



Hormones, Home, and the Contracts We Need: Oxytocin, Postpartum Depression and Planning for the Unthinkable

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I have long worked and spoken about three intertwined subjects: the hormone oxytocin, the turbulent physiology of perimenopause, and the unexpected power of a well-crafted prenuptial agreement. At first glance these topics may seem disparate — biochemical bonds, a midlife endocrine transition, and a legal document — but they converge on a single truth: long-term partnerships are high-risk enterprises and flourish far more reliably when love is guided by intention and forethought rather than hope.

Prenups, in my view, should be understood more broadly than a ledger of assets. Beyond finance, a serious premarital agreement spells out the archetype [1] by which a relationship will be lived: how decisions will be made, how parenting will be organized, whether children will be educated at home or sent away, and how the couple intends to respond if one partner becomes unwell. In other words, a thoughtful prenup is a map for the inevitable storms, not a cynical wager against love. When conflict arrives — as it inevitably will — an agreed blueprint prevents the small ruptures from becoming irreparable.

One crucial instance where foresight matters is postpartum mental health. I have not written much about postpartum depression, except to warn that it can herald a deeper oxytocin dysregulation with profound relational consequences. Yet the reality is more nuanced than a simple hormonal deficit, and that nuance deserves advance planning. Once postpartum illness emerges, it is rarely the right time to devise a strategy; you need a plan in place beforehand.

During pregnancy, estrogen and progesterone climb to levels orders of magnitude higher than baseline. Late pregnancy concentrations are astonishingly elevated; following birth those levels

can fall precipitously — a drop that frequently explains the “baby blues” of the first days after delivery. For a minority, however, mood symptoms persist and deepen into postpartum depression. Hormones are a major piece of the puzzle, but genetic vulnerability, prior mental health history, social support, sleep disruption, and systemic stresses all contribute.

My own life offers a cautionary parable. When I began a relationship that eventually produced my son, I knew enough to sense my partner's low mood. In our culture, anxiety and depressive symptoms among young women are so common that red flags can blur into background noise. Still, her early response to an SSRI was strikingly positive; for nine months the medicine transformed our everyday life into something close to idyllic. We discontinued the medication during pregnancy out of caution — a choice many couples make — and at first the pregnancy was uneventful. Then, after our son's birth, our relationship began to unravel in small, corrosive ways. She grew distant; I was gradually marginalized from the life we were building together. Her breastfeeding went on for years, and when I gently suggested that sustaining breastfeeding might be a way of maintaining oxytocin and emotional connection, the conversation collapsed. Without transparent communication and without a prearranged plan for postpartum support, minor irritations became deep divisions. By the time I sought divorce — an outcome I came to initiate out of love and concern for both of us — the damage was profound and longstanding.

It is precisely because postpartum disorders can be so destabilizing that prudent couples should make contingencies now. A prenup — or better yet, a partnered care agreement — can include nonfinancial provisions: who will manage night feeds and infant

care if a parent is struggling; a schedule for professional check-ins in the first year postpartum; an agreed pathway for accessing mental health care (therapy, medication, inpatient or outpatient supports); a role for extended family or paid respite; and explicit communications rules when one partner is emotionally raw. These advance agreements are not a betrayal of romance; they are an act of responsibility.

Obstetrics tends toward binary thinking: normal delivery or C-section, intervention or nonintervention. The psychosocial complexities of the postpartum year don't fit neatly into those boxes. That's one reason I chose not to practice obstetrics: the field often treats the emotional life of women as ancillary to the physiology. But emotional health is not ancillary; it is a cornerstone of family stability.

Are men between a rock and a hard place? Practical steps forward.

In a sense they are and the only way to avoid this is if couples prepare intentionally. Now, I fully recognize most will not be proactive and hope things just work out, but hope is not a plan. Men who withhold feelings out of fear of destabilizing the relationship are understandable; they are trying to protect the bond. But silence is an unstable strategy. There are practical, compassionate paths that let men be honest without unintentionally triggering a partner's subconscious fear responses.

Educate together about biology and context

Partners should learn the basics: pregnancy and postpartum hormone dynamics, the role of oxytocin in bonding and fear-regulation, and how sleep loss and stress amplify vulnerability. Knowledge reduces magical thinking and scapegoating.

Build a prenatal "postpartum plan"

Draft a simple, specific protocol before birth: who handles infant nights; when the partner will stop driving or return to work; agreed steps if mood symptoms emerge (screening, therapy referrals, medication choices, emergency respite). Put names, phone numbers, and timelines in writing.

Create safe disclosure rituals

Modify the "five-minute sharing" exercise so it includes built-in reassurance. For example: each partner shares for five minutes, then names one concrete reassurance ("I will handle the dishes tonight," "I will call the therapist tomorrow"). Or use mediated disclosure: first write it in a letter, then share it while practicing grounding and breathwork, or with a therapist present.

Learn co-regulation techniques

Simple practices — timed breathing, a 60-second hug before hard topics, eye-contact rituals, scheduling tough conversations after basic needs are met — reduce limbic reactivity and keep oxytocin pathways engaged.

Normalize and destigmatize help

Agree in advance on triggers and thresholds for professional support. If one partner has a history of depression, commit to low-threshold reintroduction of care (therapy, short medication trial) at early warning signs. Make mental health care part of the family budget and plan.

Use agreements, not ultimatums

Include relational contingencies in your prenup or partnership covenant — not as punitive measures but as escalation ladders: when we hit X, we will call a specified therapist, implement a temporary caregiving rotation, and access paid respite. Knowing there is a plan reduces panic and preserves trust.

Practice small disclosures

Men can begin by sharing low-stakes feelings — tiredness, frustration — and practicing reassurance language. Over time this scaffolds to deeper disclosures with far less risk.

Commitment matured by preparation is stronger than commitment left to chance. If we treat love as a project worthy of the same foresight we would bring to any other high-stakes venture — finances, health, or career — our relationships have a far better chance of surviving the storms that life inevitably brings. In a world that seems to have lost its moral compass, with social media running interference in normal human relationships having to provide guidance like this is regrettably necessary.

Bibliography

1. Stoller KP. "Three Archetypes of Love: Co-Creators, Protector-Nurturer, and the Shared Path". *Primera Scientific Surgical Research and Practice* 6.4 (2025).