Poinso F, Gay MP, Glangeaud-Freudenthal N.MC & Rufo M (2002) Care in a Mother-Baby Psychiatric Unit: analysis of Separation at Discharge. ***Archives of Women's Mental Health*****, 5/2, 49-58**

CARE IN A MOTHER-BABY PSYCHIATRIC UNIT: ANALYSIS OF SEPARATION AT DISCHARGE

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Running title: Mother-baby psychiatric unit: separation at discharge

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SUMMARY

Joint psychiatric admission to a Mother-Baby Unit (MBU) enables a mother to obtain care for psychiatric disorders and simultaneously receive support in developing her identity as a mother. This care is meant to prevent attachment disorders and mother-baby separation. Outcome on discharge, however, may differ according to the mother's admission diagnosis. Demographic data, clinical features of parent and child and clinical outcome of 92 consecutive admissions of mothers and their children to a MBU in Marseille were collected over a period of eight years (1991-1998).

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Separations occurred in 23% of the joint admissions. Women with acute postpartum psychoses and major depressive disorders had better outcomes than those with chronic psychoses: at discharge, the latter were more often separated from their children. In those cases, however, MBU admission provided time to arrange the best solution for the child's placement. Outcome was less predictable for non-psychotic personality disorders and depended not only on the mother's disease but also on the family and social context.

KEYWORDS

Mother-baby unit, Mother-baby separation, postnatal mental disorders

INTRODUCTION

The psychiatric hospitalisation of a mother with her infant requires a very specialised treatment unit (Guedeney et al, 1986; Cazas et al, 1990; Kumar et al, 1995; Durand, 1997; Poinso and Rufo, 2000). In France, these units are most often managed by child psychiatry departments, even though it is the mother who is mentally ill (Sutter and Bourgeois, 1998). We outline here the operation and goals of such a unit. We also analyse, based on a series of 92 consecutive mothers and their infants admitted into this unit, the situations that led to separation of mother and child.

Broadly, mother-baby hospitalisation can be proposed in four types of situations:

- The first indication involves acute disorders, apparently psychotic, of the puerperium (acute postpartum psychosis). Postpartum psychoses occur in one or two deliveries per thousand (Cox, 1998; Kendell et al, 1987; Brockington et al, 1982; Pritchard and Harris, 1996). They are primarily mood disorders (confusional depression, atypical manic states) that fall within the framework of a bipolar affective psychosis (Kumar et al, 1995). It is thus necessary to treat the mother's acute episode and at the same time to avoid any unfavourable consequences of an early and prolonged separation of mother and child, in particular, severe attachment disorders (Bowlby, 1977).
- A second indication concerns various disorders, anxious or neurotic, and then depressive, that can affect the mother-child relationship, and sometimes cause it to turn cataclysmic when the "transactional spiral" (Stern, 1981) goes wrong. This category includes depressive syndromes, sometimes very serious (major depressive disorders). The line that, for diagnostic purposes, separates these syndromes from acute postpartum psychotic episodes (which also include mood disorders) is not always clear. The psychotic episodes

appear in the days or weeks following childbirth. On the other hand, depression without psychotic characteristics often develops more insidiously and later, more than a month after delivery.

Postnatal depressions affect 10-15% of mothers (Cox et al, 1993; O'Hara and Swain, 1996; Glangeaud, 1999). Although its repercussions on the infant's cognitive development are substantial (Murray, 1992), it is not often considered to require hospitalisation. First, a young mother's difficulty in rapidly expressing her need for treatment is a particularity of this period of life (Lussier et al, 1995; Poinso et al, 1996). Second, the combined hospitalisation of mother and baby is an extreme measure that can be considered only when multiple problems, personal and environmental, are combined: emotional isolation, problems in relationships or at work, neurotic anxiety revived by real events, etc.

- In the third category of indications we find situations in which an early mother-child bond must be promoted in very serious medical, social, and psychiatric situations. This involves cases in which the mother suffers from schizophrenia or from serious non-psychotic personality disorders.

- Finally the fourth category involves children with functional symptoms (sleeping or eating disorders) or developmental delays (psychomotor retardation), when they can benefit from a mother-child hospitalisation setting, for short-term inpatient treatment. In the latter category, the parents normally are not mentally ill; it is the child who has a disorder.

Our aim here is to describe care in the Marseille mother-baby unit and to compare the women in our series who were separated from their babies from those who were not.

SAMPLE AND METHODS

Sample

All joint admissions of children with their mothers to the mother-baby unit at the Marseille (France) University Hospital Centre were collected over a period of eight years (1991-1998). The unit has a capacity during the week, day and night, for four "families". A limited number of mother-baby pairs can also be treated in "day" or even half-day hospitalisation, from Monday through Friday. The architectural and administrative conditions also enable the father to be hospitalised, when he is present and willing (Poinso and Soulayrol, 1998). During the study period (1991-1998), 100 children (including some brothers or sisters, and one pair of twins) and 92 mothers were admitted to our MBU. Seven mothers were hospitalised with a baby and an older child and one with a pair of twins. Among these hospitalised sibling groups, only the twins were separated from their mother. We were able to meet 69 fathers during this period. Twenty-one fathers asked or agreed to stay in the MBU while the mother and baby were there. The collection of information about the population's characteristics could not be exhaustive, because of the isolation of some mothers and their difficulty or reticence in providing us with some information. The difficulties were even greater for fathers. **Mothers' characteristics** (Table 1): The mean age of the mothers was 30 years (range: 17-47 years). More than a third of the mothers (39%) had a history of psychiatric hospitalisation. Very few had already had a child placed (4%). Fourteenmothers (18%) did not have their own home at the time of their hospitalisation. Only one third (35%) were employed. More than a third of the women were neither married nor living with a partner at their admission to the unit. **Fathers' Characteristics:** Sixty-nine fathers (75%) were seen at our MBU at least once. The mean age for fathers was 33 years (range: 21-55). Fifty-eight fathers (84%) were employed, 18 had at least a primary school education (28%) and 53 were born in France (82%). Among the 69 fathers seen at our MBU, eleven (12%) had the following psychiatric problems: schizophrenia (N=1), major depression (N=2), personality disorder (N=8). The other 23 fathers (25%) never came to our MBU for a variety of reasons: father unknown (N=8), dead (N=1), or did not want or could not participate in MBU care (n=14). Among the 69 fathers, eleven had a known history of psychiatric hospitalisation; 25 did not; and we had no information on this subject for 33 of them. **Children's Characteristics** (Table 2): Of the 48 children younger than 6 months old, half were younger than 1 month (n=25), a quarter between 1 and 3 months (n=11) and a quarter between 3 and 6 months (n=12). Only 4 children were older than 5 years at

admission (and all were admitted for eating or sleeping disorders). The mean age for children at admission was 18.5 months. The sex distribution was 52 boys and 48 girls. More than half the children presented no symptoms.

Measures and diagnostic instruments

Mothers (and fathers, when they were seen at MBU) were independently diagnosed according to *ICD-10* by two psychiatrists at the Marseille MBU. When mothers or fathers were already patients in a psychiatric department diagnoses were made after consensus among the psychiatrists. Demographic data, clinical features of parent and child and clinical outcome were collected. The children's diagnoses were based on developmental assessments performed by two psychiatrists and a psychologist in our MBU and on the observations by the child nurses of behaviour (including eating and sleeping disorders) and development. These were collected and discussed weekly until consensus was reached.

RESULTS

DESCRIPTION OF CARE IN THE MARSEILLE MOTHER-BABY UNIT

The goal of this unit is to care for a mother with her baby, sometimes from birth, and to encourage the development of a good relationship between mother and child, despite the mother's (or parents') serious psychological problems, temporary or more long-lasting. The therapeutic setting is founded on the consistency of the team, a consistency that does not prevent differentiation. What we offer is treatment: treatment of the mother's postpartum illness and treatment for the mother-baby relationship. Nonetheless we must also assess the problems presented. This assessment is sometimes made jointly with the other medical and social agencies involved with the family. It never, however, takes the form of an expert

evaluation to be submitted to the judge considering measures to protect the child. It is the treatment project that remains the exclusive reference.

Our action is based on continuity: continuity of presence for mother and child, day after day, week after week, with, nonetheless, separation on weekends when the unit is closed. During the hospitalisation, the baby is never alone, and the mother only rarely, and then only if she so wishes. The first principle of support consists of not taking over the parents' role in the child's daily care. It is the mother, sometimes the father, who prepares and gives the baby his bottle, who bathes and changes him, carries him, rocks him, and puts him to bed. The child-care giver adopts a reserved but available attitude and remain present at moments that are perceived as anxiety provoking (bath time, for example). They must nonetheless accept the mother's request to take her place when she asks, for a given moment or more regularly. The limits of our neutrality and our abstinence depend essentially on two factors: a) the protection of the child, if the mother appears inadequate, violent, or insufficiently reassuring; b) the mother's request for intervention. The relationship between the mother and the caregivers implies that parental images are projected; establishing it therefore requires that the caregivers' responses be carefully worked out. Analysis of the caregivers' interventions is an essential foundation of the weekly team meeting.

Such a unit is a privileged viewpoint for observing early mother-child interactions, as part of a clinical research aspect that is highly motivating for the caregivers working there. This observation follows the basic principles of the method outlined by Bick (1964) for direct observation of babies. We recognise now that it has a broader range of applications

than the caregiver training technique initially described by her: nurseries, day-care centres, home visits (Houzel, 1994). This observation is intended to contain the emotions and the anxious tension of baby and mother. These tensions and emotions have been conceptualised by the above-mentioned authors as projections by the baby, contained by the mother, who is herself supported by the therapists in her function of containment.

The need for increased reliance on the family and social network available to the baby and mother becomes progressively more evident. The initial isolation of the mother-baby dyad is often misleading. Time is required for the mother's circle -- whose members often have their own problems -- to come forward in a more adequate and supportive manner. Too hasty a determination by the team of what this mother and this baby require prevents the implementation of the progressive solutions and flexible childcare arrangements that in the long run seem to protect the child's development best (help from the grandmother, for example). The caregivers must be willing to work with whoever comes -- father, grandparents, uncles, and aunts. They must also accept the establishment of a sort of multi-parent situation during a transition period, because it might lead to effective long-term family support.

The work proposed in this unit thus consists in helping the parents develop an identity as a parent, through real experiences, as close as possible to everyday life. This could avoid the pitfall noted by David (1987) and Lamour (1989), who pointed out that the discourse of many schizophrenic mothers to their psychiatrist about their baby and their relation with him contradicted their attitudes as observed by the caregivers closer to the children. This situation leads to rifts between the caregivers and makes it difficult to promote either the

bond or the separation. The continuity of daily life, on the other hand, leads some mothers to accept their problems more realistically and to search for appropriate solutions with the team.

Within this mother-baby unit, different types of psychotherapeutic approaches can be offered:

- Mother-baby psychotherapy in the strict sense of the term (Cramer, 1989; Lebovici and Weil-Halpern, 1989) is rarely possible. These different types of psychoanalytic therapy, even those that do not involve an analysis of transfer, require that the parents can make links between the past and the present and can accept reintegrating the parts of themselves that they have projected onto the baby: for example "He doesn't want to eat what I give him" might become "I am anxious that he is not getting something he needs". In the situations we have encountered, this type of psychotherapy is applicable to only a minority of families, and only those with neurotic rather than psychotic problems.
- More often we deal with parental affects that have been massively divided and which the parent cannot recognise rapidly as a component of his or her own psyche. The child can thus be the parent's persecutor, or the sick child who must be cared for, etc. Psychotherapy must thus avoid interpretation; instead it should propose a review and working out of the daily experience, as support for a parental representation, recognition of the child's current needs and anticipation of his development. The consistency of the attitudes of the members of the team is fundamental. For the most seriously ill mothers, the therapist must sometimes speak to the child to translate the maternal affect, which is marked by serious confusion between the mother's own needs and those of her child, or by fluctuations in her investment in the child, with alternating approaches and withdrawals.

- Sometimes the mother wants to see the psychologist or psychiatrist alone: "It's me who has problems, not my child". Initially the therapeutic approach, even in the child's absence, is centred on the condition of parenthood and the bond to the child. For a few women, however, this therapy becomes a personal work over the long haul and can continue after the joint mother-baby hospitalisation is ended. Nonetheless even in such a case, the work on the bond between mother and child remain an essential aspect: it functions as a metaphor for a more global work on bonds, in these "borderline" or psychotic illnesses that can be considered as diseases of the bond.
- Drug treatment is often necessary. If the mother is followed by a psychiatrist treating adults, we prefer that the prescription and the surveillance of the medication be managed by this physician. When we meet the mother before any other psychiatrist does, we handle her medication during the acute period.

Our operation is on the whole based on great flexibility in the treatment we offer. This adjustment is possible within the limits imposed by the need to protect the child. It is made week after week with the family (hospitalisation during the week or for briefer periods, home visits), in partnership with medical-social agencies whose functions are different from ours. The prognosis is thus based on the capacity of the parents and child to use a supportive and caring framework.

To the extent that we do not offer hospitalisation over the weekend, separation from the unit is planned in the initial contract. This requires that a family network be mobilised. Usually, in acute postpartum pathology, the father and the grandparents take the relay for the weekend. Chronic mental illness is often accompanied by deterioration of family

bonds, and in these cases these relays are more difficult to organise. The separation of mother and child is a judicial decision that is taken from the beginning of the hospitalisation when there is no family network to handle this relay, or during or at the end of hospitalisation in our unit, if it becomes clear that the parents cannot care for the child alone.

The length of admission to our MBU ranged from one week to more than a year. Because of the wide dispersion of this duration and the transitions from full- to part-time hospitalisations, we cannot really report a mean duration of stay in the unit. We can only say that nearly 50% of these mother-baby pairs stayed in the unit from 3 to 6 months. Short-term admissions were usually due to the mother's refusal to continue with the joint admission or for practical reasons, such as relocation. They sometimes also resulted from an early transition to outpatient care.

ANALYSIS OF SEPARATION AT DISCHARGE (Table 3 and 4)

Overall, during the study period, 71 babies and their siblings were discharged from the MBU with their mothers; 22 children, including one pair of twins, were separated from their mothers: 21 mothers were therefore separated from their children.

Type of separation

The children separated from their mothers can be classified in two groups. The first group consists of children removed by judicial order and then placed in foster care (7 boys and 8

girls, including the twins). The other group of children were placed in the unofficial custody of another family member (2 boys and 5 girls). In this second group, the family temporarily organised the child's care, most often with the approval of the DGAISS. Usually, however, the children's court judge subsequently confirmed this placement in a court order. These 7 children were all placed with a family member before the age of six months: one little girl was placed with her paternal grandmother and father; we knew this father, who was not living with the mother and had no personality disorder, while the mother was psychotic and orphaned; The other 6 children (4 girls and two boys) were placed with their mothers' parents (for one little girl, her mother's grandparents). Of these 7 cases, 5 mothers were schizophrenic, and two had severe borderline personality disorders.

The separation sometimes occurred while mother and child were hospitalised in our unit. In this situation, the case had always been reported before admission to our unit (during the maternity ward admission, for example). The request for hospitalisation then came from the social and judicial agencies, which wanted to maintain a bond between mother and child in conditions offering safety and satisfactory treatment. We require for admission that the mother expressly request time to get to know the child. In some cases, however, the separation occurred from 1 to 6 months after discharge from the unit. Most of these families had refused to continue with outpatient care, either by consultations or home visits.

When we compare these two groups -- the children separated by court decision and those placed with a family member --, it appears that the type of mother’s illness is distributed

similarly in both groups but that family support was established more rapidly in cases with family placement than in those with foster home placement.

Separation according to mother's illness at admission (Table3a)

Table 3a reports the overall distribution of maternal illness at admission (92 mothers). No statistically significant correlation was observed between the parental diseases and children's symptoms at admission. Inversely, we noted that the very young children hospitalised together with psychotic mothers seemed to have fewer symptoms than the children admitted to the unit with parents who did not have a mental illness but were seeking help for the child's reactive disorders (eating or sleeping disorders, etc.).

Only two of 11 mothers hospitalised for an episode of acute postpartum psychosis were separated from their children. These two still presented residual schizophrenic-type disorders after the acute episode, at discharge.

Most mothers with schizophrenia (12 of 16) were not able to live with their children. The 4 mothers with schizophrenia able to continue to raise their child had the benefit of stable spousal support from a partner who, while he often had a rigid personality structure, showed good social adaptation.

Separation according to family status and fathers' illness

Of the 15 children placed in foster care by a judge, only 3 had a father who came for at least one appointment to our MBU. One father had schizophrenia, another, not mentally ill, was deported from France and imprisoned in his own country, and the third, also not mentally ill, separated from the baby's mother during her relapse into bipolar depression. Of the 7 children separated from their mother and placed with other family members (without initial judicial intervention), we knew 3 fathers: two who were not mentally ill, and a third with a borderline personality disorder.

Separation according to child's age (Table 4)

Sixty-eight percent of the children separated from their mothers were younger than 6 months old. Children who were separated were younger (mean age 8.9 months) than the overall group at admission (mean age18.5 months). All the children placed within the family were younger than 6 months old.

DISCUSSION

The hospitalisation of very young children with their parents is a difficult practice because the therapeutic space is strongly threatened by the anxiety of each participant, within the team itself or among those who initially requested our intervention. The safety of the child -- expressed as the threat of separation -- is often put forward, subsequently, to thwart either the establishment or the maintenance of the mother-child bond. Nonetheless there is no strict correlation between the gravity of the psychiatric disease and the possibility of caring for and bonding with a baby. Immediate danger to the child is, in our experience,

very rare. As we will argue below, for maternal mental illness, the mother's isolation is what seems to us to be the most significant indicator of danger and of poor prognosis for the mother-child relationship.

Separation did not occur only in cases where the mother was psychotic. In our series, 6 of 21 mothers separated from their children had non-psychotic personality disorders (borderline state). Maternal psychosis, however, confronts a particular type of mother-child separation: the decision is made preventively, on the basis of future deficiencies extrapolated from the mother's behaviour or discourse, or in the name of a theoretical position on what is a psychotic object relation. The situation is different for mothers with personality disorders: separations are ordered after the observation of serious relational difficulties with the child, sometimes after violence has occurred.

Children whose mothers are mentally ill represent a group at high risk of emotional disorders both during childhood and in adult life.

According to Anthony (1969), at the age of 10 years, 15% of the children of psychotic mothers have global developmental disorders (manifestations of a schizophrenic type), 45% have serious behaviour disorders, 10% are considered vulnerable but can also be brilliant and creative, and 30% have no psychiatric disorders.

Studies among adults have essentially considered the incidence of parental schizophrenia. Different studies have consistently established that there is a 10-15% risk that the child of a schizophrenic mother will develop schizophrenia in adulthood (Mednick and Schulsinger

1965; Schulsinger, 1976) and a 20-30% risk for the child of 2 schizophrenic parents (Rosenthal, 1971; Kringlen and Kramer,1989).

Adoption studies (Heston, 1966; Higgins, 1966, 1976) have shown, however, that the early adoption of these children, from the second week after birth, does not reduce their risk of schizophrenia in adulthood. Moreover, some authors have reported non-schizophrenic psychological disorders in separated or adopted children (more suicides, for example, among children separated from their mothers than among those who were not); this finding indicates that separation induces an additional handicap.

Recently Higgins et al (1997) confirmed these findings, although the studies involved substantial methodological problems (for example, recruitment bias).

Analysis of the problems that the schizophrenic mother has in mothering her child requires a different kind of observation. Duchesne and Roy (1991), reviewing the criteria proposed by Bowlby (1977) and by Lebovici (1985), thus proposed a classification of the risks to the child according to specific traits of the mother's disease, correlated with various particularities of mothering:

The inadequate care provided by mothers who are either hebephrenic or catatonic can lead to immediate physical risks for the child and also to the risk of overall developmental retardation because of the lack of stimulation.

Mothering by a dissociated and delusional mother is distorted and encloses the child into a relational bubble, as if the latter wants to be excluded from his mother's mental illness.

In the inadequate care caused by poor continuity (observed among those with intermittent psychotic relapse), the principal risk for the child lies in the non-acquisition of self-consciousness.

When the mother has a serious non-psychotic personality disorder, the relationship between infant and mother has fewer profound distortions, but the mother's investment in the child is questionable: there may be an alternation of movements toward and away from the child. The child is also the target of projections and made responsible for his parents' episodes of anger or anxiety. Some violence may emerge to repeat the mother's own early relationships with her parents. The separation between parents and child, contrary to what occurs for schizophrenic mothers, is imposed by the onset of serious events that cause physical danger to the child.

The consequences of acute postpartum disorders on the mother-child relationship and on the child's development have been studied much less, for they are rarer: 1-2 postpartum psychoses per 1000 births. They generate attachment disorders because of the separation. But the series published in the United Kingdom (Kumar et al, 1995) has modified professionals' viewpoints about these episodes. The ranking of the frequency of diagnoses for episodes labelled "postpartum psychosis" has changed, just as it has for acute psychoses during adolescence: the most frequent diagnosis now seems to be bipolar affective psychosis and not schizophrenic disorder. Joint hospitalisation of the mother and baby allows treatment simultaneously for the mother and for the mother-child relationship while avoiding the early and prolonged separation of mother and child to which these acute situations inevitably lead when this specific type of hospitalisation is not available.

Whether the disorder is acute or more chronic, joint mother-baby hospitalisation leads to a new type of situation and to treatment conditions that provide an alternative to immediate separation.

Accordingly, we can now, instead of simply deploring offhand all the mothering disorders induced by maternal illnesses, base our observations and our research on the possibilities offered simultaneously to babies and their mothers to use a supportive environment available on a daily basis.

The experience of joint mother-baby hospitalisation demonstrates babies' capacity to develop such a setting. What is most remarkable is the baby's early identification, from the third month, of the mother's ability to relate to him at each moment and his search for substitute interactions with the caregivers he knows. Nonetheless, absent early separation, it is the mother who remains the principal attachment figure. The baby is then generally sufficiently alert to his mother's behaviour to renew contact as soon as she is again able to.

On the mother's side, the prognosis for her relationship with her child seems to us to be strongly correlated with her capacity to use the various treatments and other help -- those of the MBU, those of the family, or other means available in the society: services from the Protection Maternelle et Infantile (PMI), Direction Générale des Affaires et des Interventions Sanitaires et Sociales (DGAISS), and Aide Educative en Milieu Ouvert (AEMO, judicial measures). This leads us to consider simultaneously: (a) the clinical forms of the mother's illness; (b) the short-term course of the parenthood process, an identity process that can have a profound influence on the mother's development, not so much on the mental process in the strict sense of the term as on the treatment alliance of a

woman who can and wants to take her place as a mother in society; (c) but also the presence of the father and his possible difficulties (Poinso and Soulayrol, 1998); (d) the dimension of the couple (unstable, or more solidly constructed); (e) support and relays from family, and even from friends or a broader social circle.

In a MBU, the project is based on the progressive improvement in the relationship, an improvement for which the dimension of time is essential. First, we are dealing with unstable maternal illnesses: their evaluation, especially after pregnancy and childbirth, cannot be reduced to a label given by the person who referred this mother and this baby to our unit. Second, the mother and child's circle will itself undergo a longer or shorter period of hesitations and uncertainties, before some projects can be planned.

Our experience leads us to think that early separation is not only prejudicial to the quality of maternal attachment but is also a source of suffering for the baby, well before the second half of his first year, contrary to what is often said on the basis of theories of maternal object representation. The child very early establishes ways of interacting with his mother; he knows her voice, recognises her smell, adjusts to how she carries him. After 6 months he expresses his anxiety or refusal of separation more directly, but that certainly does not mean that he does not suffer serious consequences from a much earlier separation. Mother-baby units, in approaching the need for a separation prudently, allow its progressive development and have an important role in these often dramatic situations.

Finally our study shows that the relational prognoses of schizophrenia and acute psychoses are very different.

Acute postpartum psychoses are often related to affective psychoses (bipolar forms) and can indeed be their initial manifestation in young women (Kumar et al,1995). The general prognosis, the possibility of effective treatment in this acute period, the possibility of drug treatment, are essential reasons for preserving insofar as possible the continuity of the bond between the mother and child.

Moreover, these acute episodes occur in a very different family setting than that of the women with schizophrenia. The family is present, expresses its appropriate concerns, participates in the treatment, enables home visits over the weekend, and takes over some of the baby's care. The father is most often present and active.

On the contrary, for women with schizophrenia, the isolation is much greater, and the baby's father often absent, or even unknown. The mother's bonds with her own family, and in particular with her own mother, are usually quite frayed. In our study, the only women with schizophrenia who were not separated from their child were those who had established a sufficiently stable conjugal relationship and who were able to take care of their child because the father was also present at home. This was the case for 4 of 16 women.

Those who did not have stable support from their partner were all separated from their children.

CONCLUSIONS

In France a medical-social agency in each of 95 administrative regions throughout the country (la Direction Générale des Affaires et des Interventions Sanitaires et Sociales -

DGAISS) administers the placement of children (in foster families or institutions), but the Children's Court judge, after an investigation by a court social worker, makes the decisions about whether the child remains in the family or is separated and placed. The organisation of the hospitalisation and the post-hospitalisation situation requires co-ordination with DGAISS and with the Children's Court judge. From our vantage point as a hospital unit, however, we do not want to serve as the experts who assess the situation. In France, medical ethics keeps clearly separate the mission of an expert providing an opinion from the mission of treatment. Moreover, from a pragmatic point of view, any observation intended for expert-witness purposes durably prevents the realisation of our mission -- the establishment of a setting to care for the mother-child relationship. We inform the DGAISS and the judge of our proposal for care, but we propose it first to the mother or parents. The framework and the ethic of our care and its setting are based on the explicit agreement of our patients to the care we provide.

The units providing for joint hospitalisation of mothers and babies allow time to assess the problems and to promote the possibility of a relationship between a very young baby and his mother, when she suffers from psychiatric problems after delivery. But the indications for admission to such a unit are diverse and relate to different situations.

When it involves acute postpartum disorders (major depression, depressive or manic state, confusional disorders), the prognosis for the mother's illness is generally good, especially if the conditions of hospitalisation will permit continuity in her relationship with her child. This allows psychiatric treatment for the illness and at the same time supportive care and attention during the process of constructing a maternal identity ("motherhood").

For schizophrenic disorders, the prognosis is less good, for the disease development does not seem to be fundamentally modified by the birth of a child (Yarden et al, 1966), and separation is almost ineluctable in the absence of a stable relationship with a partner who is the child's father, as our series shows. Even if the mother cannot care for her child alone, however, a period of the hospitalisation allows the best possible compromise, often with the help of the mother's family, for the child's subsequent custody and for the maintenance of some bond with his mother.

In non-psychotic personality disorders, separation sometimes occurs, but the family environments, the seriousness of the maternal illness and the circumstances are too diverse to allow any general developments to be deduced from them.

These data lead us to envisage a variety of goals for hospitalisation in a MBU, depending on the mother's diagnosis. To the extent that only a joint unit can treat an acute postpartum psychiatric illness while developing the relationship between mother and child on a daily basis, it is the priority indication for this type of treatment.
The work proposed to a mother with schizophrenia enables useful progress in the relationship between mother and child. This work has enables us to describe clinical elements while taking into account these babies' psychic construction, in these particular circumstances. But other measures are available in France (early separation with meetings between mother and child, organised by the DGAISS medical-social agencies). Mother-baby hospitalisation is especially useful when the mother has expressed a strong desire to care for her baby and when that does not comprise the child's safety. A (sometimes long)

period of reflection on the conditions of the relationship or of the separation, may then be necessary.

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Table 1 : MOTHERS' CHARACTERISTICS AND HISTORY

(N=92)	N	(%)
Employed	29	(35)
Education level (Primary school)	28	(33)
Born in France	70	(85)
Marital status (single mother)	33	(39)
Parity (Primiparous)	56	(67)
Own housing	64	(82)
History of previous psychopathology	36	(39)
History of obstetric complications	12	(14)
No antenatal medical care	3	(3)
Drug detoxification of infant at birth	3	(3)
Other children placed in foster care	4	(4)

Table: 2 : CHILDREN'S AGE DISTRIBUTION AND DISEASE ON ADMISSION

2a: Age distribution	**N=100**
<6 months	48
6-12 months	9
1-2 years	14
>2 years	29
2b: Disease distribution	**N=100**
No psychiatric disease	52
Eating or sleeping disorders	14
Learning or motor skills disorders	13
Reactional disorders	7
Personality disorders	8
Autistic disorder	1
Behaviour disorder	2
Mental retardation	1
Other psychiatric disease	2

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Table 3 : SEPARATION ON DISCHARGE ACCORDING TO TYPE OF MOTHERS' PSYCHIATRIC DISEASE ON ADMISSION

	3a: ON ADMISSION Mothers' Psychiatric diagnosis	**3b: ON DISCHARGE Type of Separation from the mother**		
Psychiatric diagnosis (ICD-10 diagnosis)	**Entire sample** N (% of total sample)	**All separations** N (% of each disease)	Placed in foster care by a Judge N	Placed within the family N
Acute psychosis	**11** (12)	**2** (18)	2	0
Schizophrenia	**16** (17)	**12** (75)	7	5
Mood disorders	**16** (17)	**1** (6)	1*	0
Neurotic symptoms	**8** (9)	**0** (0)	0	0
Personality disorders	**24** (26)	**6** (25)	4	2
No psychiatric disease	**17** (19)	**0** (0)	0	0
Total	**92** (100)	**21** (23)	**14**	**7**

*MDP

TABLE 4: SEPARATION ON DISCHARGE ACCORDING TO CHILD'S AGE

Age group	**Separation from mother on discharge**		
	Placed in foster care by a Judge N	placed within the family N	**All separations** **N**
<6 months	8*	7	**15**
6-12 months	4	0	**4**
1-2 years	2	0	**2**
>2 years	1	0	**1**
Total	**15**	**7**	**22**

*Including one pair of twins

No other child hospitalised with sibling was separated from his mother.