

Managing Postpartum Mental Disorders: An Inside Look at a Mother and Baby Unit

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Abstract

Multiple studies have underscored the value of a nurturing relationship between a mother and her newborn child. This relationship may actually become harmful to the baby, however, if the mother is suffering from a mental illness that prevents her from bonding with and responding to her new baby. What kinds of sociocultural factors complicate the experience of mothers suffering from postpartum mental disorders and of the families of these mothers? What support and treatment models exist for these mothers? This paper stems from my rotation as a medical student at an East London mother and baby unit and its affiliated women's acute mental health ward. It aims to provide an inside glimpse of these mother's stories and to illustrate how this mother and baby unit, in conjunction with local community service agencies, provided a comprehensive system of support and treatment for its patients.

Key Words: mother and baby unit, postpartum mental disorder, mental health services, women's health services

During the postpartum period, up to 80% of women may suffer from a mood disorder, which includes new onset mental disorders as well as the relapse of preexisting mental illnesses. The spectrum of postpartum mental disorders ranges from "baby blues" (experienced by 50-80% of the population) and postpartum depression (seen in 13-15% of

women), to postpartum psychosis (seen in fewer than 1% of the population).¹ These disorders manifest at a period when both the mother and infant are most vulnerable and in need of strong nurturing relationships. In this setting, it becomes imperative that medical professionals and the community offer the family an organized plan of action that balances the mother's need for treatment and support, the child's right to a secure and comfortable environment, and the shared right of mother and baby to stay with each other in the crucial early postpartum period.

I had the privilege of observing one model of dealing with this important public health dilemma during the summer of my first year of medical school when I rotated through a mother and baby unit (MBU) in an East London hospital. Dr. Thomas F. Main conceived the idea of MBUs in the late 1940s at Cassel Hospital.² Today, MBUs are present in select-

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ed hospitals in the United Kingdom, Australia, Canada, and New Zealand, with limited programs available in the United States, France, Israel, Switzerland, and Holland.² The MBU I visited, a four-bed unit linked to a women's acute mental health ward, provides inpatient mental health management to women with severe mental illness during the first postpartum year. The mother and infant are admitted together to a comfortable ward, where an interdisciplinary team consisting of registered mental health nurses, nursery nurses, occupational therapists, and psychiatrists care for them.

The unit provides assessment and treatment and minimizes stress on the mother as she is gradually nursed to an acceptable level of functioning. By keeping the mother in close contact with her infant during this time, the unit ensures bonding between mother and infant in the crucial early months of the infant's life. At the same time, the unit facilitates liaisons with the mother's family and outside support agencies, forging a supportive network, which she and her baby can rely upon after discharge from the unit.

Case 1: "They took her away!"

It was Monday morning, and we were in the middle of weekly ward rounds at the mother and baby unit. The consultant psychiatrist, the student house officer (what we would call a "psychiatry resident"), the occupational therapist, the pharmacologist, and myself, a visiting medical student from the United States, were in the conference room.

I was sitting across from a patient named Shanta who, when questioned about her mood, responded with her usual blank stare and said to her interpreter in Bengali, "I feel like my body is here, but my mind is somewhere else... far away." After some more questioning; however, I finally saw signs of emotion on Shanta's face as she bawled, "They have taken my baby away. They took her away!" I felt a jab of pain in my chest as I looked on, trying hard to maintain a professional demeanor.

Shanta had been in the MBU for the past month, since the birth of her daughter Kiran. She had a 12-year history of schizoaffective disorder, and had been admitted to the acute mental health ward multiple times during this period. Shanta's poor compliance with her medical regimen led to frequent relapses, yet she had had the good fortune of regain-

ing almost complete functioning upon recovery from each episode. This time it seemed, however, that Shanta's luck had run out. She had suffered a massive relapse just prior to her labor and was now unresponsive to treatment.

Social services had taken Kiran after the parenting assessment done by the MBU's multidisciplinary team had pronounced Shanta unfit to be Kiran's caretaker in her present condition. Shanta's husband, Mr. Ahmed, could have challenged the social services decision and requested guardian status, yet in doing so he would have had to show evidence of legal status in England, which he did not have.

Case 2: Denying domestic abuse...

Another interesting patient whom I met during my clerkship was Pinar, a Turkish immigrant. After her postpartum relapse into schizophrenia, Pinar was not considered safe enough to be admitted to the MBU with her baby. Instead, her baby was sent home with her husband, Abdul, and her toddler, Hamdi, and she was admitted to the women's acute mental health ward. Here, after several weeks of treatment, Pinar stubbornly maintained her psychotic delusions.

Pinar was convinced that she was being targeted by evil spirits who were "doing prayers, in Arabic, on her soul" and would, at times, "stuff her with animal spirits" using a TV cable attached to her chest. These spirits told Pinar that she was a bad Muslim because she did not pray and commanded her to take away her children's souls.

What was so unusual about Pinar was that despite these terrifying delusions of persecution, she always appeared calm and, in fact, took special care of her appearance before coming to rounds. Another unusual factor in Pinar's case was that despite improvement at the hospital, she would relapse when sent home for any extended period of time. Pinar had once hinted to her nurses that Abdul had hit her in the past, but denied this on subsequent questioning. Was this stress the cause of Pinar's relapses? Or was Pinar forging her illness to get away from her husband?

Case 3: A happy ending...?

Lastly, there was Saeeda, who was almost ready for discharge from the MBU when I met her. She had been admitted after a classic case of postpartum psy-

chosis. She had presented with mania, screaming and kicking, throwing objects at people and even assaulting one of the nurses on duty the day after she delivered Ismail. After a few weeks of hospitalization and treatment, however, Saeeda was recovering remarkably. She had no more psychotic symptoms, and was bonding well with her son.

At today's ward rounds, both Saeeda's husband and mother were present. Saeeda's mother was eager to have her daughter home soon (They lived in a joint-family system). The psychiatrist emphasized that while her discharge was imminent, Saeeda was still quite vulnerable to stress. She reminded Saeeda's family to take her to the psychiatrist at the very initial signs of a relapse, such as restlessness and insomnia.

Finally, she turned to Saeeda's husband, "and Mr. Khaled, I hope that you will keep in mind our conversation about the importance of planning Saeeda's future pregnancies very carefully. There is a 50% chance that Saeeda will relapse if she gets pregnant a second time. I understand the two of you will be discussing these issues with Saeeda's general physician at your next appointment?" Mr. Khaled nodded gravely, as Saeeda covered her face with her shawl in embarrassment.

The psychiatrist was well aware that while Saeeda had privately admitted to multiple past attempts at suicide, this was her first psychiatric hospitalization. It was clear that Saeeda's family had played a big role in hiding her mental illness, a big stigma in their Somali culture. This had caused Saeeda's obstetric team to be caught off guard with her current psychotic episode.

I was surprised to see that many of the women admitted to the MBU and women's ward during my visit were Muslim and others belonging to minority ethnic groups. These women were struggling with many of the sociocultural challenges facing Muslim women in the United States who have mental illness, such as immigration difficulties, domestic violence, and cultural/familial stigmas. To deal with such issues, the MBU put these patients in touch with local culturally oriented counseling organizations, such as the Nile Center, a 24-hour mental health crisis center for African Caribbean people, and the Asian Women's Advisory Service (AWAS).

I had the pleasure of visiting the AWAS office to learn more about their services. A group of South

Asian Muslim women started AWAS. Trained counselors from numerous religious backgrounds catered mostly to the South Asian population in the neighborhood. AWAS serves as an advocate for mothers and their families, providing immigration counseling, attending hospital visits with mothers and ensuring that they are informed of their rights to healthcare benefits. In order to facilitate social involvement of the mother and heighten her awareness of her own health, AWAS sponsors opportunities for "culturally sensitive innovative physical activities," such as a Monthly Eat for Your Health program and regular exercise programs.

AWAS affords its clients the opportunity to interact with other women of similar backgrounds going through similar experiences, and to receive support from trained counselors who were aware of the specific cultural and religious challenges they face. When asked about how she addresses a woman who may be severely depressed and ambivalent about seeking treatment, one of the AWAS counselors answered, "I do not put my own religious views forward. However, if she happens to be Muslim, as I am, and brings up concerns with a religious basis, I try to explain the importance of seeking treatment for an illness in the Islamic faith."

A number of studies have shown the negative impact of maternal mental health disorders on the development of children. Boys whose mothers suffer from depression in the first year postpartum have been found to score one standard deviation lower on IQ testing than their normal counterparts. These boys also have more behavioral problems in class at 5 years of age, while girls from similar backgrounds appear to be excessively submissive.³ There is evidence to suggest that interventions aimed at facilitating healthy mother-infant bonding (cognitive behavioral therapy, skills training), or helping to improve the mother's mood have some effect on reducing such long-term behavioral problems in their children.⁴

My summer experience instilled in me an appreciation of how devastating maternal mental illness can be for families, even in the short-term. Treating these illnesses is not as simple as treating diabetes or hypertension and can not be limited to medications. Hospitals and local community support services need to work synergistically to also address the multiple sociocultural obstacles. There is a lot that we

can learn from the comprehensive model of the described East London MBU and its associated community organizations, such as AWAS.

Note: The patients and stories described in this article are hybrids of multiple cases seen during my rotation. The names of patients and their family members have been changed to protect the privacy of the individuals.

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