get home from work, you'll both need some time to decompress from a long day. Make sure to give her as much time off from baby duty as she needs. Plan relaxing surprises for her, such as a massage, every once in a while to make sure her emotional needs are being met. Work together to create an evening schedule that allows both parents ample baby-free time. Alternate being responsible for bath time, reading, the bedtime routine, and so on, to give both of you free time to do relaxing things. Just because you're away from baby all day doesn't mean that you should be the sole caregiver once you get home.
- **Ask her about her day.** Just because she's not in meetings and dealing with bosses doesn't mean she won't need to talk about the challenges and events of the day. Be sure to ask how she's doing — it's easy to do, but easy to forget.

- **Don't think of her as your maid/errand girl.** Just because she's home all day doesn't mean picking up your dry cleaning, making dinner, grocery shopping, and vacuuming are all her responsibilities. She has more time to do things around the house, but don't give her a list of things to do for you. Being a stay-at-home mom doesn't mean you're her boss. Thank her profusely for everything she does do, which benefits the both of you every day.

Some days you hate your job, and the same rings true for the stay-at-home parent. Imagine how you'd feel if you never got a day off from your job. A stay-at-home parent works every day, nights and weekends, too, so if your partner reaches the boiling point, don't hesitate to offer her a day off. Either take a vacation day to stay home with your child or encourage her to find alternate childcare for the day.

You may be surprised how much stress will be removed from your life when your partner transitions to full-time childcare and can take care of some of the chores and tasks that eat up your precious weekend, but don't have unrealistic expectations. Taking care of a baby is a full-time job as it is. To help both of you adjust to her stay-at-home schedule, sit down together and work out what her new role will look like so that you expect the same things. Create a "job description" that will benefit the entire family and help avoid frustration down the road, and be open to modifying it if she discovers that, say, doing all the laundry and cooking in addition to her childcare duties is exhausting her.

Becoming a stay-at-home dad

By no means is the stay-at-home dad a norm in our society. As of 2008 there were roughly 140,000 stay-at-home dads in the United States, a number that has grown slowly every year in the past decade. If you decide to stay at home, remember that the rules outlined for the stay-at-home mom are no different than the rules for you.

Following are some special considerations for the stay-at-home dad:

- **Fight for your right to "daddy."** If you've never experienced sexism in your lifetime, get ready for an onslaught. As a stay-at-home dad, at every turn you will be confronted by people who are surprised at your choice, concerned that you don't know what you're doing, and judgmental of your decision to "throw away" your career. Strangers, especially women, will fawn over you and even say that it's so nice of you to "baby-sit" for mom. Be confident in your decision and let the world

know that you're excited about your new career and that men are capable of more than changing a diaper. Taking care of a baby is a lot of hard work, but it's not rocket science — you can do it!

- **Make friends with other parents.** Be it moms at the park or daddy playgroups, reach out to other stay-at-home parents in your neighborhood even before the baby comes. You will need friends to lean on for advice and last-minute baby-sitting, and the more you help out your new-parent friends and neighbors, the more options for help you'll have when you need it.
- **Utilize your unique skills.** Babies are mesmerized by everything, so use your stay-at-home time as an opportunity to play guitar, further your baking skills, or even start an out-of-the-home business. Having a daytime activity will provide you a much-needed creative outlet, and down the road, your kid will learn to appreciate (and mimic) your skills.
- **Turn off the TV.** It's tempting to keep ESPN on in the background all day, but too much TV isn't good for babies and children. Limit your TV time to two hours or less a day while baby is awake. Naptime is all yours.

Exploring the Expected (And Unexpected) Costs of Baby

One of the first things you'll hear from other parents is how expensive it is to have and raise a child in today's high-cost world. According to the U.S. Department of Agriculture, you can expect raising your child to the age of 18 to cost between $125,000 and $250,000, and possibly more.

Some costs of having a child are fixed and can't be avoided. Babies need food, clothes, diapers, wipes, and a safe, warm place to sleep. Babies don't need an entire closet jam-packed with enough designer-label clothing to make Suri Cruise weep with envy. You and your partner need to control the urge to shower your baby with every possible toy or accessory.

The following sections help guide you in spending your money wisely on only the things baby truly must have.

Deciding what baby really needs

Experts estimate that baby's first year of life, including daycare, diapers, clothing, and medical expenses just to name a few, will cost you about $11,000 — and far more if you live in a city where

childcare costs alone can exceed $11,000 annually. You'll find quickly that the choices you make with your cash have to count. Some costs arrive early: The average hospital delivery costs between $7,000 and $11,000, and even with a great insurance plan you will still be getting hit with a portion of the bill.

Contact your insurance company in advance of baby's birth to verify what is covered and up to what cost. This information gives you a rough idea of how much of the medical bills will be your responsibility and may even help you make some decisions based on what you want versus what is covered.

After you bring baby home, his needs are rather modest, but the costs will add up very quickly if you don't stick to the basics. Before you run out and buy the baby bouncy chair, swing, play mat, and so on, spend some time getting to know what your baby likes so you won't be stuck with a lot of unused toys that cost you a lot of dough.

Most towns have a vibrant baby resale shop or, if not, a hopping garage sale culture. One thing you'll learn quickly is that the life span of baby goods long outlasts the amount of time your child will actually use it, and there is nothing wrong with buying used items instead of new. Just make sure that what you buy is clean, in good condition, and meets current safety standards. Buying secondhand is a great way to get inexpensive clothing, toys, and strollers, especially since your baby will grow out of all of them before you know it.

Network with the other parents you know, especially those with older babies or toddlers born in the same season as your baby. Many parents will happily pass along or sell you the things they no longer use, which frees up space in their home and cuts down on the cost for you.

Whenever possible, before you buy anything, give your child the chance to try it out. Pull down the floor sample or take it out of the box to make sure your child is engaged with what you're about to buy. You may think all bouncy chairs are the same, but your baby inevitably will like one more than another. To make sure you get your money's worth, buy what your baby shows interest in.

Bracing yourself for the costs of must-have baby supplies

Babies don't need a lot of stuff, but what they do need tends to be a bit on the expensive side. If your partner isn't breastfeeding, you'll have to spend a great deal of money on formula, which is quite expensive. Parents opting to use only organic, chemical-free goods for their baby will find the costs increase as well.

Every choice you make will change the weekly amount you spend, but here is a basic look at what to expect:

- **Diapers and wipes:** If you develop an allegiance to a national brand of disposable diapers, you're going to spend $12 to $15 every week. Many big-box stores offer their own brands, which can cut the cost in half. Baby wipes present the same conundrum, with the name-brand options costing $10 to $15 for a month's supply.

  For both diapers and wipes, the cost-per-unit goes down when you buy a larger-sized box. You're going to be using wipes for the foreseeable future, but baby will outgrow diapers, so make sure not to buy a box that may go to waste. Also, buy only what you have room to store — it's worth a little extra to not have a house overfilled with diapers and wipes.

  Upfront costs are higher for cloth diapers than disposable, but you will save money in the long run. Expect to pay about $200 for the diapers, sized for up to age 6 months, and another $200 for diapers sized up to age 2. Cloth diapers increase your energy and water use as well as the amount of baby-safe laundry detergent you must buy. Total cost for babies' first two years in cloth diapers will be about $500. Bonus: you can use the same cloth diapers for any subsequent children you have, which makes the cost extremely low. Cloth diaper services are also available, which provide fresh, clean diapers in exchange for your dirty ones. It cuts out the hassle of cleaning but does increase the cost.

- **Feeding supplies:** Whether your partner breast-feeds or uses formula, you'll have costs to meet.
  - **Breast-feeding supplies:** Breast milk may be free, but you still need supplies, especially if mom is going back to work. Aside from a decent breast pump (a one-time cost of $150 to $400), you need freezer storage bags ($8 to $12 for a two-week supply), as well as nursing pads for a while ($8 to $12 for a two- or three-week supply).
  - **Formula:** Expect to spend between $150 and $200 per month on formula, depending on the brand and formula you choose to purchase. Specialty formulas, including those for sensitive systems and organic brands, cost even more. Also, if you use bottles with liners, expect to spend another $15 to $20 per month.
- **Insurance and medical expenses:** Adding baby to your insurance plan increases the monthly amount withdrawn from your paycheck. The change in policy must be completed within 30 days of baby's birth and generally increases the amount by

$50 to $100 per month, depending on the quality and cost of your insurance plan. Account for one doctor visit per month in the first six months to be on the safe side, with the only cost being the amount of your copay.

- **Clothing and laundry:** Baby-safe laundry detergent costs more than the stuff you buy for your own clothes, and you will have to use it for the first 18 to 24 months of baby's life. Expect to pay between $8 and $15 for a month's supply. And, seeing as babies grow at a rapid pace, you need to allot anywhere from $50 to $100 per month on clothing, which includes hats, shoes, sleepers, coats, socks, onesies, and outfits so cute they could make a puppy bark with jealousy.

Some parents opt to use dye-free detergents, such as Tide Free or All Free and Clear, which are intended for adult use. Using these detergents for the whole family will simplify the laundry process and save you money. Make sure to read the label of any product to make sure it is nontoxic. Also, for babies with sensitive skin, use 1/2 cup of vinegar in the wash cycle in lieu of fabric softener.

You can save money on clothing by checking out consignment shops and garage sales and asking for hand-me-downs from friends with older children. All babies outgrow clothes before they're worn out, so you can find a lot of perfectly nice used items at a fraction of the cost of new.

College may seem a long way away, but it's never too early to start saving for your kid's education. However, if you don't have a retirement fund or an emergency fund for your own future survival, start there. You have to take care of your future first, and that responsibility sets a good example for your child. And if you can't pay for that college education someday, well, that's what student loans are for!

Comparing childcare options and costs

Paying someone else to care for your child 40 to 50 hours each week will become your new number-one expense. In fact, depending on where you live, it very well may cost you more than your mortgage or rent. Taking care of a baby is big business, but it's also a huge responsibility, so it comes with an equally huge financial burden.

Like when shopping for cars, you have many options when choosing childcare. Depending on whether you're looking to buy a luxury

car (an in-home nanny) or a two-door compact (your neighbor's in-home daycare) or something in between, the costs will vary depending on the services you are promised.

Regardless of which option you choose, create a contract (unless the provider has one of his own) to make sure you're getting what you expect and that you won't have unexpected costs when you pay the bill. Go over the following questions with your daycare provider and get the answers in writing:

- Are you licensed to provide childcare in this state?
- What training have you received in childcare and education? What about your staff?
- Are you insured in case of accident?
- Who is providing the food?
- How often and on what day are you expected to pay?
- Do you need my permission to take my child in a car?
- How much notice do you need to give in order to terminate the agreement?
- Do you frequently have visitors? Are they allowed to interact with the children?
- Will my child always be under your care, or will your spouse/child/friend/family member be helping?
- Do I have to pay when my child is sick or we are on vacation?
- How do you discipline children?
- What do you charge for days I need to drop my child off early/pick him up late?
- What security provisions are in place?
- Are you certified in both infant and child CPR?

Outlining your expectations in writing will reduce your fears and help prevent any unexpected surprises or litigation down the road.

If after you check out the costs of daycare you're reconsidering quitting your job (or having your partner quit her job) and staying at home, be sure to carefully weigh the points outlined earlier in "Deciding to be a stay-at-home parent." Staying at home is expensive in its own way and isn't a decision to be made lightly.

Private in-home daycare

A friend, neighbor, or local daycare provider who operates a facility out of the home likely will be your cheapest option, depending on the sophistication level of the facility. Expect to pay between

$150 and $300 per week depending on your location. Many providers who work in their own homes are also watching their own children, which can reduce the cost to you.

Be sure to visit this type of daycare on a regular weekday during business hours to see how things function during "high-volume times." Some states require certifications for any daycare providing care for a certain number of children, and you should research the regulations in your state and make sure the provider is compliant.

Daycare center

A daycare center, also sometimes called corporate daycare, is any facility that accommodates many children and employs multiple staff members to care for a wide age-range of children. Depending on the facility and the qualifications of the people it employs, this service can cost between $200 and $500 per week. For instance, if the daycare has child-development specialists on-staff and a play facility that pulls all the punches, costs will be higher than at a basic facility.

Make sure the child-to-adult ratio at the facility meets accepted guidelines. The U.S. Department of Health and Human Services recommends a 3:1 ratio for babies age 0 to 24 months; 4:1 for 25 to 30 months; 5:1 for 31 to 35 months; 7:1 for 3-year-olds; and 8:1 for 4- to 5-year-olds.

Your own in-home nanny

Paying someone to come into your home to provide full-time childcare for your child and your child alone is a custom and very expensive option. For many parents, the peace of mind involved in this setup is worth every penny, especially when you factor in the time, gas, and stress saved by not having to take your child to the sitter every day. Costs typically range from $400 to $800 per week, depending on your location, expectations of the care provider, the provider's experience level, and the number of hours the provider is expected to be in your home.

Managing Your Money

Regardless of your financial situation, the impact of a baby will be felt early and often. Aside from the frightening amount of supplies, toys, doctor visits, and clothing, the enormous cost of childcare will leave you with a lot less cash — and financial freedom — than you had in the past. Depending on where you live and the option you choose, you may be paying your childcare provider the same amount you'd pay for a car payment — every week!

So perhaps your days of three-dollar lattes are behind you. Maybe you'll be buying one less album online each month. Regardless of your vices and other financial obligations, you'll need to get your spending habits in tip-top shape to absorb the high cost of having children.

Prioritizing your needs

The difference between what you want and what you need is a gulf roughly the size of the Grand Canyon. The same can be said for what you want for your baby and what your baby actually needs in order to thrive. As a parent you have to get the needs of your entire family in check to secure a financially sound future for all.

Every family's situation and needs are different, but one rule is universal: Make a budget. Start by taking a realistic look at where your money goes. Call your credit card company and ask for an analysis of how you spent your money in the past year (some companies send you this statement automatically each year), and look at your bank statements from the same time period, If you struggle to make cuts, consider meeting with a financial planner. Figuring out how to spend, save, and survive is a big job, and you don't have to go it alone.

Factor in the monthly costs of housing, food, transportation, investments, insurance, and any medicines you take regularly. You also have to plan for the unexpected, and with a baby in the equation you'll have a lot of unexpected. Starting an emergency fund is easier said than done, but it's a must. When you have a kid, absorbing an unexpected job loss, income reduction, or family emergency can be debilitating. Try to slowly work your way up to having six months' expenses set aside just in case life throws you a curveball.

As unpleasant as thinking about tragedy is, now is the time to make sure you have sufficient life insurance coverage for you, your partner, and your baby. Work with a reputable insurance agent to make sure that your family will be provided for if the worst were to happen. Also, make sure that you have short- and long-term disability coverage through your employer. If not, consider buying your own policy. Missing even one paycheck can spell disaster for some families, so try to be overprepared for emergencies. See Chapter 15 for more on insurance and disability coverage.

Determining where to cut costs

Giving up things you love isn't easy, but it's a must now that you have someone to provide for. Consider cutting costs in the following areas:

- **Food:** Prepackaged and/or snack foods tend to be expensive. Items such as chips, ice cream, candy, beer, frozen dinners, and soda are not only bad for your body, but also bad for your budget. You may not be willing to give them up all together, but try to cut down on the number of purchases of these high-cost, low-nutrition foods. Also, consider making a big casserole or stew to eat for numerous meals, which will reduce both your time in the kitchen and your grocery bill.
- **Utilities/bills:** Take a long, hard look at your monthly expenses. Do you need both a cellphone and a home phone? Can you downgrade any of your plans to a lower-cost option that still suits your needs? If you live in a cold-weather climate, can you go on a monthly payment plan to evenly spread out the costs of heating your home throughout the year? Are you in good standing with your credit card company? If so, ask to reduce your interest rate. Call every insurance company you do business with and see if you can get a lower rate. Don't be afraid to ask all of the companies that you do regular business with for a financial break.
- **Entertainment:** Take a look at the last six months of expenses and try to cut or reduce the monthly cost of these nonessential items, which are the biggest expendable category for cost savings. Cable is not a utility, and if you're struggling to make ends meet, consider cutting your package down to basic or even getting rid of cable altogether, even just for a little while. If you have both cable and a mail-based movie subscription, do you truly need both? Baby will automatically limit the days you can go out to dinner, catch a movie, or get tickets to a football game, but monitor and limit these expenses, too, especially if you have to pay for a baby sitter when you go out.
- **Convenience purchases:** Sure, buying lunch is simpler than getting up early to make it in the morning. Same goes for coffee. If you find yourself a constant consumer of takeout food, taxis, dry cleaning, bottled water, and other nonessential costs that simply make your life easier, cut back. Even one less purchase per month can make a major impact on your bank account.

Turn to Chapter 15 to find out more about budgeting and cutting costs.

Chapter 15

Planning for Your New Family's Future

In This Chapter

- Organizing your finances and putting safety nets in place
- Saving for your child's education
- Buying life insurance for worst-case scenarios
- Choosing the right health insurance
- Creating a will and designating a guardian for your child

During this time of immense joy, you probably resist worrying about the ifs, ands, or buts that could bring all of that happiness to a screeching halt. You may also think it seems a bit premature to begin squirreling away cash for her education when your baby hasn't even mastered the art of sitting up. But, as the time-honored, cliché goes, they grow up so fast.

Planning for the future, whether for planned events or unexpected ones, is the least enjoyable part of being a parent because it reminds you just how fleeting life can be. And nobody wants to think about what would happen if they died, especially with a newborn just beginning to enhance life. However, now is the time to make sure your child will be taken care of, regardless of the circumstances.

Securing a Financially Sound Future

New parents are saddled with an enormous uptick in caretaking responsibilities. In fact, your role as caretaker now involves getting your financial life in order so that you can properly care for your child today, tomorrow, and even after you and your spouse die.

It's not the cheeriest item on the new-parent to-do list, but it's one of the top priorities.

In this section we share some financial tips that will help to ensure a bright (and green!) future for your entire family.

Prioritize your expenses

Singling out purchases that you can — and should — live without can be a real buzzkill. Giving up the little things in life can be a difficult adjustment, especially for new parents who are already sacrificing sleep and freedom. For most new first-time parents, the financial strain of having a child means looking at where you can cut down on your own expenses. If you fall into this category, this section helps you make some tough choices.

Your fixed costs are food, housing, electricity, heat, and transportation. The rest is a mix of choices made by you and your spouse about how to live your lives. There are no hard-and-fast rules about what to axe from your life, but depending on your particular needs and your income, the following areas are good places to cut back:

- **Entertainment:** This category includes movie tickets, concerts, cable, magazine subscriptions, music, books, DVDs, hobbies, sporting events, and so on. With baby occupying most of your free time, time constraints will help you cut way back on sporting events, movies, and concerts. And instead of spending money on some of the other items, get a free membership to your local library; most have extensive DVD and CD collections as well as books and magazines. Borrow movies from your friends, too, or host a movie night and share in the rental and food expenses.
- **Food:** Whether you eat out often, always dine in, or regularly grab coffee, you can make a change in your food spending. Look at your past expenses and find places to save. Even choosing to eat out one less time each month or spending $10 less per week at the grocery store will save you big over the long haul.

  To replace the fun of eating out, host a dinner party or start a rotating dinner club with a group of friends. Assign each attendant a different course so you can drink and dine in style at a fraction of the cost.
- **Luxury:** New clothing, spa visits, hair care, skin-care products, and new jewelry are a few items that can be downgraded, reduced, or perhaps axed altogether.

- **Interest rates:** If you have high interest rates, you're essentially spending money on nothing — clearly a spending habit you won't mind changing! Refinancing your home can save you a bundle in the long run, and if you have good credit, try to negotiate down your interest rate with your credit card company. It's not always easy or possible, but it's always worth a call to find out if — and how — you can save.

Create a budget (and stick to it)

After you put your expenses under the microscope and find places to cut back, make a plan and stick to it. Knowing what you plan to spend each month allows you to explore savings options, such as setting up a college account for your baby. Saving money can be a fun game. The more you save, the more thrilling it becomes to push yourself further and watch your personal worth rise.

If you find yourselves struggling to spend only what you have designated for each item in your monthly budget, use cash. If you take $100 to the grocery store, you have exactly that much to spend. Calculating what you can buy takes more time, but before long you'll be able to eyeball what you can and can't afford.

To make a budget, start by breaking down your finances into the following categories, placing a monthly spending allotment next to each:

- Mortgage/rent
- Home/rental insurance
- Electricity
- Gas
- Cable
- Water, sewage, trash
- Phone
- Internet
- Home maintenance
- Car payment, insurance, and gas
- Childcare
- Groceries
- Entertainment

Parenting on the cheap

People tell you that babies are expensive, and, for the most part, they're right. All of the things that babies need to survive add up quickly, especially over time, which is why buying only what you need is of the utmost importance.

Baby stuff is cuter and more expensive than ever before, and more and more parents are buying high-end goods. If you don't have the money for the $1,000 stroller that all of the other parents in your neighborhood seem to have, don't buy it. Your baby doesn't need — and won't remember having — an expensive crib, stroller, or bassinet, and he certainly doesn't need nicer clothes than you wear.

Create a monthly budget for your baby expenses. Buy the essentials first and use any leftover money to buy secondary items, such as new toys. Babies don't need a lot to play with; in fact, your tot will probably like the packaging the toy came in better than the toy itself.

Resale shops aren't just for hipsters and low-income families. Buying lightly used goods will save you a fortune, and, considering that babies grow in and out of clothes, toys, and furniture very quickly, you're likely to find exactly what you want at a fraction of the cost. You can also utilize online sites such as Craigslist, eBay, and Freecycle to get what you need for cheap or even free!

Many excellent software programs, books, and Web sites can help you make and maintain a monthly budget. QuickBooks is one of the most popular computer programs for managing your personal finances and even paying your taxes, and `www.mint.com` offers a popular (and free!) online service. For the Dummy-phile, check out *Personal Finance For Dummies,* 6th Edition, or *Managing Your Money All-in-One For Dummies* (both published by Wiley) for everything you need to know to get your finances in order.

Pay down your debt

Not all debt is equally bad. Some debt, such as student loans and real estate mortgages, tends to have low interest rates and build future value. Bad debt is anything with a high interest rate; mainly credit cards, and especially credit cards used to purchase unnecessary or disposable goods and subsequently not paid off every month.

Pay off your high-interest debt first, which is most likely your credit card bills, and do so as aggressively as your finances allow. Don't use your cards until all of your debt is paid down and after that, only use your card for emergencies and essential expenses, such as groceries. Using it for limited, essential items (that you've budgeted

for) will ensure that you can pay off the balance every month. Pay for nonessential items with cash, or you'll end up paying even more for them if you don't pay off your balance each month.

After your credit cards are paid off, start paying off your debt with the next highest interest rate, likely a car loan. Also, paying one additional mortgage payment every year can take years off of the length of your loan. Remember, this isn't about getting rid of debt altogether. Everyone has debt, and it helps build your credit score. The goal is to get rid of unnecessary and high-interest debt.

Create an emergency fund

An emergency fund can be a lifesaver for a number of reasons. Job loss happens when you least expect it. Family members get sick and require your time and attention. Houses and cars break down all too often. Whatever life throws at you, it's going to cost you some dough. The rule of thumb changes all the time, but most experts advise saving enough money to cover anywhere from 6 to 12 months of expenses.

If you managed to read that and not faint, take heart — most people don't have that much money tucked away, and a lot of folks never will. However, you have to start somewhere, and the less you spend, the more you can save. And now that you have a baby to care for, being able to handle the unexpected expenses is more important than ever.

Make a plan that works for you and your family. If it's easier to start a savings account and slowly move over money each month after bills are paid, go for it. For some, having a set amount or percentage of salary automatically moved into an account each month is easiest. To begin saving, try putting 5 percent of your paycheck into a separate savings account. If after a few months you find you still have extra money in your primary checking account, start saving more.

Buy disability insurance

Most companies provide employees the option to buy short- and long-term disability coverage, which generally pay 60 percent of your salary in the event that you are injured and unable to work. If you haven't signed up for that coverage, do so immediately. You are far more likely to get injured than die, and the loss of a salary can sink your family into financial ruin in no time. Short- and long-term disability can provide a source of income for around two to five years if you're unable to work.

If you're self-employed or your company doesn't offer coverage, contact a local life-insurance representative or financial advisor to help determine the right amount of coverage for you. It's essential to have a policy that can cover your family's expenses if you're out of commission.

Contribute to a retirement account

Taking care of yourself first means ensuring that your kids won't have to in the future. It is vital that new parents begin saving for their own retirement. As your kids grow, so will your financial needs, which means you need to start saving when you're young in order to have enough to live the way you want to when you retire.

If your work has a 401(k) or a similar program, make sure you contribute the maximum amount allowed each year, especially if your company matches that amount. Consider opening a Roth IRA account, which allows you to contribute a certain amount of your earnings to the account each year while making tax-free withdrawals when necessary.

For all of the information you need to establish your retirement security, check out *Retirement For Dummies* (Wiley).

Work with a financial advisor

If numbers make your head spin or if you're not sure you that you have the right kind or enough of the savings, insurance, and retirement accounts you need for your lifestyle, you may benefit from working with a financial advisor. Consultations are free, and the advisors work on commission from sales (of life insurance, investments, and so on), so it won't cost you anything except your time.

If your advisor is unnecessarily pressuring you into buying her company's wares, beware. Her main role is to help you prosper financially, and if you are not interested in or in the position to buy something she's pushing, seek counsel from someone else. Yes, she has a job to do, but don't get suckered into something you don't want. Always take a day or two to think about a financial advisor's advice before committing to anything and, when possible, seek a second opinion.

Mind your credit score

If the only scores you keep track of involve the doings of professional athletes, you're probably long overdue for a check of your

credit scores. Your credit scores change all the time, so periodically check to make sure you're on track and your credit history has no mistakes. Your credit score affects the interest rates of every line of credit you have, and a mistake may be costing you on your mortgage, car payment, credit cards, and student loans.

Credit scores range from 350 to 850. A very low credit score is any number below 600. An average credit score is between about 650 and 700. An excellent credit score is anything above 700. Your credit score is reported by three different agencies that provide three different scores. Checking all three is important so that you can clear up any mistakes. You can request your free credit report once a year from each of the following:

- Equifax: `www.equifax.com`
- Experian: `www.experian.com`
- TransUnion: `www.transunion.com`

Saving Money for Your Child's Education

Every parent wants his child to get the best college education money can buy. Not all parents, however, can afford that education, nor do they want their children to accrue mass amounts of student loan debt.

If you have the luxury of being able to save some money for your child's education, you have a number of options. Following are a few common savings options (check out *529 & Other College Savings Plans For Dummies* [Wiley] for more specifics):

- Parents can invest money in a Coverdell Education Savings Account (CESA), which allows you to save $2,000 a year tax-free. However, CESA funds are considered student assets and can reduce the amount of student loans available to your child.
- Every state offers at least one 529 plan, a state-sponsored college savings plan that allows you to choose the aggressiveness and amount of money you want to invest. It grows tax-free and it only requires you to fill out an easy form, usually available on your state's Web site. After you file the paperwork, you begin depositing money according to the plan you chose. The investments are even managed by a professional. Plus, you can begin saving before your child is born.

- You can save in a personal investment account — that is, a savings, stock, bond, or mutual fund account. These accounts give you more control to add or remove money, and you earn capital gains, interest, or dividends. You pay taxes on the income each year you earn it, but these accounts give you more freedom to use the savings when and how you see fit. Depending on what level of access you want your child to have to the money, set it up to as a trust that can be accessed with conditions, or simply pay the tuition bills yourself.

If you don't want a college fund to go to a child if he decides not to attend college, or you don't want him to coast through high school knowing he doesn't need scholarships, set up a personal investment account in your own name. If your child doesn't go to college, you'll be able to dispense the money at your discretion or keep it for yourselves. If he does go to college, you can reward your child for his hard work when the time arrives.

For parents looking to save for college, make sure first that you have an emergency fund in place and your own future is secure with retirement savings. Don't prioritize your kids' education above these other crucial savings. After all, you don't want your money tied up in a college savings account if your house burns down, and although there's no such thing as a retirement loan, kids for generations have been taking out student loans to pay for college.

Getting the Lowdown on Life Insurance

Purchasing life insurance policies in the event that you or your child dies couldn't be more outside the spirit of happiness that comes along with welcoming of a newborn. However, tragedy can strike in many ways and at any time, and although it's not pleasant to think about, life insurance is a must.

Making sure you and your partner have adequate life insurance

Ensuring your child is well cared for in the event of an emergency means confronting your own mortality as well. Buying life insurance for both you and your partner provides a security policy that will allow your family to continue living the life you're all accustomed

to without financial ruin in the event one or both of you were to die. Now that you're a parent, it's your responsibility to make sure that bills can be paid and food can be put on the table — even in the event of your death.

Policy needs vary based on your financial circumstances, but the amount you buy should be enough to cover not just funeral costs, but a few years of your current income and expenses, as well as funds to pay off any bad debt you currently have. This safety net will keep your family financially sound while they deal with their grief.

Considering a policy for your baby

Buying life insurance for your baby is a controversial and unsavory topic. Many financial experts say it's a waste of money because a life insurance policy is necessary only when the death of the individual will cause financial stress on a family. For many lower- and middle-income families, however, a policy that would cover the cost of the funeral is well worth the monthly payment.

Whole-life coverage versus term

Not all life insurance policies are the same. Some policies are "rentals," covering a child through a certain age and then offering no more benefit. If you elect to go the "buying" route for a policy, it will start your child on the right track to financial security for retirement. You can choose between two basic types of policies that determine the price, coverage level, and longevity of the policy:

- **Whole-life coverage:** As the name implies, a whole-life policy stays with your child for his or her entire life. This permanent insurance has a fixed premium that never increases as your child ages and offers the policy owner a guaranteed cash value against which the owner can borrow money in case of emergency.

  The coverage is generally between $25,000 to $150,000. Buying whole-life coverage for your baby usually doesn't require a medical checkup. One of the more popular plans is available through Gerber, but most life insurance providers offer competitive plans, too. It is important to speak with a professional before purchasing. You will not be able to cash out the whole-life policy at any time for full value, and depending on your financial situation, saving money in an interest-yielding account may be a better idea. That way, you can always access the money you have invested.

- **Term coverage:** Term insurance is sometimes referred to as a "rental policy" because the named person on the policy will never own it like one does with whole-life coverage. Think of it as magazine subscription with huge financial benefits: As long as you have a subscription, you're covered. But when the subscription runs out — the policy expires — you stop getting coverage.

  The money you invest is simply going toward "what if" protection. The cost is generally a fraction of the price of whole-life coverage, which is why it's such an attractive option for some parents. Plans generally come in 10- to 30-year terms, with coverage ranging from $25,000 to $150,000. However, premiums are not fixed and do increase as your baby ages.

How much coverage is enough?

Determining how much coverage you should buy depends on your budget. Buy only what you can afford. The more payout benefit you purchase, the more you pay each month. If you're purchasing term insurance, you don't need to buy a policy that will exceed the costs of a funeral and, perhaps, any wage losses due to unpaid leave during your grieving period.

Buy only what you can afford to pay every month. Talk with a financial planner to determine if a whole-life policy is actually the best investment for your child or if another form of savings would yield bigger rewards for him down the road — and still provide you a safety net in case of death.

Health Insurance Options for Newborns

Navigating the health insurance mélange has always been a bit of a headache. HMO, PPO, what does it all mean? For the most part, your insurance won't be any different after you have a baby. The only thing that definitely changes is the cost. For those parents without insurance — or those who can't afford it — the process is a bit more complex.

Adding baby to an existing work-paid plan

Don't worry if baby doesn't arrive during your company's insurance open season. Whenever a major life event occurs, such as the birth of a baby, you're allowed to change your insurance coverage.

Check with your HR department to get the proper paperwork for adding baby.

You won't actually add baby until after he is born. Your insurance company will need his name, sex, and birth date in order to issue a policy. However, baby's medical expenses will be covered according to your current plan's postnatal coverage. Policies are retroactive back to birth, but won't continue to cover baby's expenses forever. Most plans require you to add baby within the first month of life or your child will not be covered under your plan.

The most important thing to consider when adding a baby to your insurance is the cost of plans. If you purchased your company's top-notch insurance plan, the cost may skyrocket out of your price range with the addition of a child. Don't just add baby to your existing plan without first looking at the price of all of the family plans your company offers. A different plan may save you hundreds of dollars every month.

Look for the plan that offers the highest level of coverage that you can afford. Also be sure to choose a plan with a reasonable copayment, because your child will be going to the doctor frequently.

Be sure to call your insurance company to add your child to your plan as soon as possible. Some companies give you as little as 30 days to make the change following the birth of a baby, and because you'll be going to the doctor multiple times in those early weeks, you want to get the changes made ASAP so you won't be on the hook for some huge expenses. When you add a child to a plan, the insurance company usually has a time limit for submitting proof of birth, such as a copy of the birth certificate, to make it official. Check with your insurance company for the deadlines and paperwork specific to your plan.

Buying coverage just for baby

Statistics show that more than 46 million Americans live without health insurance. That number includes 9 million children. If you are living without health insurance and are about to have a baby, you're facing the high costs of labor and delivery, but the money hemorrhage won't stop after baby arrives. Your child must have wellness checks and vaccination appointments frequently, which means you'll be shelling out a large portion of your hard-earned cash to your child's pediatrician.

Consider buying a health insurance policy for your child. Even if you can't afford to buy them for you and your partner and have to pay for labor and delivery out of pocket, coverage for your baby

is essential. Policies generally start around $100 per month, and, ultimately, you'll spend much less than if you pay 100 percent of the bills yourself.

Obtaining free and low-cost care for uninsured kids

If you do not have a work-sponsored health insurance program and can't afford to buy a policy for your child, but earn too much to qualify for Medicaid, explore the free or low-cost coverage options provided by both the federal and state governments. Your child may qualify for coverage if you meet certain low-income standards. Visit `insurekidsnow.gov` to see if your family qualifies for federal coverage and to find a provider in your state.

If you don't meet the low-income guidelines, many state-sponsored programs offer coverage. For the contact in your state, visit the National Association of Insurance Commissioner's Web site: `www.naic.org/state_web_map.htm`.

Taking Care of Legal Matters

Arranging legal matters is an important step in ensuring your child's well-being in the case of your early death. As unpleasant as the topic may be, you need to sit down with your partner as soon as possible and make decisions about what will happen to your assets and who will take care of your child if you die, and what should happen if either of you is incapacitated. Then make those decisions legally binding by creating a formal will and establishing power of attorney. These tasks aren't fun, but the peace of mind you'll have is worth it.

Although most of the forms you need to make these decisions and declarations are available for free online, the only way to make sure that your forms are valid and written in accordance to state and federal laws is to have them reviewed by a lawyer. It's an added expense, but it's worth the money to know your family will be taken care of in the event you are no longer around.

Creating a will

Drawing up a will doesn't have to be as macabre as reading a Stephen King novel. As a soon-to-be or new parent, having a will can bring you peace of mind by leaving no question about what will happen to your possessions (and children!) when you die. A will includes three provisions:

- **Who will inherit your bank accounts, real estate, vehicles, and personal property when you die.** Most dads have simple wills that leave everything to their partners and, in the event they both die, to their children.
- **Who will be your children's guardian in case you and your partner are incapacitated or die.** This is your chance to make sure your child will be cared for by the person of your choice and not put into foster care.
- **Who will manage any property and money you leave to your child until she reaches a designated age.** Most people name a single executor of their will who is charged with carrying out their wishes. However, some people are more comfortable having the person responsible for carrying out the will's commands to be separate from the person who controls the money.

A will doesn't trump the beneficiaries listed on life insurance policies. Make sure to contact your life insurance company to make the desired changes to those policies, such as adding your new child as a beneficiary.

Making your will

You don't have to go the lawyer route to make a will. Several do-it-yourself computer programs and books (such as *Wills and Trusts Kit For Dummies* [Wiley]) provide simple step-by-step instructions for arranging what happens after you die.

Filling in the blanks and hitting print doesn't automatically offer you the protection you need. Any will not made with a lawyer still has to be notarized in order to be valid in the eyes of the law. Leave a copy of your will with your executor as well as in a safe-deposit box.

Make a separate will for each parent. A joint will is binding after the death of even one person, and that makes it difficult for the surviving parent to make changes that may better suit his changed circumstances. Separate wills are especially important when kids are involved, because finances change and you want your partner to have access to funds in order to care for your kids. Name your spouse or partner as the sole beneficiary to ensure that she has 100 percent control of your assets, and have concrete, detailed discussions about how you want the dispersing of money and property, as well as your funeral and burial, handled in the event of your untimely demise.

Appointing guardians

If you have children, guardianship should be addressed when you create a will. If you work with a lawyer, she will be able to help you fill out all the necessary paperwork. However, if you use an online

form or a software program, be sure that it includes the appropriate form for your state.

If you are unsure of the legal requirements, consult your state's courts Web site to find the necessary forms. Most forms require a signature from both parents and the appointed guardian as well as notarization.

A will allows you to designate temporary guardianship in the case that your named guardian lives a few states away or can't come for your child immediately until the new guardian arrives. This temporary situation will keep your child out of the foster care program and in the loving home of your choice.

Guardianship is a huge responsibility for the person you ask. When approaching him, keep in mind that you may not get an immediate yes. In fact, if the person you ask needs some time to think it over, it's a good sign that he understands the responsibility and won't make rash decisions he may later regret. This person will not only be in charge of your child but will also have to cover any of the financial gaps not covered by the money you set aside to be used for your child's upbringing.

If the person you ask declines, ask for more information about why he refused. Perhaps you have information that can assuage any fears he may have about the job. However, if the person you ask (even after further discussion) isn't up for the job, find someone else. Yes, it will be disappointing, but respect that person's honesty and forthrightness in admitting he is the wrong person for the job. And when it comes down to it, finding the right person is most important.

Appointing an executor

The person you appoint as executor is in charge of *executing* your will, or making sure that taxes and debts are paid and your estate is distributed according to your will. Avoid appointing someone as an executor who is also a beneficiary of your will. You can name coexecutors if you want one person to manage your money and the other to manage, say, your property. It can be good to utilize different people's skills and gives you backup if one person drops the ball.

You designate an executor using the same online or software program you use to make a will, or when creating a will with your lawyer. Make sure that the person you designate is willing and able to perform the role. Most forms that designate an executor for your will require you to provide one or two contingency executors in case the first named executor cannot perform the job. Some states only recognize executors who live in the same state as the deceased. Check your states rules before you designate.

Questions to ask yourself when choosing a legal guardian

When deciding who would make the best guardian for your child in case of your death, consider the following questions:

- Does the person love my child?
- Is the person good with children in general?
- How important is it that my child's guardian be family?
- Will my child be uprooted from his/her home to move in with the guardian?
- Does the person have the same parenting philosophies I have?
- Is the person going to raise the child with the same religious beliefs?
- Does the person have any medical conditions that would prevent him from being a long-term, able-bodied guardian?
- Will your child cause too big of a personal, professional, or financial strain for the person?
- Does the person have a stable home life and career?
- Will this person guarantee your child has access to family?
- Does this person value the same things I do (education, music, community, and so on)?

When there's no will

State laws vary, but if you don't have a will, less than half of your property and money will go to your spouse and the rest will be divided among your children. If your children aren't 18, all money and property will be managed by a state-appointed trustee until that time arrives, which means your partner won't have access to your money in order to raise your children.

In the event that both parents die without a will, the state will designate a guardian for the children, which likely will be the most closely related family member willing to accept the job. While guardianship is arranged, your child will enter the state's foster care program.

Establishing power of attorney

Granting power of attorney to someone gives that person the power to make decisions — both legal and medical — in the event that you're incapacitated. The person you name will be able to

make important decisions about life support and control of your bank accounts.

Knowing your options

You can designate four main types power of attorney. Not everyone appoints a person for each, and appointing the same person to serve in multiple roles is common:

- **Limited power of attorney:** The person you designate will only be allowed to act on your behalf for a specified amount of time. This, most likely, will not be helpful when creating a will that covers the care and guardianship of your children.
- **General power of attorney:** The American Bar Association refers to this person as your *agent,* and she has the power to act on your behalf in every capacity that you did prior to your incapacitation. This person literally becomes you in the legal sense until you are capable again of handling your own affairs.
- **Durable power of attorney:** Granting someone this power means his authority ceases to be recognized by the law after you pass away, except in the areas you give him control.
- **Healthcare power of attorney:** This person is empowered to make important medical decisions but has no control over your finances.

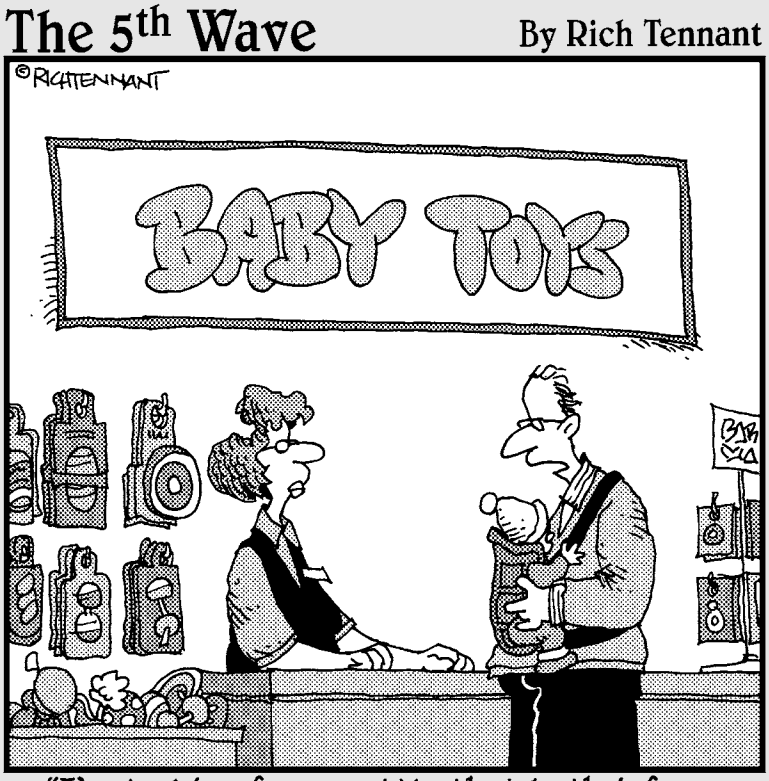
Appointing a power of attorney

Generally included as part of the will-making process, appointing power of attorney takes only a simple form that usually must be signed by you and the named power of attorney and then notarized.

Experts suggest choosing someone you trust but who isn't a close friend or family member. After all, even if you've made it clear that you don't want to be on life support for an extended period of time, your mother may have difficulty pulling the plug. Select a person who you can trust to follow through with your wishes.

The power of attorney should follow what you outline in your will, so go over your will with that person to make sure he is comfortable following your orders. If not, find someone else, or complications may arise that will cause added stress for everyone involved. What's most important is finding a person you can trust who will be informed about your wishes and make sure they're followed.

Part V
The Part of Tens



"I'm looking for a rattle that both informs and entertains."

In this part...

The Part of Tens provides practical tips on everything from reading your partner's mind to being a super dad. We also look at the wonderful world of stay-at-home fatherhood, should you be considering that increasingly common route.

Chapter 16

Ten Things She Won't Ask for but Will Expect

In This Chapter

- Showing your excitement about being a father
- Helping your partner with emotional and physical support

During the course of your partner's pregnancy — and many months thereafter — she will expect myriad tasks, words of comfort, and loving gestures from you without her having to ask for what she wants. Sadly, you weren't born with advanced psychic aptitude, and therefore you'll have to infer a few *musts* to keep peace around the house.

Follow these ten simple tips to make sure your partner gets everything she needs.

Keep It Complimentary

Face it — you'll never know what it's like to give up your body so that someone else can grow inside of you. That said, it probably isn't too hard to remember the last time you got a new haircut or lost ten pounds and then waited around for someone to tell you how nice you looked.

Going fishing for compliments is never a fun or fruitful excursion, so try to spare your partner from going to that length. When her hormones and ever-increasing waistline are waging a full-fledged attack on her insecurities, remind her early and often exactly how beautiful she looks. And the best part is, you won't have to lie. It may be hard to imagine finding your partner gorgeous when she's carrying around 30 to 40 extra pounds, but pregnant women glow, and knowing that she's having your baby can be extremely attractive.

When she asks you how she looks or if she has gotten fat (and she will ask you!), flatter her to no end, deny it vehemently, and thank her for her sacrifices.

Start a Baby Book

Baby books, with their endless pages of blank space calling out for someone to fill in the missing data, can be a daunting undertaking, especially when chronicling the journey is left solely to the mom-to-be/new mommy. Most women won't admit it, but during pregnancy they're looking for constant signs that you're just as committed to raising a child together as she is. Filling out a baby book together can be the perfect way to put into words just how ready you are for baby.

A great way to exhibit your commitment and excitement to the baby she's carrying is to buy the best baby book on the market that suits your styles. If you and the mom-to-be are the long-form journaling types, pick one that offers lots of space to write about how you're feeling during each trimester and your thoughts about becoming a parent. If you fall into the less-is-more crowd, choose a book that adheres to a mostly fill-in-the-blank format. Many themed books are available, running the gamut from religious to hipster chic, so choose one that represents both parents.

The baby book is a time-honored time capsule that chronicles the pregnancy and early days of your baby's life, and like any good time capsule it should be something fun to put together as a couple that captures the time and place. Someday that book will mean the world to your child, so make sure to buy one that you'll realistically finish.

Disguise Fitness as Fun

Exercise is of the utmost importance to both baby and mommy, but try telling your partner to get up off of the sofa and go for walk without having something hard thrown at your head. Getting a loved one involved in fitness is never easy to do without hurt feelings, so instead of telling her that she needs to exercise, help her exercise without making it personal.

Turn fitness into a social activity: Plan walks with friends and family members, or schedule errands together that require you to get up and move around. Plan a "treasure hunt" date to local baby stores to scope out the latest gear, or even a hunt with a romantic bent. Even a trip to the mall can be good exercise so long as you steer clear of the food court.

If your partner has a particular interest in a certain type of exercise, give her a free pass as a gift. Be it yoga, spinning, or running, most fitness clubs or personal trainers offer prenatal versions of their classes. Many classes welcome partners, too, and by making it a couples' affair it won't send the message that you think she's fat.

Curb Your Advice

Never has there been a better time to let go of your desire to be right at all costs than now, even if you really *do* know best. Let your partner complain about her job, her body, the mere fact that she's pregnant, or whatever, and don't take her complaints, gripes, or outbursts personally. Now, that doesn't give her free reign to be a raving lunatic just because she's pregnant, but don't try to solve her problems with your sage wisdom unless she specifically asks for it. Listen to her and validate what she's feeling, but don't tell her how to fix it.

Also, avoid telling her what to eat, when to exercise, that she needs to sleep more, and so on. Instead, lead by example. If you think she should eat more fruits and vegetables, buy more fruits and vegetables. Or better yet, make meals packed with pregnancy power foods. If you think she needs to rest more, ask her to sit down and do a crossword with you. Telling her what to do will not go over well, so don't waste your breath.

Attend Prenatal Appointments

Repeat after me: Prenatal appointments aren't just for the mothers. Yes, she is carrying the baby, but that baby didn't get there on its own. You're in this together, and if she has to make time in her schedule to attend countless appointments, ultrasounds, and tests, so should you. It will demonstrate to her that you're a team in the raising of this baby, and you'll be much more excited and invested in the process by being just as involved as your partner.

Childbirth is an empowering experience for both mother and father, and the more appointments you attend, the more knowledgeable you'll be about the entire process. Being an involved father starts long before the baby arrives. In fact, if you plan on being a 50-50 partner in the raising of your child, it's won't just happen overnight. You wouldn't play a baseball game without practice, and you shouldn't enter into parenthood without practicing the type of dad you want to be.

If your work schedule doesn't allow for you to attend every appointment, go to as many as possible. Follow up with her immediately after each appointment you miss and ask her for a recap. Ask lots of questions; your partner will be grateful to know you care. Many important decisions and discussions occur during prenatal visits, and even if you can't be present, make sure you remain part of the discussion.

Plan a Getaway

After baby arrives it won't be easy to abandon ship and head for the hills when you need a relaxing reprieve from life. And as the long wait for baby drags on and you both begin to realize how much is going to change in your personal lives after he comes, you may find yourselves looking for one last couples retreat.

Take the lead and plan a trip. Keep in mind that the later she is in her pregnancy, the closer to home you'll want to be in case she goes into labor. Also, her body (and especially her bladder) won't be up for sitting in a plane or in the car for long periods of time. Wherever you go, make the trip romantic, personal, and quiet. Make it a time to focus on your relationship — just the two of you — because it won't be the focus of your lives for some time to come.

If you plan something during the third trimester, keep in mind that many airlines have restrictions about how close to her due date your partner can travel. Check with your airline before booking tickets, because many require a doctor's note for travel.

Register for a Prenatal Parenting Class

The days of prenatal parenting classes that focus solely on breathing and birthing techniques are over. Today's classes offer opportunities for parents-to-be to explore birthing options, relationships, the type of parents they want to be, CPR, and infant care. Find a class that's welcoming to both mother and father and register, either through your local hospital or birthing center, or by searching online.

Many communities have fatherhood experts that offer a new brand of class just for fathers-to-be that explores the myths of fatherhood, what it means to be a father, and male bonding exercises. It

allows men to confront their fears of fatherhood and any issues they have in regards to their own fathers. Putting in the work before baby comes only increases the odds that you'll be the best dad you can be.

Do Your Homework and Spread the Word

Clearly, if you're reading this book, then you've already done the majority of your homework. Congratulations — you're going to be a great dad. Now don't be afraid to toot your own horn. Not every dad-to-be is as equipped and awesome as you, and you deserve credit. Make a point of telling your partner how much you've found out in these pages. Ask her, "Did you know . . . ?" and "Have you thought about . . . ?" Who knows, you just may teach her something she didn't know. And is there any better feeling in the world than feeling accomplished?

At the very least, you'll set a good example of your own involvement in the future of your relationship. In the past, fathers weren't expected to know anything about pregnancy, and it wasn't all that long ago that the majority of men stayed out of the delivery room and returned to work the day after delivery. The more you know, the more your partner will trust you to care for the baby. Trust is earned, and by getting educated about babies, you're earning that trust that many fathers of the past forfeited.

Learn Prenatal Massage

Pregnancy puts stress on all the body's joints and ligaments as muscles (and even bones!) shift and expand, causing mothers-to-be to walk, stand, sit, and sleep in ways that often are at odds with their normal movements and positions. Add an additional 30 to 40 pounds hanging off her front, and it's no wonder that your average pregnant woman gets achy, tired, and downright sore.

Learning the basics of massage can help you help her alleviate many of those aches and pains — and will make you her hero after a long day of carrying around your child. Many hospitals and birthing centers offer prenatal massage classes. Doulas often are trained in light massage, and if you hire one, be sure to learn techniques from her. If you can't find someone to learn from, buy or rent a DVD about prenatal massage, or even buy a book that offers ample illustrations so you'll know what to do.

While you're at it, consider learning the ins and outs of infant massage. Research shows that infant massage can help babies digest foods and sleep better, and helps prevent and treat colic. Check with your hospital or birthing center for more information.

Clean High and Low

The closer you get to delivery time, the more likely your partner is to desire a clean, tidy home. Limited by a rather large belly and an unflinching tiredness, your partner won't always feel like cleaning or be able to do it. Areas that fall below your partner's knee level and things out of her reach are particularly difficult for her during the latter stages of pregnancy.

But her limitations don't mean that you have to clean everything all by yourself. In fact, the exercise involved in cleaning can be beneficial for her. However, assign yourself the job of picking up everything from the floor on a frequent basis. Clutter-free floors and walkways will prevent her from falling and will keep her from pulling a muscle in her back trying to reach down.

While you're down there, you have a good view of what baby will see when he's crawling around your home. You can always begin baby-proofing your abode; the extra time you give yourself will let you get used to the new limitations and restrictions.

Though it's a myth that a pregnant woman will strangle the baby if she raises her arms above her head, it may be a rather uncomfortable experience. Take the lead on cleaning the blinds, putting away dishes in the cupboards, changing light bulbs, and dusting.

Chapter 17

Ten Ways to Be a Super Dad from Day One

In This Chapter

- Learning how to bond with your baby
- Reading, teaching, and playing for fun and for learning
- Mastering the art of baby-and-daddy time

When it comes to parenting, what you don't know won't kill you, but it sure can keep you from making the most of the greatest, most joyous time in your life. After nearly a year of waiting for baby to arrive — or longer in some cases — don't forget that now is the time to have fun. Yes, bringing a teeny, tiny baby into your home evokes a great deal of worrying, but babies aren't as fragile as you may think. If you want to be a super dad, try to follow these tips on how to be a confident, loving, and cool father from day one.

Overcome Fragility Fears

Animals can sense fear, and when they know you're afraid, they exploit your weakness at every turn. The same goes for babies, albeit without the evil ulterior motive. If you're afraid of holding your baby, you probably aren't providing a solid, sturdy base for him, and he'll fuss and cry until somebody who is confident takes over the reins. The same holds true for diapering, feeding, and cuddling.

Repeat after us: I am not going to break my baby. He's designed to survive a first-time parent like yourself, and as long as you're not trying to juggle knives while burping him, chances are that you're both going to be just fine. Babies are small, but so long as you take reasonable safety precautions like never leaving him unattended, always securing him in a car seat, and listening closely to the baby monitor during sleep time, you aren't going to hurt him.

The most important tip is to take deep, steady breaths and hold your baby in the same casual-yet-protective way you grasp your iPad. Don't fumble with the baby as you lift him up onto your shoulder. Use firm, fluid movements. The more you act like you know what you're doing, the more the baby will like what you're doing.

Trust Your Instincts

Because babies are designed to be cared for by people who don't have any education in the raising of children, you have no choice but to follow your instincts. Babies have been around since, well, the dawn of man, and all the parents since that time have raised them their own way. It wasn't all that long ago that parents and parents-to-be told stories of their experiences around the campfire instead of relying on modern inventions such as parenting classes and Lamaze. We are born with the instinct to care for our children, and so long as you don't have mental or emotional impediments (such as postpartum depression), you'll just know what to do.

Just remember that nobody can know your baby better than you do, and despite the seeming lack of faith others may show toward your judgment (how warmly you dress him, how often you feed him, how you hold him, and so on), the only truly vital task of the parent is to ensure safety. Trust yourself, educate yourself, and you will not steer that little one wrong.

Bond Skin-to-Skin, Eye-to-Eye

Mothers get an amazing opportunity to spend skin-to-skin time with baby while breast-feeding. This sensory bond is so important that mere moments after the baby is born, the doctor or midwife will often place her on mom's bare chest. Studies show that skin-to-skin contact increases the bond that both mother and child feel, as well as the soothing feeling babies experience from listening to mom's heartbeat. Also, a newborn's eyesight is just powerful enough to see the distance from the breast to mom's eyes.

You won't be breast-feeding, so you have far fewer opportunities to experience the same closeness. Yes, baby's head will rest on your hands and arms, and you can get close and make eye contact, but that doesn't provide the same bonded feeling. When baby is only in her diaper, take off your shirt and place her on your chest. It may sound a little cheesy, but it's an important bonding experience for every parent, not just mothers, and it gives you and baby the opportunity to meet skin-to-skin and eye-to-eye for the first time.

Manage Frustrations

Admit it — your son or daughter is the most beautiful sight you've ever seen. As you stare into the wondering eyes of your newborn you may think it impossible to ever feel anything but absolute adoration for this child. However, babies often are exhausting and unmanageable beings who wake you up in the middle of the night, cry endlessly without giving you a clue as to what's wrong, and require 100 percent of your attention.

Feeling frustrated is okay, because parenting, especially when you're brand new at it, can and will be a frustrating experience from time to time. In preparation for when that cute bundle of joy becomes an obstinate teen, here are some simple ways to manage your frustration:

- **Control the controllable.** It's easier said than done, but some things you can change and some things you can't. Babies do not sleep through the night. Babies spit up. Babies cry for no good reason. Don't waste your time trying to solve problems that aren't really problems. If your baby has a clean diaper, a full belly, and a gas-free stomach, yet still continues to fuss, just put on some noise-canceling headphones and let him cry. Unless something is wrong, don't worry about him.
- **Monitor baby's routine.** Keep a log of when baby sleeps, wakes, eats, poops, and pees. Understanding his routine takes a lot of the guesswork out of determining what he needs at any given time. If you discover that your little one starts getting fussy after being awake for 90 minutes, you'll know how to structure your day to make sure that everyone — including you — gets what they need to function.
- **Blow off steam.** Pick your poison — running, video games, bowling, reading — whatever it is that puts your mind at ease, and make sure you take time to continue engaging in it. If you find yourself getting frustrated, spend five minutes doing your favorite activity. Even a walk around the block can be a great way to hit your reset button.
- **Lean on your support system.** When the going gets rough and you feel like you need to get out of Dodge, do it! Call a sitter, a friend, or a family member to fill in for you, even if it's just for an hour so you can run to the grocery store in peace. Don't discount the benefits of time alone or with your partner to make your frustrations dissipate.
- **Sleep in shifts.** Sleep is a hot commodity among the parenting set, and before long you'll be coveting every available minute of shut-eye. However, if baby is constantly waking during the

night, both you and your partner will quickly lose patience in the wee hours of the morning. Though it's not the ideal situation, try taking turns sleeping for blocks of time in the night and throughout the day while on leave (or the weekends). You need to get as much sleep as possible, even if those hours aren't consecutive. The key to keeping your frustrations in check just may be two hours of peaceful slumber.

Embrace Your Goofy Side

By now you've probably made a list of all of the things you're not going to do as a parent. For many too-cool-for-school dads, that list includes such things as baby talk, funny faces, and the pure lunacy of dress up, tea parties, and dancing that requires dads to check traditional masculinity at the door in favor of fun.

Do all the things on that list. Don't feel stupid and don't feel restrained by how you think men should behave. Babies (and kids, for that matter) love expressive faces, singing, and goofy voices, and while acting silly may leave you in a shroud of self-consciousness, you'll get over it the instant your baby laughs or smiles at your goofball antics. Allow yourself to have fun, and you'll reap the rewards for life.

Get Out

Going to work doesn't qualify as getting out of the house. Yes, it may be a nice change of pace to spend time doing things that don't require baby wipes and a Pee-Pee Teepee, but the kind of getting out you need is of the date variety.

You may be surprised to know that getting out of the house is easier when your baby is younger. Make sure to schedule a date within the first month of baby's arrival. Start slowly — new moms (and many dads) find it hard to leave baby for the first time. Ask a trusted friend or family member to watch baby while you grab a quick bite to eat at your favorite restaurant.

Ground rules? Don't talk about the baby. You may not achieve this almost impossible goal, but shoot for the stars. You need to connect as adults again, not just as parents, and that brief time away will remind you why you love your partner so much. And, upon returning home, you'll have a welcome reminder of just how much you love that baby.

Teach Baby New Tricks

You may think babies discover the world of their own volition, but the truth is that you need to give your little one a push. In fact, the more time you put into teaching and nurturing your baby, the prouder you will be when she learns to roll over, clap, wave bye-bye, or play with a toy. Bonding happens daily with babies, and a child's way of thinking is practically set in stone by age 3. You can have a huge influence on the rate at which your child develops, but more importantly, you can have a huge influence on your child's entire life by getting involved in playtime and the open expression of love.

Following are some milestones you can help baby achieve in the first six months:

- **Tracking objects:** Slowly move a colorful object back and forth and up and down in front of baby's eyes. This activity helps the brain begin to follow movement. Sound tracking can also be done in the same way.
- **Making sounds:** Your baby makes a lot of strange sounds, and a supremely important part of language development is hearing you repeat those sounds back to her. Babies have their own language that you don't understand, and the more they hear it the more they will talk, which aids in language development down the road.
- **Reaching and grabbing:** Dangle colorful toys and baby-safe objects in front of your child and wait for her to reach for them. Encourage gripping by wrapping baby's hand around the object and letting go.
- **Peek-a-boo:** Babies will laugh as you disappear and reappear time and again, all while beginning to understand the idea of cause and effect. Showing baby the mirror is also a fun, mind-expanding game.
- **Rolling over:** Lay your baby on her back on a play mat or a colorful rug to encourage her to turn over and begin to explore. When she can support her own head, give her plenty of tummy time on her belly, which develops the stomach muscles and allows her to roll over.
- **Crawling:** New studies show that the way babies' brains react during crawling (the right brain controls the left side of the body and vice versa) is an important milestone that can help reduce behavioral and mental disorders in children. Help ensure your child can crawl by putting a coveted toy just out of reach and waiting for her to come and get it.

Roughhouse the Safe Way

Though we don't want to engage in gender stereotyping, fathers are often more likely to get physical during playtime with their kids. And although you probably won't be wrestling with your newborn (please, don't wrestle your newborn!), go ahead and swing him in your arms, hold him up high over your head, rub your scratchy face into his belly, tickle him, and chew on his feet. Mom may think it's too much, but more than likely, baby will think it's hysterical. As long as you're being safe, have fun.

Read Aloud . . . and Not Just from Baby Books

Read to your baby every single day. Not only will she love the sound of your voice, but she'll also learn to speak from hearing the constant repetition of speech patterns. And the more you read to baby, the more likely it is that she will develop a strong vocabulary and the ability to speak at a younger age.

While baby is too young to truly enjoy kid's books, don't be afraid to read her passages from the novels you want to read. It's a good way to engage in adult activities while also helping your baby grow smarter every single day.

Send Mom Away

Unless you're fortunate enough to be a work-at-home dad like coauthor Matthew, you'll need to make sure that you block off some one-on-one time with your baby. Finding your own way as a parent and learning how capable you are are important steps in feeling empowered as a new dad. Which means that mom needs to go away for a while.

Book an appointment at the spa for your partner and spend the afternoon doing everyday things with just you and your baby. Take him for a walk, feed him, change him, or even go out to the coffee shop and read the paper with him. Regardless of the activities you do together, this time establishes one-on-one intimacy with your child and proves to yourself and your partner that you are capable of taking care of your child on your own.

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A practical, hands-on guide for fathers-to-be

When it comes to pregnancy, your role as a dad has changed so much in the past few decades that it's hard to know where to turn for guidance. Now you do! This hands-on, friendly guide is packed with practical information for fathers-to-be, covering all of the logistical, physical, and emotional aspects of pregnancy from your unique perspective.

- ***Take the fear out of fatherhood* — find out what modern fatherhood means, determine if you're ready for the financial and emotional demands of a baby, and learn what you don't know about conception**
- ***Pregnancy and childbirth 101* — get the lowdown on what to expect during pregnancy, labor, and delivery, from your perspective as well as your partner's**
- ***So you're a father — oh, boy (or girl)!* — discover how to care for your newborn — from bottle feeding to changing diapers to soothing your baby**
- ***Be the perfect postpartum partner* — support your partner by helping with the baby and household, and by attending to her emotionally as well**

Open the book and find:

- **How a fetus develops in every trimester**
- **Advice on when and how to share the good news**
- **Tips on baby gift registry and setting up the nursery**
- **What to expect during labor and delivery**
- **What to expect the first six months after the baby arrives**
- **The 4-1-1 on feeding and changing diapers**
- **Tips for dealing with common illnesses and emergencies**
- **Survival tips every new dad needs to know**

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$15.99 US / $18.99 CN / £12.99 UK

ISBN 978-0-470-76790-0