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Nursing Mentally Ill Mothers with their Babies

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ABSTRACT

Caring for psychiatrically disturbed mothers and their babies together is an area of psychiatric nursing which has its own particular rewards and difficulties. This paper describes a specialized Mother and Baby Unit with particular emphasis on the role of nurses in assessment and management of mothers and their babies. Risks such as violence and cross infection are dealt with briefly. The particular skills that nurses in this unit have developed in the assessment of the mother/baby relationship and the management of specific bonding difficulties are described in detail. The role of nursing staff in rehabilitation and possible future developments in the service are briefly discussed.

INTRODUCTION

Caring for psychiatrically disturbed mothers and their babies together is still a comparatively rare part of a psychiatric nurse's experience, but it is an area of psychiatric nursing which has its own particular rewards and difficulties. Special experience and understanding can be gained from the intensive care of groups of patients with similar problems; in the case of puerperal mental illness the problems are both practical, for instance caring for a baby when in a disorganized mental state, and psychological, such as coping with conflicts about dependency. This article attempts to share some of our experience in working in one such unit, the Mother and Baby Unit (MBU) of the University Hospital of South Manchester (UHSM) in England. Particular emphasis is placed on the special skills developed by nurses on the MBU in the assessment and management of difficulties in the mother–baby relationship.

THE MOTHER AND BABY UNIT

The Mother and Baby Unit is one of many facilities for admitting mothers with their babies in England and Wales (Aston and Thomas, 1987). It consists of a

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purpose-built ward situated in a 160-bed General Psychiatric Department. This in turn is sited in the University Hospital of South Manchester, a district general hospital which also provides obstetric and paediatric services. The MBU offers a regional service to a population of just over four million, although three-quarters of this population live within 30 miles of the unit. Thus the majority of patients are admitted from within 20 miles of the hospital, even though the majority live outside the catchment area of UHSM.

The Manchester MBU has been open since 1972 and since then has admitted over 600 patients; admission rates in the last five years have been between 50 and 60 mothers per year. Mothers and babies are admitted together as it is believed:

1. The mother's prognosis might be improved.
2. It is important to maintain the mother and baby relationship, and early regular contact with the baby is a significant part of this process.
3. An assessment of the mother's ability to care for the baby is a necessary part of management and may well influence decisions such as time of discharge (Margison, 1982; Margison and Brockington, 1982).

There has been considerable debate about the efficacy of joint admission, but on balance the evidence seems to suggest that keeping mothers and babies together improves outcome (Manning, 1978; Bardon *et al.*, 1968; Lyndsay, 1975; Baker *et al.*, 1961; Lueppker, 1972; Shawcross and McRae, 1986) and that mother and baby units provide valuable centres for categorization of puerperal disorders and research into treatment and outcome (Kumar *et al.*, 1986; Meltzer and Kumar, 1985; Margison and Brockington, 1982).

THE STRUCTURE OF THE UNIT

There are beds for nine women and their babies, with facilities for one set of twins if needed. Each mother has a room of her own, fitted with a cot and supplied with necessary equipment for looking after the baby. The unit policy is to allow mothers and babies to be together as much as possible, including sleeping in the same room. There is a nursery area where babies can be nursed separately from their mothers, either totally or for periods during the day or night. There are also kitchen and laundry facilities and a leisure area. These facilities are designed to allow as normal a routine as is possible within an institutional environment. This routine forms the basis of the pattern many mothers and babies will follow at home, on leave or after discharge.

ADMISSION POLICY

Mothers

The unit offers a regional service to the following categories of mentally ill mothers and their babies:

1. Mothers with psychoses in the puerperium. Admission is for treatment and later help with establishing or reestablishing the mother–child relationship.

2. Mothers who develop a psychiatric illness within 12 months of the birth, who have already established a stable bond with their babies. Admission is for treatment without disrupting the mother–child relationship by separation.
3. Mothers with preexisting mental illness (e.g. schizophrenia) that relapses during the puerperium. Admission is for treatment and later help with establishing or reestablishing the mother–child relationship.
4. Mothers with preexisting mental illness (e.g. schizophrenia) and ongoing symptoms. Admission is for assessment of the mother's ability to cope with the new baby, and to help with the development of coping skills.
5. Non-psychotic mothers who have difficulties in the relationship with their babies that have given rise to significant psychiatric symptoms. Admission is for detailed observation and assessment of difficulties, specific treatment of psychiatric symptoms and to take advantage of the milieu of mothers, nurses and babies.

Excluded are mothers showing no signs of significant psychiatric illness, including social problems and cases of actual, potential or suspected baby battering, and mothers of babies over one year old.

Babies

The babies are admitted as patients in their own right and are seen and examined on admission by a paediatrician from the hospital. Only healthy babies over 5 lb in weight will be nursed on P4, which may delay admission of the mother until such time as the baby is considered well enough to accompany her to the MBU. Most equipment for baby care is provided but mothers are asked to bring their own feeding bottles and clothing for the babies.

THE WARD COMMUNITY

A relaxed, informal ward environment is essential to developing a cohesive ward milieu; an environment of 'family' closeness and trust, in which patients with shared problems can assist and support each other, pool resources and develop self-help skills. A daily routine has developed such that the day is structured in a similar way for all patients. The morning is occupied with practical tasks and chores (changing sterilizers, preparing feeds, etc). There is a recognized break for 'tea and toast' taken by staff and patients in the mid morning, and this time is used to relax and socialize. This group acts as an informal meeting of the ward community, and is often used as a forum for ventilation of feelings or resolving practical problems.

In the afternoon social activities take precedence; patients may go shopping, attend occupational therapy (often geared to domestic skills), entertain visitors or relax with each other and their babies. Twice a week, at a time that can vary according to the needs of mothers and babies, there is a more formal community meeting; this concentrates both on practical aspects of ward organization and, more importantly, on interpersonal relationships within the community. Otherwise hidden fears can be aired; for example, if an assessment of a mother's ability to cope is in progress, other patients will be aware of this and may fear the staff's

powers to remove their own babies. Raising such issues can relieve unrealistic fears and also help the mother being assessed to explore her own feelings about her situation. Other issues that repeatedly arise include safety against threatened or actual violent behaviour; the meaning and nature of puerperal illnesses; and relationships with, and support from, husbands and families.

ASSESSMENT OF MOTHERS

1. At the initial interview with the patient the admitting nurse will make an assessment using the nursing process. This is a problem-orientated assessment, much like that widely used in nursing care. The problem areas of particular interest are baby care, mental state, physical state and social circumstances. Nurses are also directed to focus particularly on the patient's premorbid personality, problems and worries during the pregnancy and labour, and her attitude to the baby, such as was the pregnancy wanted and what were the patient's hopes or disappointments?

2. A bonding chart (discussed further below) is completed twice daily on each new patient.

3. If patients have difficulty expressing themselves verbally it may be of value to have them complete a card-sort rating developed on the ward. In this assessment patients are given a number of cards with statements on such as 'I hear voices'; 'People are behaving strangely'; 'I can't express myself'; 'I can't see any way out'; 'My conscience is clear'; and 'I feel at ease with other people'. They are asked to sort these cards into statements which are true about themselves or statements which are false by 'posting' them in turn through slots marked True and False in a wooden box. The resulting self-assessment can be quickly scored to give an indication of current psychopathology and problems, and the procedure can be repeated during the admission to monitor changes.

MANAGING MOTHERS AND BABIES TOGETHER

Staff need to possess skills in managing mothers and babies together, with an awareness of the special problems that may arise.

Violence to the baby

There is an ever-present risk of violence to a baby if the mother is psychotically disturbed or has a bonding problem with her child (Lynch and Roberts, 1977). Risk factors are high in patients with loss of control of their impulses (e.g. mania, personality disorder), experiencing despair (depressive illnesses), or expressing delusional misinterpretations (depression, paranoid illnesses). The risk is assessed from the patient's observed behaviour, and from that recorded in the bonding charts, for example handling the baby roughly, excessive irritability or shouting, or psychotic ideas that may represent a threat to the baby ('he should be put out of his misery'; 'he's the devil, sent to bring evil into the world').

The close links with the other clinical teams afford the possibility of transferring a mother to a general psychiatric ward, or the specialist ward for acutely disturbed patients, if it is felt that she or the baby or both would benefit from temporary

separation. It is usual to reestablish contact as quickly as possible, usually with gradual reintroduction under supervision.

Having the nursery in the ward permits easy access to the baby while allowing supervision and minimizing potential risk. Nurses are responsible much of the time for determining the amount of contact mothers should have with their babies and therefore it is important that they should have adequate skill and experience for this task. A mother deemed to be at high risk is never left alone with her baby (ideally two staff members should be present) and invariably sleeps apart from the baby.

The risk of infection

Babies are at particular risk of infection, especially gastrointestinal infections. Preserving the mother's caretaking role increases the risk of infection as the mother herself, who may well be disorganized or have poor concentration due to illness, takes responsibility for both hygiene and feeding. Nursing a group of babies aged between one day and one year old in close proximity, using shared facilities and allowing mothers who are often disturbed or disorganized to carry out much of the care carries a substantial risk of cross infection. There may be outbreaks of infection and occasionally babies have had to be transferred to paediatric care.

ASSESSMENT OF THE MOTHER–BABY RELATIONSHIP

Nurses on the MBU have developed the ability to assess a mother and baby relationship through structured observation and recording using 'bonding charts'. This enables them to identify problems and provide or recommend appropriate interventions. Disorders of the mother–baby relationship (Margison, 1982) occur in:

1. Mania. Manic patients show marked disorganization of practical care, and their disinhibition and disorganization may pose a risk to the baby through rough handling or carelessness.
2. Depression. Depressed patients may express flattening or deadening of their feeling for the baby, or show irritability or anger. They may have obsessional ideas about harming the baby. Psychotically depressed mothers may harm the baby under the influence of delusional ideas.
3. Neurosis. Neurotic difficulties may be expressed as anxiety, with fears of inability to cope with the baby and preoccupation with minor setbacks. Severe ambivalence about childbirth or mothering may lead to overt rejection or hostility to the baby. Phobic or obsessional patients may feel revulsion or disgust for the baby.
4. Chronic schizophrenia may be characterized by flatness and deadness of feeling and an inability to respond emotionally to the baby.

Although there is controversy as to whether there is a unique 'sensitive' period in the first weeks of life during which bonding can occur, there is a large body of opinion that the mother–baby relationship is an important focus of interest during puerperal psychiatric illness (Franklin, 1981; Herbert *et al.*, 1982; Lynch and

Roberts, 1977) and a recognition of the role of the nurse in management of disturbances in this relationship (Clark, 1976; Harrison, 1976).

The baby also plays a part in forming or disrupting the relationship. Some babies are excessively restless or sleepless, or cry a lot, or show less social responsiveness to their mothers than others. Feeding difficulties can also interfere with the relationship, especially if the mother is anxious about her role.

Bonding charts

The mother–baby relationship has been an interest of staff on the mother and baby unit for several years, and research carried out on the unit has been described elsewhere (Margison, 1982). This work has allowed staff to develop a standardized assessment scheme that is now routinely used with all admissions. The charts are filled out by the patient's primary nurse or the nursery nurse working with the mother and baby.

Example of a bonding chart

To be written twice a day until no problems relative to bonding occur.

Competence: e.g. disorganized — unable to concentrate or perform tasks with the baby. Indecisive — seeking support and guidance. Baby in staff care.

Response: e.g. no emotional or physical response. Appears mostly unaware of baby, although visited him in the nursery this morning when invited by staff. Responsiveness to baby varies with mental state and mood.

Affection and concern: e.g. little affection demonstrated at 9.00 am but since than has ignored baby. Concerned as to how he'd taken his 9.00 am feed and if he'd been good, but then abdicated all responsibility.

Statements made: e.g. "I shouldn't have had him, then all this wouldn't have happened".

Incidents: e.g. extremely tense at lunchtime. Tried to persist and feed baby but handed over to staff, saying she felt shaky, before falling to the floor in the corridor. Can only have baby in her room during daytime and with staff in close surveillance, due to the safety risk.

MANAGEMENT OF BONDING DIFFICULTIES

The importance of regular contact between mother and baby cannot be overemphasized in the prevention and treatment of bonding disorders. In many psychotic patients the mother's capacity to help with the care of her baby is one of the areas where function is least impaired.

The bonding chart as described above provides a narrative record of a mother's behaviour with her baby. It has the advantage that it can be used by relatively inexperienced staff, but if reviewed regularly by more experienced staff will show any difficulties and dangers that arise. Factors that particularly indicate possible difficulties with bonding are lack of mother–baby eye contact, poor feeding and absent or mechanical handling of the baby.

Overprotectiveness may mask ambivalent feelings towards the baby. Bonding records are used to generate four 'stages' of mother–baby relationship:

1. No relationship problem noted.

2. Isolated areas of difficulty only, for example specific difficulties in practical skills, or expressing abnormal ideas while otherwise coping.
3. Miscellaneous problems, i.e. no overt hostility or rejection but difficulties noted in several areas, for example handling, social responsiveness and practical skills.
4. Evidence of overt rejection or hostility.

Interventions at the nursing level are primarily aimed at support and improving practical competence, reestablishing confidence and self-esteem and assisting patients to return to their previous level of functioning while encompassing the presence of the new baby in their lives. Staff become involved in the care of the baby alongside the mother, offering both practical instruction and a role model. The transfer of care back to the mother is done gradually and in response to her growing ability, confidence and feeling for the baby.

When bonding disorders are not relieved as symptoms of the acute illness remit then nurses implement a behavioural programme, working closely with the mothers. Areas of difficulty are identified, both deficits (handling, failure to respond to cues) and excesses (shouting at or smacking the baby), and short- and long-term goals for change are set. Areas of competence as well as areas of enjoyment are also identified, and a programme is drawn up with the aim of reducing anxiety and enhancing enjoyment for the mother in her relationship with the baby, making activities such as playing, holding and dressing the baby rewarding for both participants.

If there is marked failure to respond appropriately to social signals from the baby then cue cards may be used; for example, if a mother's only response to a baby's crying were to offer a dummy then a checklist of other things to try (nappy, feed, winding, etc) may be given to the mother, with appropriate instruction and demonstration. Nurses work to shape the desired behaviours – acting as a model for the mother, introducing her to new techniques and ideas, positively reinforcing successful interactions, especially by demonstrating the baby's response to her new skills. Illustrative methods may be used to demonstrate aims and progress to the mother. For example, graphs of the relationship between anxiety and enjoyment are used to show the mother how her anxiety may be hindering her experiencing and expressing her positive feelings. Self-rating scales are devised, using the mother's own language, to monitor changes in a mother's self-perception as a mother, attitude to the baby, inappropriate expectations (e.g. too high ideals) and feelings. These scales, usually in the form of visual analogue ratings, are completed with a nurse available to discuss, and help modify if necessary, a mother's subjective evaluation of her progress.

Where bonding difficulties are related to anxieties produced by the birth reactivating feelings in the mother from past important relationships, supportive interventions from the staff can help to break the vicious cycle of anxiety leading to poor coping leading to increased anxiety. However, in this situation more formal psychotherapeutic approaches may be indicated. Occasionally it is felt that exploratory psychotherapy or family therapy are indicated; so far it has not been possible for nurses to be actively involved in these areas. The development of nursing skill in both behavioural and dynamic psychotherapies seems an interesting prospect for the future if adequate training and supervision could be provided.

REHABILITATION AND DISCHARGE

Although patients on the MBU are usually acutely ill during their admission, we aim to keep as much contact with their home environment as possible. Visiting is encouraged at the convenience of the families, who may have work commitments or other children to consider. As soon as it is deemed safe patients are encouraged to spend time at home, beginning with a few hours and progressing to weekends or periods of extended leave. These latter allow assessment of coping at home before ultimate discharge. Health visitors are encouraged to visit during these periods of leave, and local supports such as mother and baby groups can be contacted and involved.

Patients are generally discharged to the care of their local psychiatric services, but usually they are seen at one or two initial outpatient appointments at UHSM. Contact with the ward at this time continues support, allows reinforcement of the positive aspects of recovery, enhances the patient's self-esteem and is good for ward morale. Old patients share their experiences with others on the ward, providing an optimistic example to new patients and encouraging and supporting those facing discharge. It is an important part of the nurses' role to organize or coordinate the delivery of such ongoing support as is felt by the clinical team to be necessary on discharge. For patients within the catchment area of UHSM the community psychiatric nursing services can play an active role in this process. There is also an outpatient support group run by nurses on the MBU for recently discharged mothers.

Rehabilitating and preparing patients for discharge involves liaising with community services so they are informed of both mother and baby's special needs, and potential problems or difficulties. It is unit policy always to inform the local health visitor (who has usually been involved throughout the admission) and the area social services if they have been involved. If there are particular difficulties, or doubt about whether a mother can cope, this may include presenting an assessment of the patient's 'mothering' capacity at case conferences. The social service representatives may rely on nurses' professional judgement as to how much support or supervision to provide, or even whether to take a baby into care.

For the group of patients whose degree of competence is felt to be satisfactory at a basic caring level, but who seem to respond less well to the baby's more subtle emotional or intellectual needs, attempts are made to secure more structured support, for example family care or nursery placements. Here the mother can attend with the baby to continue supervision and education in the community. Mothers may begin attending nurseries before discharge, using the MBU as a support and base during the period of establishment. Family aids may be introduced to assist Social Services in the support of vulnerable patients, and the ward provides a valuable meeting ground where such a relationship can be established.

In addition there are facilities in the unit for conducting a joint assessment of a couple's parenting skills, if both parents intend to contribute to the care of the baby. This is of particular value when each parent may be able to compensate for deficiencies in the other; on several occasions, for example, this facility has been used when both parents suffered from chronic schizophrenia. The family can share a flat within the Department of Psychiatry, a short distance from the MBU, and

care and budget for themselves and the baby with minimal supervision, simulating the demands of domestic life post discharge.

Failures of mothering and family separation

In general most patients suffering from psychotic or neurotic disturbances who exhibit difficulties in competence handling their baby have only temporary problems that resolve, with help, when the illness is treated. With a small group, the outlook is less optimistic.

Some patients are admitted for assessment of their ability to cope with their baby. One such group regularly admitted to the MBU are chronic schizophrenic mothers who have become pregnant. Admission to the MBU is therefore part of an intensive rehabilitation programme. In many cases these mothers are able to take care of the baby, but sometimes the outlook in these terms is poor.

For this reason, when mothers are admitted for such assessment all possible outcomes are made clear from the outset, and an approach is adopted that tries to avoid any sense of reproach or blame from the staff. Other patients will be aware that such an assessment is in progress, and an open approach helps to reduce fears that their babies may be at risk of going into care. In such an assessment it is necessary to observe the patient with the baby as much as possible, so every effort is made to keep mother and baby together, including their sleeping in the same room.

Sometimes it happens that mothers are unable to cope with their babies due to chronic illness or personality difficulties. These children will often become the responsibility of the local social services, and nursing staff may have to attend case conferences and meetings where these decisions are made, perhaps to present their own views. These are always very difficult decisions, and require not only considerable responsibility but also a great deal of strength and understanding to cope with the stress this could place on the relationship with the mother.

Rarely, a mother is aware of her inability to cope but her guilt and anger make it difficult for her to accept this. Staff need to be sensitive when such anger is 'acted out' in the ward and avoid responding angrily. Such patients may place staff in the role of 'uncaring agents of society stealing her baby'. This accusation, however false, can be difficult for staff to handle, especially if an involuntary care order is being invoked.

FUTURE DEVELOPMENTS IN THE SERVICE PROVIDED BY THE MBU

As has already been suggested, development of nursing skills in different forms of psychotherapy is envisaged. Behavioural and psychodynamic methods of helping with bonding problems, family intervention techniques and outpatient group treatment could all be improved, although nursing involvement in these activities will depend on the availability of adequate training and supervision. Ironically, although psychological problems encountered on the ward are related to the birth of a new child, this is found commonly to resurrect in the mother unresolved grief – for a previous stillbirth or dead baby, for a recently deceased parent or relative (especially if the loss occurred during the pregnancy), or for the loss of a parent in childhood. Skills in dealing with issues of loss and bereavement would seem to be valuable, and this needs further assessment. All such interventions need full evaluation – firstly descriptive and then in terms of outcome and the effective (including cost-effective) use of resources.

At present the possibility of introducing a regional community psychiatric nurse, specializing in puerperal disorders, is being explored. The aims of such a service

would include assessing potential admissions in the community, thus ensuring appropriate admissions to the MBU; advising and educating local services so that patients can be cared for locally as far as possible; and continuing liaison with local services providing such care. The educational function would also include teaching primary care workers to recognize psychiatric disorders developing in the puerperium and provide early, effective intervention. The CPN would institute and supervise domiciliary rehabilitation programmes and provide a follow-up service both in the home and by encouraging local support, for example self-help groups. This could potentially reduce the average length of stay on the MBU. There would also be a prophylactic role for a CPN, providing care during pregnancy to mothers who are vulnerable by reason of previous puerperal illness or preexisting mental illness. Finally there is an important role for such a worker in support and education for the husband and the rest of the family. The effectiveness of this sort of extension to traditional care of women with puerperal mental illnesses has never been formally studied, and the development of such a service would have to include careful evaluation.

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REFERENCES

Aston, A., and Thomas, L. (1987). 'Mother and baby facilities in England and Wales 1985–1986', *Marce Society Bulletin*, Summer: 3–12.

Baker, A.A., Merison, M., Game, J.A., and Thorpe, J.G. (1961). 'Admitting schizophrenic mothers with their babies', *Lancet*, **ii:** 237–239.

Bardon, D., Glaser, Y.I.M., Prothero, D., and Weston, D.H. (1968). The mother and baby unit: a psychiatric survey of 115 cases. *British Medical Journal*, **2:** 755–758.

Clark, A.L. (1976). 'Recognising discord between mother and child and changing it to harmony', *American Journal of Maternal Child Nursing*, March: 100–106.

Franklin, A.W. (1981). 'Mother and infant bonding', *Journal of the Institute of Health Education* **19:** 5–9.

Harrison, L.L. (1976). 'Nursing intervention with the failure-to-thrive family', *American Journal of Maternal Child Nursing*', March: 111–116.

Herbert, M., Sluckin, W., and Sluckin, A. (1982). 'Mother and infant bonding', *Journal of Child Psychology and Psychiatry*, **23:** 205–221.

Kumar, R., Meltzer, E.S., Hepplewhite, R., and Stevenson, A.D. (1986). 'Admitting mentally ill mothers with their babies into psychiatric hospitals', *Bulletin of the Royal College of Psychiatrists*, **10:** 169–172.

Luepker, E.T. (1972). 'Joint admission and evaluation of postpartum psychiatric patients and their infants', *Hospital and Community Psychiatry*, **23:** 284–289.

Lynch, M.A., and Roberts, J. (1977). 'Predicting child abuse: signs of bonding failure in the maternity hospital', *British Medical Journal*, **i:** 624–626.

Lyndsay, J.S.B. (1975). 'Puerperal psychosis: a follow-up study of a joint mother and baby treatment programme', *Australian and New Zealand Journal of Psychiatry*, **9:** 73–76.

Manning, M. (1978). 'Babies in mental hospitals', *Community Care*, July: 22–24.

Margison, F. (1982). 'The pathology of the mother–child relationship'. In: Brockington, I.F. and Kumar, R. (Eds) *Motherhood and Mental Illness*, Academic Press, London.

Margison, F., and Brockington, I.F. (1982). 'Psychiatric mother and baby units'. In: Brockington, I.F. and Kumar, R. (Eds) *Motherhood and Mental Illness*, Academic Press, London.

Meltzer, E.S., and Kumar, R. (1985). 'Puerperal mental illness, clinical features and classification: a study of 142 mother and baby admissions', *British Journal of Psychiatry*, **147:** 647–654.