

MOTHER-BABY UNITS IN PSYCHIATRIC HOSPITALS

By COLIN PROTHEROE

Consultant Psychiatrist, Newcastle upon Tyne

Middlewood Psychiatric Hospital, Sheffield, has recently provided facilities for the admission of babies with mothers suffering from psychiatric illness. The venture was sufficiently novel and noteworthy to receive mention in national newspapers, and one gathers that medical and nursing staff are pleased and encouraged by their experiences with their first few mother-infant pairs.

The principle of admitting mother-child pairs

Paediatricians have long recognized the advantages of admitting mothers to hospital with their sick infants. Sir James Spence (1947) introduced the practice at the Babies' Hospital in Newcastle upon Tyne as far back as 1925, considering that it produced greater contentment and less disturbed emotional development of the child, while giving the mother the opportunity of continuing to build her own confidence in the caring role. Bowlby's revelations in the 1950s of the ill-effects of 'maternal deprivation' upon emotional development further supported the cause of those concerned with avoiding separation. Most Children's Hospitals now provide accommodation for mothers with younger children. However, it is still common practice for recently delivered mothers to be discharged from maternity hospitals while their premature or ill babies remain, despite the growing evidence for there being a maternal 'sensitive period' early in the puerperium during which the capacity for establishing mother-infant attachment ('bonding', 'motherliness') is greatest (Kennell *et al*, 1975; Leiderman and Seashore, 1975).

It is surprising that psychiatrists, so conscious of therapeutic atmosphere and group interactions, have shown so little interest in providing for the fostering of the mother-infant relationship, when the mother needs hospital admission for psychiatric illness. Douglas (1956) appears to have been the first British author to describe the advantages of having the babies available to involve in the psychotherapy of psychotic women. Baker *et al* (1961) compared the results of treating schizophrenic mothers accompanied by their infants of under one year in a special unit at Banstead Hospital with those from a group of unaccompanied mothers. They demonstrated a quicker recovery rate and improved quality of recovery, as well as superior

mother-child relationships. Fowler and Brandon (1965) and Bardon *et al* (1968) treated mothers suffering from all diagnostic categories of illness, although predominantly psychotic.

Previous accommodation arrangements

Accommodating children within the psychiatric unit necessitates making special arrangements according to the age limit and the numbers expected, as well as the degree and nature of disturbance of the mothers to be accepted. Some of the mothers are potentially harmful and would abuse or neglect their children. Main (1958) described how he and his colleagues at the Cassel Hospital had admitted babies and toddlers under school age with mothers suffering from neurotic illnesses. They were integrated into the general ward activities, dining, etc, with all the residents. Grunebaum and Weiss in 1963, and in many publications since, have written of their experience of admitting mothers and babies to adult disturbed wards in the Massachusetts Mental Health Centre, the babies being accessible to very disturbed psychotic patients and often involved in their psychotherapy. No physical harm has come to the children.

Fowler and Brandon (1965) managed their pairs in the side rooms of an acute female psychiatric unit, whereas Bardon *et al* (1968) modified a whole ward at Shenley Hospital for the purpose, with its own establishment of nursing staff in a completely integrated unit.

Accommodating older children in the usual adult psychiatric unit would impose great demands upon the available nursing services, space, etc, and a unit specially established would need a constant throughflow of pairs to justify its maintenance. Such units would now appear to have the greatest priority for the assessment and treatment of the disturbed parent-child relationship as discussed by Lynch *et al* (1975).

Less space and other resources are needed if the age of the accompanying infants is limited to under six months. It does, however, allow for what must surely be accepted as the humane and rational management of patients with psychiatric illness precipitated postpartum and those with longer-standing illness who happen to have recently been delivered.

A relatively new but increasing population consists of chronic schizophrenics and women with recurrent affective psychoses who because of the efficacy of maintenance therapy are now living at home, marrying and becoming pregnant. Such arrangements allow for their treatment, assessment and often further manipulation of social circumstances.

Personal experience of admitting mothers with babies under the age of six months

St Nicholas Hospital, Newcastle upon Tyne, is an average-sized psychiatric hospital. It has a relatively modern female acute admission unit of 38 beds. In 1963 a small suite of rooms at one end was modified so as to become our 'Mother-Baby Unit'. It consists of a central nursery which takes up to five cots, and three smaller interconnecting rooms: a milk kitchen, utility room for bathing and weighing of babies, etc, and a small bedroom which accommodates two adult beds.

A large reinforced plate glass window allows mothers, relatives and other patients to look in upon the babies at any time.

The principal criterion for admission of a mother-baby dyad is that the mother suffers from a psychiatric illness which would usually merit hospital treatment. Mothers are admitted like any other women to the acute unit, and apart from the baby-caring take part in the ward activities. They are treated by the particular consultant who admits them, but the unit itself is administered by the writer and a member of his team, a general practitioner clinical assistant, who supervises the medical needs of the babies and advises the mothers on contraception, etc. Usually there is a nursery-trained nurse available in the unit, but when not our married nurses have more than adequately provided the supervision and caring. Because we admit pairs irrespective of the degree of disturbance of the mother, we only allow the mothers into the nursery when a nurse is present. We encourage mother-baby contact as early as practicable, but sometimes several days pass before women admitted with excited psychotic states are able to handle their babies safely or concentrate on feeding. Also, it is not always therapeutically wise to pressurize hostile neurotic women to be with their babies initially. As mothers improve, they may sleep in the small adjoining bedroom and take the babies out walking, and home at weekends.

Up to the beginning of 1976, 190 mother-baby pairs had been admitted. Sometimes we have babies waiting for vacancies while at other times the nursery is empty. Overall, the number of cots caters well for the catchment area of approximately 400,000.

Accounts of the illnesses of those 190 women and the involvement of the babies in them are being prepared for publication.

Outstanding, compared with previously reported series of women admitted with psychiatric illness postpartum, is that 100 mothers suffered from non-psychotic illnesses (82 neurotic reactions and 18 with personality disorders). The whole spectrum of neurotic reactions was represented, often the baby being the object of exaggerated fears or hostility. Obviously; not separating mothers and babies made hospital admission more acceptable as well as allowing for rational therapy.

We cannot prove the value of our unit in statistical terms, but medical and nursing staff would not wish to do without it believing that it is necessary for the provision of a comprehensive psychiatric service. Its existence:

- (1) results in easy and informal admission of many mothers who would otherwise object to separation.
- (2) provides a more therapeutic environment for the treatment of psychiatric illnesses which do involve the babies, and allows stimulation of, and training in, mother-care.
- (3) prevents ill-treatment of some babies and fosters better mother-child relationships, which in the long term will influence the personality of the children and the domestic lives of the mothers.
- (4) allows medical and nursing staff to witness and study the fascinating and poorly documented process of mother-baby interaction and the often dramatic beneficial influences which our treatments can have upon it.
- (5) has a civilizing and comforting influence on an environment which at times is awesome to both patients and staff.

REFERENCES

- BAKER, A. A., MORISON, M., GAME, J. A. & THORPE, J. G. (1961) Admitting schizophrenic mothers with their babies. *Lancet*, *ii*, 237-9.
- BARDON, D., GLASER, Y. I. M., PROTHEROE, D. & WESTON, D. H. (1968) Mother and baby unit: psychiatric survey of 115 cases. *British Medical Journal*, *ii*, 755-8.
- DOUGLAS, G. (1956) Psychotic mothers. *Lancet*, *i*, 124-5.
- GRUNEBAUM, H. U. & WEISS, J. L. (1963) Psychotic mothers and their children: joint admission to an adult psychiatric hospital. *American Journal of Psychiatry*, *iii*, 927-33.
- KENNEL, J. H., TRAUSE, M. A. & KLAUS, M. H. (1975) Evidence for a sensitive period in the human mother. In *Parent-Infant Interaction*. Ciba Foundation

- Symposium 33. Amsterdam, Oxford, New York: Associated Scientific Publishers.
- LEIDERMAN, P. H. & SEASHORE, M. J. (1975) Mother-infant neonatal separation: some delayed consequences. In *Parent-Infant Interaction*. Ciba Foundation Symposium 33. Amsterdam, Oxford, New York: Associated Scientific Publishers.
- LYNCH, M., STEINBERG, D. & OUNSTED, D. (1975). Family unit in a children's psychiatric hospital. *British Medical Journal*, *ii*, 127-9.
- MAIN, T. F. (1958) Mothers with children in a psychiatric hospital. *Lancet*, *ii*, 845-7.
- SPENCE, J. C. (1947) The care of children in hospital. *British Medical Journal*, *i*, 125-30.

TEACHING THE TEACHERS—AN ENCOUNTER

By JOHN SUMNER STEAD

Chairman, Psychiatric Sub-Committee, South West Thames Regional Postgraduate Committee

The psychiatric tutors in the South West Thames Region recently got it into their heads that as no one had ever taught them anything about how to teach it was high time they explored the possibilities. This idea, backed by Professor Dick, the Postgraduate Dean, roughly coincided with the appointment of John Heron as Assistant Director of Medical Education to the Postgraduate Federation. He has been known for years, while working at Surrey University, as an advanced educationalist alarmingly inclined to the use of encounter group methods. Undaunted, the tutors sent out a reconnaissance party, then digested a provisional programme in the form of a contract which talked of facilitative and cognitive learning, the need to study the relationship between teacher and taught, to forego the idea that teachers are born and not made, to accept that techniques of teaching do not take you far unless the relationships are right, and hence the need for group experience and some personal disclosure.

Nine of us met at the Adult Education Centre at Fittleworth, which provides homely surroundings and home-made food. We all knew each other, but we did not know what we were in for, so the first day was spent looking at what tutors actually do and mapping out a programme for the week. Tensions began to express themselves, and two dropped out. That evening we had a gentle introduction to encounter group techniques which resulted in a sudden reduction of tension and the involvement of all in serious discussion. Thereafter for four days we worked hard from 9.30 am to 10.00 pm on an extraordinary mixture of experiential learning, intervention analysis, role playing and role testing and increasingly intense group activity,

with even twenty minutes of didactic teaching thrown in for good measure. It was remarkable to see how, under skilled management, a group of well-defended middle-aged professionals like ourselves could within three days be exposing and helping to resolve some very disturbing personal hang-ups. None of us was untouched by the experience, and I came away knowing that for the first time I did know just a little about the teaching/learning process, but also with that hard-to-describe sense of freedom and elation which comes when some internal knots have been untied. We meet again, three times, for half-day sessions of evaluation and review in the coming weeks.

So the experiment was a success, and we can confidently recommend that senior registrars and tutors in other specialties could benefit from the same experience. In John Heron the Postgraduate Federation has made an appointment which could have a significant and growing influence on medical education.

Thinking more broadly: the subject matter of undergraduate medical education undergoes a slow process of evolution and development. Most would say much too slow. Postgraduate education and vocational training are expanding fields, but have we yet begun to think about medical education as a whole—starting on entry to a medical school and ending on retirement? And how much attention is being paid to the educational process and its techniques? And how much to the teaching of teachers? How many, in fact, of the hundreds of medical teachers in this country have had more training than this small group of tutors in this brief but successful experiment?