Reproductive Mental Health and Postpartum Wellness

Rachelle Garcia Seliga, CPM©
www.InnateTraditions.com

When it comes to our HEALTH –
whether tending to our own health or tending to the health of those in our care –
we tend to do what we were taught to do,
and/or,
we do what was done to us,
RATHER THAN doing what is -right- according to our PHYSIOLOGY.

This booklet serves as a short, but deep dive into a holistic understanding of POSTPARTUM WELLNESS – according to our PHYSIOLOGY.

'Postpartum' is a time after birth.
It is not a syndrome.
We can say that the postpartum period lasts for:
6 weeks - 3 months - 1 year - 3 years - 7 years - all of life.
And all of these answers are TRUE.
Women are postpartum after the birth of a live baby
and after the birth of a stillborn baby.
Women are postpartum after a miscarriage
and after an abortion.

The quality of CARE that women receive during the postpartum period will determine a woman's recovery – mentally, emotionally, physically, and spiritually.

What we are most accustomed to seeing within the modern world is the DEGENERATION of women's health after birth. Collectively we normalize what is common. Therefore, we have collectively 'normalized' the degeneration of woman's health through the postpartum period – examples being: peeing in our pants when we sneeze; postpartum depression/perinatal mood disorders; hair loss; retaining of baby weight; etc. *This degeneration is most often the result of one or more of the following: deficiencies present prior to pregnancy, interruption in the physiologic process of birth, or lack of postpartum care.*

It is with –proper postpartum care– that women can actually become HEALTHIER and STRONGER through the postpartum period. Postpartum traditions from around the world are VIRTUALLY IDENTICAL. The reason that cross-culturally postpartum traditions are virtually identical is because they COME FROM our physiologic mandate; they are a TRANSLATION of our physiologic needs after birth. And what these ancient traditions have always done is SAFEGUARD WOMEN'S HEALTH IN THE POSTPARTUM, in the name of women's LONGTERM WELLNESS.

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Pitocin & Maternal Health

Synthetic oxytocin (pitocin) is routinely used in obstetric medicine to both induce labor, as well as for 'Third Stage Management' – meaning to 'prevent postpartum hemorrhage' (even if there are no risk factors), as well as to tend to an actual postpartum hemorrhage. While pitocin can indeed be a life-saving tool, it is severely overused on women birthing in hospitals throughout the United States (and increasingly in many parts of the world), and very little is actually known about the short- and long-term implications of its use.

HOWEVER – what we DO know because of really recent research is that pitocin GREATLY increases the risk of postpartum depression and/or anxiety in women.

Data was collected through the Massachusetts Integrated Clinical Academic Research Database (MiCARD) to analyze postpartum outcomes for all women who had a live birth at University of Massachusetts Memorial Health Care between January 2005 and April 2014. The sample included 9,684 deliveries with peripartum synthetic oxytocin exposure (defined as within two weeks of delivery date) and 37,048 deliveries without peripartum synthetic oxytocin exposure. Depressive or anxiety disorders, defined as a record of diagnosis and/or receipt of antidepressant or anxiolytic medication prescription, were divided into three timeframes: pre-pregnancy (diagnosis/prescriptions more than one year before delivery), pregnancy (diagnosis/prescription during pregnancy or 40 weeks ahead of delivery date), and postpartum (diagnosis/prescription one year following delivery).

The analysis showed that women with no history of pre-pregnancy depression or anxiety who were exposed to synthetic oxytocin had a *32 percent increased risk of postpartum depression or anxiety compared with non-exposed women, while women with pre-pregnancy symptoms had a 36 percent increased risk.*

> *"We know how oxytocin affects uterine contraction, which is what it is used for during labor. But so many other tissues including the brain have oxytocin receptors, which can lead to a range of unintended consequences when we manipulate this hormone system during delivery."*
> *~ Kristina Deligiannidis, M.D., Associate Professor of Psychiatry and Obstetrics and Gynecology at Hofstra Northwell School of Medicine in Glen Oaks, New York*

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When a Mother is experiencing 'depression' or feelings of difficulty bonding and attaching with baby in the early postpartum – and you KNOW that she was administered pitocin during labor and birth – this information MUST be taken into account. Mothers need to understand that it is not 'their fault' they are feeling disconnected with baby or having difficulty in attaching – rather affirmed that this is most likely a consequence of the drugs used during labor. Simultaneously, bonding and attachment in the present time need to be facilitated. [Feelings of depression and disconnection as well can manifest through ANY interruption in the physiologic process of labor and birth].

The place of REPAIR in the postpartum period is: Mother and baby *skin-to-skin*. Repair after ANY INTERVENTION during birth can not happen through talk therapy alone. It must happen through the body, through touch, through smell –through the senses. It is through the BODY and physical PRESENCE (Mother/baby/Father-Partner) that the physiological wiring that needs to happen for ideal bonding and attachment CAN and WILL happen.

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Impact of Sleep Deprivation

LACK OF SLEEP has been shown through studies to CAUSE depression.

Newborn babies' *physiologic needs* require care 24 hours/day. ALL of newborn babies' physiologic processes (temperature, blood pressure, respirations, stress/cortisol levels) are kept at a constant tempo WHEN IN CLOSE CONTACT WITH MOTHER. The converse is also true when babies are separated from their Mother.

We also know that infant's bellies are SMALL, and therefore require: ON DEMAND FEEDING (a whole other conversation in and of itself!)

- Day one after birth: An infant's belly is the size of a CHERRY and can hold 1-1.25 teaspoons of liquid
- Day three: An infant's belly is the size of a WALNUT and can hold 0.75-1oz of liquid
- One week old: An infant's belly is the size of an APRICOT and can hold 1.5-2oz of liquid
- One month old: An infant's belly is the size of a large EGG and can hold 2.5-5oz of liquid

Meaning: Mothers (and Fathers/Partners) are providing care around-the-clock to their babies, which MOST DEFINITELY AFFECTS THEIR SLEEP. Compounding this is the reality that most families in the modern world live within a nuclear rather than extended-family set-up.

> *"Some research suggests that in the first year postpartum, the average sleep debt of Mothers is 700 hours."*
> *~ Dr. Oscar Serrallach M.D.*

> *"Medical residents are notorious for being sleep-deprived, and their situations may be similar to new parents in that their sleep is chronically restricted and fragmented. Studies on medical residents show that sleep loss is associated with more intense negative emotions and hostility. One study found that interns who became chronically sleep-deprived over the course of their first year of training had seven times the odds of becoming moderately depressed, compared to those managing to get enough sleep."*
> *~ The Effects of Sleep Loss on Medical Residents' Emotional Reactions to Work Events:*
> *The U.S. National Library of Medicine and the National Institutes of Health*

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This is ONE reason why postpartum support for Mothers to be able to REST and SLEEP, especially in the first 6-weeks postpartum, is ESSENTIAL. This is the work that extended families once did (and still do in some places), which in the modern world can be tended through: community support (FORMED DURING THE PRENATAL PERIOD); postpartum doulas; family help; etc.

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Fathers & Postpartum Depression

Many new studies are revealing that MEN are experiencing postpartum depression – revealing that up to 1 in 4 new dads have Paternal Postpartum Depression.

The research paper entitled 'Sad Dads: Paternal Postpartum Depression" by Pilyoung Kim, Med, BA, and James Swain, MD, PhD, FRCPS, from the US National Library of Medicine – National Institutes of Health states:

> *"Paternal PPD might be related [in part] to changes in prolactin levels. Prolactin is important for the onset and maintenance of parental behaviors. Prolactin levels in men rise during pregnancy and continue to rise during the first postnatal year. High prolactin levels are related to greater responses to infant stimuli among new fathers. Thus, a lower prolactin level could cause a father to experience difficulties in adapting to parenthood and thus exhibit more negative moods."*

Essential information to add to this understanding that postpartum depression in Dads is caused -in part- by low prolactin levels *is that prolactin levels RISE in Fathers when Fathers are intimately involved with their baby along with the Mother.*

Rises in prolactin levels in Fathers is what provides for BONDING AND ATTACHMENT within a family system (along with oxytocin and other hormones).

It is the PRESENCE of Father after the birth/with the Mother/baby that physiologically forms bonding and attachment.

So then, if there is no paid paternal nor maternal leave; no community support to assure families STAY TOGETHER (through practical, hands-on care that PROVIDES for the family); 40+ hour work weeks; and on and on, THERE IS A PHYSIOLOGIC INTERRUPTION OF THE BONDING AND ATTACHMENT THAT SHOULD BE TAKING PLACE WITHIN THE FAMILY SYSTEM BECAUSE OF LACK OF-PRESENCE, manifesting as depressive symptoms in Fathers.

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Community specific, culturally appropriate ways to assure that families are able to BE together – ESPECIALLY during the early postpartum period.

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Pelvic Health in Relation to Whole Health

When we speak of pelvic health in relation to women's health, we are speaking to women's: Reproductive, Sexual, Urinary, and Bowel health.

Cross-culturally, it has always been the MIDWIVES who have tended to what we are now calling 'reproductive mental health.' 'Reproductive mental health' refers to: the psychological and emotional well-being of women in and through our reproductive and regenerative experiences.

According to a 2008 study by researchers at the California HMO Kaiser Permanente, about 1 in 3 women suffer from a pelvic floor disorder (a category that includes urinary incontinence, fecal incontinence, and prolapse – which can be uterine, bladder or rectal prolapse), and roughly 80 percent of those women are mothers.

If a postpartum Mother is:
– Peeing in her pants (as in urinary incontinence)
– Pooping in her pants (as in fecal incontinence)
– Has any kind of pelvic organ prolapse (as in her bladder, uterus, or rectum slipping out of her vagina)
– Has painful sex
– Experiences discomfort at all in her pelvic region after birth
THIS WILL AFFECT THE PSYCHOLOGICAL AND EMOTIONAL WELL-BEING OF THAT MOTHER – MANIFESTING AS DEPRESSION, ANXIETY, OR BOTH.

Within the modern world, we have the compartmentalization of our health care. The majority of women in the United States are birthing with doctors/hospitals – and so seek the support of Obstetric doctors when experiencing pelvic problems. Obstetric doctors will often tell women in turn: 'You had a baby, these pelvic symptoms you are experiencing are normal.' While this statement is absolutely anecdotal – if you have any doubts, simply think about what your own OBGYN told you in regards to a pelvic floor problem or ask just about any Mother you know about their experience/s. Additionally, allopathic medicine has very little to offer women for resolution of pelvic problems apart from surgery, which statistically have very poor outcomes: Nearly one-third of women who have pelvic-floor surgery will go on to have at least one more.

Mental Health Professionals are now often the ones to work with women who are feeling depressed, however, very little training has been offered to the Mental Health Professional community on how to appropriately broach the subject of women's pelvic health and then how to properly resource women for follow-up care.

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Women's pelvic health MUST be taken into account in regards to mental health – and in regards to WHOLE HEALTH. If we are care-providers and it is not within our 'scope of practice' to offer pelvic work ourselves, we MUST know who to refer women to for help. Those who can help in the U.S. are: Midwives, Women's Health Physical Therapists (WHPTs), Holistic Pelvic Care providers, some Osteopathic Doctors, Sexological Bodyworkers, STREAM Practitioners. Outside of the U.S., each country/culture will have its place-specific practitioners who can be of support. Allopathic medicine is only able to offer women surgery or hormonal replacement in regards to pelvic health care – rarely bringing about holistic resolution. When pelvic health is tended in the postpartum period (and at all times for that matter), a tremendous amount of pain, agony, distress, depression, and anxiety can not only be treated but can also be PREVENTED.

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www.InnateTraditions.com

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Maternal health is foundational to society's health.

INNATE Postpartum Care is working to bridge the worlds of Midwifery and Mental Health – to optimally and holistically serve postpartum Mothers WORLDWIDE.

For more information on the work we are doing, please look through our website www.InnateTraditons.com and contact us with any questions you may have.

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In dedication to THRIVING LIFE,
Rachelle Garcia Seliga, CPM