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Women with Postpartum Psychosis and Their Babies: Then and Now

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Introduction

In March 1881, a 31 year old housewife, 'Mrs Z', was admitted to the Royal Edinburgh Lunatic Asylum. According to her case notes, she had given birth a month previously. The medical staff recorded that she "constantly moaned and cried ... thought she was lost...There was considerable motor restlessness with wringing and claspings of hands... her sleep and appetite were poor... she believed that she had committed some terrible crime, that God was to punish her and would never forgive her. She said that there was no hope for her and that she must go to hell." She had to be restrained to prevent her from committing suicide. (Rehman et al, 1990, p.865).

Nine years later another woman, 'Cecilia M', was admitted to Bexley Asylum near London. She had given birth seven days previously. In a letter written later, while she was recovering, she wrote, "I believe I was raving mad for over a fortnight ...I could not sleep after baby was born so I suppose that affected my head. I was took away about the 6 January and I did not realise anything until about a fortnight ago, and every day since then my memory gets stronger. I believe I gave them a lot of trouble. It took four of them to hold me down at times" (cited in Hide, 2014, p.128). The hospital case notes reveal that she indeed need to be restrained, both manually by asylum nurses but also chemically by a variety of drugs. She was experiencing vivid hallucinations and refusing food and drink (Hide, 2014).

'Puerperal Insanity'

Their stories are just two examples of a phenomenon that has long been recognised in that some women experience mental distress and illness in the period related to their giving birth (Seager, 1960). It was only in the early nineteenth century, that this was formally labelled as 'puerperal insanity.' It was an obstetrician, Dr Thomas Gooch, who first defined and described it in 1820. He said, "During that long process, or rather succession of processes, in which the sexual organs of the human female are employed in forming, lodging, expelling, and lastly feeding the offspring, there is no time at which the mind may not become disordered; but there are two periods at which this is chiefly liable to occur, the one soon after delivery when the body is sustaining the effects of labour, the other several months afterwards, when the body is sustaining the effects of nursing" (Gooch, 1820,p.364)

Marland (2004) has argued that physicians in the nineteenth period concentrated almost exclusively on, what was then described as, violent mania and severe melancholia. This term was therefore, in many ways, the precursor of what is now often termed puerperal or postpartum psychosis. There was, she argues, little discernible interest in less severe forms of mental distress which would today be described as postnatal depression or dysphoria and the 'baby blues'. As Loudon (1988,p.76) notes, "it was the acute and sudden onset of mania ('raving madness') which was the most obvious, the most florid form of puerperal insanity and the most common form in lunatic asylums." It was also, "at least as common, if not more so, in the upper as in the working classes" (Loudon, 1988,p.78).

Dr MD Macleod, Medical Superintendent of the East Riding Asylum in Yorkshire, described some of the women he had seen in an address on puerperal insanity in 1886. "The patient neither eats or sleeps well" he said. "She is unconcerned about her child, or actively hostile to it, and she is suspicious about her husband and relatives". In its manic stage women can experience, "great restlessness, loud and rapid talking, fleeting delusions, and vivid hallucinations" such that other people are "mistaken for fiends, devils and monsters: volleys of abominable oaths and obscenities are discharged at them" (Macleod, 1886,p.239). Women with melancholia (or depression), were in his experience, less common than those with "excitement" (mania) and often, he said, were "morbidly anxious about her husband and child, and she is fretful, and does not readily enter into conversation." (Macleod, 1886,p.240). Theriot (1990,p.74) in her study of puerperal insanity in the nineteenth century argued, that "by far the most shocking symptoms of puerperal insanity" to physicians were women's indifference or hostility to their babies and/or husbands and women's tendency to obscene expressions. So frequently was "hostility or aversion to husband and child" noted that it was considered by doctors to "one of the defining characteristics of the disease, and physicians recommended that the woman not be left alone with her infant" (Theriot, 1990, p.75).

The locus of care

A common feature of women's mental health care is that it became increasingly institutionalised as the nineteenth century progressed (Showalter, 1985). Brockington (1996) has described the asylum era as having a "disastrous effect" on the management of women with puerperal psychosis which continued for much of the twentieth century also. "Many of these patients have been incarcerated in asylums", he argued, "exposed to infection and out of touch with their infants and family" (Brockington, 1996, p.234). This was supported by Howard (2000,p.1) who investigated medical attitudes and management of postpartum psychotic disorders with respect to the care of the mother with her infant from 1900 to 1960 and found that, "there is considerable evidence from many sources that mothers with postpartum psychosis in the first half of the twentieth century were usually separated from their infants, whether they were managed at home or, in the case of the poor, in asylums."

However, while the locus of mental health care is often seen as being the remit of the institution well into the late twentieth century, writers such as Bartlett and Wright (1999) have argued that the situation was much more complex and that many mentally ill people did remain at home. As Shepherd (2014,p.79) notes, "It is overly simplistic to suggest that husbands and other relatives routinely used asylums to dispose of unwanted individuals ... there is a great deal of evidence from patients' letters and case book notes which show that many families of all classes, cared deeply about their unwell relatives ... (and) sought custodial care as a last resort."

This encompasses women experiencing postnatal distress and Marland (1999) argues that many women seemed to have remained at home. This could be by default, she argues, because the family simply struggled on until the woman recovered or in the case of wealthier families, private care may have been obtained either at home or in a smaller private institution. For example, Isabella wife of the author, William Thackeray who developed puerperal mania and attempted suicide after the birth of her third child in 1840 was eventually cared for by a nurse in Camberwell after Thackeray found himself unable to entrust her care to an asylum, even the well-regarded York Retreat (Marland, 1999) Sometimes the woman was removed to another location such as a country cottage or to the seaside, if funds allowed.

Treatment approaches

Treatment varied but generally took the form of, what was known as, moral management, which "stressed the authority of the physician, the importance of attendants and the avoidance of excitement" (Marland, 2003, p.61). Husbands, children, family and friends were all excluded and replaced by attendants or nurses. Whether at home or in hospital, skilled nursing care was advocated, and initial treatment could include a nourishing diet, seclusion from the baby, husband and relatives and promotion of rest and sleep. Generally, "hefty drug regimes" were avoided in favour of tonics such as beef tea and gently purging (Marland, 1999, p.49), although drugs were used when women were unable to sleep, or were so agitated restraint was deemed necessary. The need for close supervision was also stressed as the risk of self-harm or harm to others was recognised. Once she began to improve, exercise and

activities such as sewing and knitting and visits from friends and family were all used to promote recovery (Macleod, 1886). Part of Mrs Z's treatment in Edinburgh (1881) consisted of extra milk and custards, 6 ounces of sherry, a pint of porter, a tonic, potassium bromide and chloral. She was discharged as 'recovered' three months after admission (Rehman et al, 1990,p.865).

Interestingly, Marland notes (2004, p.60) that in all the discussion about where and how the patient should be treated, the baby got "short shrift". It was, she argues, simply assumed that someone would take care of the newborn in the mother's absence. In poorer families infants were boarded out under Poor Law provision to be cared for by other women, but many infants were kept at home with family members, or, in richer households, a nurse was employed. As she notes, "the absence of debates on the impact of separation of the infant from the mother is striking" (Marland, 2004, p.60). Medical textbooks, when they did mention this topic firmly advocated that the mother and baby should be kept apart. For example, in their 1932 work, 'The principles and practices of psychiatry' Cannon and Hayes stated, "In all cases of puerperal insanity the child must be taken away from the mother as soon as the first signs of mental disorder manifest themselves. The mother must not be allowed to nurse it" (cited in Howard, 2000, p.2) This could be seen as a negative aspect of treatment at this time, although it could be argued that the ultimate goal was to get the mother better, so that she could then be restored to her baby and family.

The inter war years were to see a rise in popularity of a variety of physical treatments in psychiatric practice and this included, from the 1940s, electro-convulsive therapy (ECT) The 1950s were to see the introduction of new drugs such as anti-depressants and neuroleptic tranquilisers such as chlorpromazine (Nolan,1998). While the diagnosis of puerperal insanity seems to have been a nineteenth century diagnostic term, woman continued to be admitted in mental distress following childbirth (Allan Campbell, 2017). Some women with symptoms of what was increasingly termed puerperal or postpartum psychosis would have experienced some of these physical treatments also (Nolan, 1993).

Legislation also heralded changes in the situation for mothers admitted to psychiatric hospitals. Before 1930 all inpatients in mental health institutions were committed or compulsorily detained and it was only with the Mental Treatment Act of 1930 (later extended by its successor the Mental Health Act of 1959) that the concept of the voluntary patient was introduced (Rogers and Pilgrim, 2001). As McCrae and Nolan (2016, p.77) note this meant that, "a mother with puerperal psychosis...could now be admitted without the stigma of committal under the Lunacy Act".

Mothers and their Babies.

Four main assumptions have been posited to explain why medical staff felt that mentally ill mothers should be separated from their children on hospital admission (Grunebaum et al, 1975, cited in Howard, 2000). The first assumption was concern about the mother demonstrating hostility towards her child and a lack of affection for

the baby. The second assumption was drawn from many early twentieth century textbooks which warned of the risk of murder or suicide due to the belief that in her violent rages the mother may seriously injure or harm the child. The third considered the threats or potential dangers that the child may have faced from other patients in the institutional setting. Finally, the fourth assumption was based on a perceived belief that the presence of a young child on an adult psychiatric ward would have seriously disrupted the therapeutic management of the ward and thus been harmful to other patients. However, there were other reasons why mothers showing any form of mental illness were kept away from their children. Medical staff including psychiatrists in the early twentieth century were mainly male and the few female doctors who worked in the institutions were of low professional status, as were the nursing staff. They may have been more open to the advantages of keeping a mother and baby together during this traumatic experience but male psychiatrists often paid little attention to child care issues that could occur when mothers were separated from their babies. An analysis of papers published in their professional journal, the *Journal of Mental Science*, between 1910 and 1960 on this subject do not make any mention of childcare other than the importance of separation and the danger of harm and possible murder (Howard, 2000).

Mother and baby units

The traditional practice of treating mothers with post-natal illness by separating them from their babies continued until the 1960s but changes started to occur in 1940s and 1950s. Some health care staff had become increasingly aware of the disruption in the mother-child relationship that can be caused when mothers and their infants are separated, thanks to the pioneering work of René Spitz and John Bowlby (and later Mary Ainsworth amongst others) who played a key role in researching and identifying this, including the concept of attachment (Howe, 2011).

Pioneering psychiatrists such as TF (Tom) Main at the Cassell Hospital in Surrey began to admit mothers with their children from 1948 onwards and by 1955, he made it a condition of admission that mothers should bring their young children with them when being treated for a mental health problem (Main, 1958). Howard (2000) notes that these admissions sometimes had a practical basis as there was no-one available to care for the patient's children and indeed Main's first admission in 1948 of a mother and her toddler was for this reason (Brockington, 1996). Nevertheless, they were to pave the way to a profound change in practice and prognosis. As Main (1958, p.847) noted, "in the hospital, severely disturbed mothers, terrified, depressed, or impulse-ridden women become able to mother their children, with increasing mutual benefit, and eventually to help other mothers and children".

It is also important to note that these early admissions had what were described as neurotic symptoms rather than being psychotic, so arguably the babies were at less risk. The Cassell Hospital was atypical in that it concentrated on neurotic disorders and pioneered the use of psychotherapy. Dr Gwen Douglas, writing in the *Lancet* in 1956, published a series of case reports on treating mothers with the more serious postpartum

psychosis together with their babies at the West Middlesex hospital (Douglas, 1956). Again, the mothers received psychotherapy. At Shenley hospital, a large psychiatric hospital near St Albans, another pioneering psychiatrist, Russell Barton established a mother and baby unit in 1959, having first admitted a mother and her baby in 1956 (Barton, 1977).

At Banstead Hospital in Surrey Dr AA Baker and colleagues reported their work in admitting “schizophrenic mothers with their babies’ (Baker et al, 1961, p237). They compared twenty admissions with another twenty women admitted without their babies. They argued that amongst the former group, the mothers tended to make a better recovery than the latter, have a lower relapse rate and were more likely to look after their babies after their discharge. They remarked, that “on reflection it seemed possible to us that the prognosis was made worse by the practice of separating mother and baby, and that their admission together might be therapeutic” (Baker et al, 1961, p.237). One woman, who was admitted to Severalls Hospital in Essex after the births of all her three children with severe post-natal depression, contrasted her experiences in an oral history interview and her story illustrates these changes well. Her first admission was ten days after the birth of her child. “When they sent me away” she recalled, “I didn’t have my baby with me, they took my baby away from me, I mean my baby was only two weeks old. I was in Severalls for three months without my baby. I was only 19” (Gittins, 1988, p.130). The admission following her second delivery was also without her baby. By the time she had her third, Severalls had opened a mother and baby unit (in 1967) and she reported that she felt she had a closer bonding with her third child as a result (Gittins, 1988).

The situation today

Today postpartum psychosis (sometimes referred to as puerperal or postnatal psychosis) remains a serious mental health issue which often begins suddenly following childbirth. Symptoms can include hallucinations and delusions, often with mania, depression or confusion. It has been estimated that over 1400 women experience it each year in the UK, that is between 1 and 2 in every 1000 mothers (Action for Postpartum Psychosis, 2018) An episode can be very frightening for women and their families. Most women go on to make a full recovery, however the journey to full recovery can be long and difficult. Jane Fisher, herself a community mental health nurse, gives a vivid account of her own experience of postpartum psychosis, following the birth of her third child, Bella, which resonates with the nineteenth century experiences at the beginning of this article. “My distorted mind told me Bella did not know who I was and she wasn’t even mine” she said and “these paranoid and suspicious thoughts developed further and I felt people were watching me. I worried about cameras being hidden in windows and people watching me from cars. (Fisher, 2017,p.5).

Aiken (2000) argues that statistics show that women are 33 times more likely to be admitted to a psychiatric unit after having their first child than at any other time in their lives. Mother and baby units (MBUs) therefore continue to provide inpatient

psychiatric care for mothers who may be exhibiting serious mental health issues following the birth of their baby. These issues can range from displaying signs and symptoms of postpartum psychosis to severe depressive, anxiety and bipolar disorders (Gillham and Wittkowski, 2015). Mothers are normally admitted to the units with their infants up to a year after childbirth. Current UK clinical guidelines state that “women who need inpatient care for a mental health problem within 12 months of childbirth should normally be admitted to a specialist mother and baby unit, unless there are specific reasons for not doing so” (NICE, 2014). However, these units have been scarce in the UK, with only 17 in total. Mothers sometimes having to travel great distances to access them or find that there are no available beds and have to be admitted to general psychiatric wards where they are unable to have their babies with them (Stephenson et al 2018). Last year NHS England pledged to invest £365 million to provide 4 more units and stated that those that already exist will be given extra beds (NHSE, 2017). This illustrates that mother and baby units remain the recommended treatment choice (Kenny et al 2013, Christl et al 2015, Stephenson et al 2018). Gillham and Wittkowski’s review (2015) found evidence that MBUs positively impact on maternal mental health, the mother–infant relationship and possibly child development. Their review however highlighted “the limited quality of existing research” and suggested “future studies should include detailed analysis of the units under study, including size, staffing, and intervention approaches, allowing units to be contrasted and outcomes compared” (Gillham and Wittkowski, 2015 p. 474).

Other research studies have found that mothers have mixed feelings about their experiences of MBUs. For example, Neil et al (2006), who developed the Mother and Baby Unit Satisfaction Questionnaire, discovered that mothers’ satisfaction was high, especially with the baby equipment available, visitor arrangements for partners/relatives and partner involvement with the baby, in the unit they studied, but that mothers were least satisfied with their involvement in their care and organised activities. It seemed that some mothers did not always readily adapt to staying in the MBU with their babies. Instead some found aspects of being in hospital challenging due to the loss of freedom and the very structured nature of the hospital routine. Aiken (2000) interviewed 9 women who had been on MBUs (in addition to discussing her own experiences.). She found that whilst they all valued the support given to them as an inpatient, they felt that continuity of care at home can be missing following the birth of the baby as the relationship with the midwife is normally a fleeting occurrence. A common theme across those interviewed seemed to be a need for more collaborative partnerships between professionals and mothers (Aiken,2000).

Conclusion

This article has provided a brief overview of postpartum or puerperal psychosis, then and now. It has charted how both diagnosis and care has evolved over time and how attitudes towards separating women and their babies have changed to an acceptance that, if possible, admission to a mother and baby unit is the most appropriate and evidence based source of action for both mother and baby.

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