

Postnatal depressive disorder — F53.0

The information below consists only of supplementary information specific to postnatal depression (see also the **Depression** guideline, page 47).

Between 10 and 15% of women become depressed in the year following delivery of an infant.¹ Women at higher risk include those with a previous history of depression (especially postnatal depression), who had psychological problems during pregnancy, lack social support or someone to confide in, have marital problems, have had a recent negative life event (eg bereavement), have lost their own mother when young or are ambivalent about the pregnancy.²

Presenting complaints

The patient may present with multiple physical complaints, repeated minor concerns about the baby's health, exhaustion, problems sleeping, irritability, feelings of being overwhelmed and being unable to cope. Staff at the Mother and Baby Unit (MBU) may refer because of concerns about the mother's lack of interest in herself or the baby. The mother may resist reporting depression directly for fear of the baby being taken away from her.

Diagnostic features

There is usually a gradual onset, usually within 6 weeks of delivery, some within 6 months, and occasionally within 12 months.

Low mood and/or loss of interest and pleasure (including lack of pleasure in the baby) for most of the day for at least 2 weeks plus four of the following items.

- Sleep disturbance.
- Appetite disturbance.
- Frequent tearfulness.
- Tiredness and poor concentration.
- Feelings of guilt or worthlessness.
- Agitated behaviour (eg pacing).
- Slowing of movement or speech.
- Suicidal thoughts.
- Increased irritability and aggression.

The following symptoms are also common.

- Anxiety and/or panic, eg being afraid to be alone with the baby, having constant worries about the baby's health, having fears about losing the baby.
- Fear of having a heart attack or of going mad.

The more severe the depression, usually the greater number of symptoms and (most importantly) the greater the degree of interference with normal social or occupational functioning. Biological symptoms are more common in more severe depression.

The Edinburgh scale should be used in routine clinics, eg 6-week baby check, to screen for postnatal depression. However, this does not give an accurate assessment of severity (there is a copy on the disk). Women at a high risk of postnatal depression often score about 12, but clinical impression is more important and any positive score on the item relating to suicidal thoughts should be taken seriously.

Differential diagnosis

- **Maternity/baby blues:** symptoms of weepiness, unusual emotional sensitivity, crying spells, mood swings, insomnia, a feeling of rejection by carers occur around days 3–5 and resolve within a few days. Maternity blues are common and 50–80% of women experience them. Treat the symptoms with reassurance, sleep and arranging short-term support in caring practically for her baby.
- **Panic disorder — F40.0** (page 67).

- **Alcohol misuse — F10 or Drug-use disorder — F11#** (pages 18 and 55). If heavy alcohol or drug use is present. Substance misuse may cause or increase depressive symptoms. It may also mask underlying depression (see **Comorbidity**, page 191).
- **Puerperal psychosis** where delusions and, less commonly, hallucinations occur.
- **Chronic mixed anxiety and depression — F41.2** (page 33).
- **Delayed maternal response** (see **Problems of the mother–baby relationship**, page 144).

Some medications may produce symptoms of depression. These include β -blockers, other antihypertensives, H₂-blockers, oral contraceptives and corticosteroids.

Comorbidity

Depression frequently coexists with anxiety and panic, unexplained physical complaints and problems in the mother–baby relationship (such as delayed maternal response). Specific treatments are indicated for each set of problems. See the relevant guidelines.

Essential information for the patient and the primary support group

- **Feelings of helplessness, hopelessness, anxiety and emotional swings are all symptoms of the illness.** They do not mean that you are going mad. Postnatal depression is very common and anyone can get it.
- **Learning to care for a new baby is hard and tiring work.** Mothering takes time to learn. Practical help is needed.
- **Not feeling the way you expected to towards the baby.** This does not make you a bad mother, nor does it mean that you will harm your baby.
- **You will get better, but it may take time.** Arrangements must be made for you to be supported until you have recovered. There are several different treatments that may speed your recovery.
- **The illness may recur in subsequent pregnancies.**
- **Asking for and accepting help with the depression will increase the chances of the baby being allowed to stay in the MBU.** Babies are only separated from their mothers if there is imminent risk to the baby or if, for health reasons, the mother can no longer look after the baby.

Advice and support for the patient

For advice on management, including suicide risk assessment, see the **Depression** guideline (page 47). In addition:

- **Assess the risk of harm to the baby**: ask: How do you feel about the baby? Have you had any unusual thoughts? Have you been worried that harm might come to your baby, or even that you might harm him/her?:
 - If there are signs of harmful intent towards the baby, involve the mental-health services and the liaison social worker, following the prison child-protection procedures. Consider transfer to an in-patient unit, preferably one with an MBU.
 - Where there is no sign of harmful intent to the baby but the depression is chronic and the mother cannot meet the baby's emotional needs (eg the baby appears flat and avoids eye contact with his/her mother), treat the depression and involve the social services. Involving the liaison social worker should be seen as a way of obtaining additional support for the mother and baby.
 - Be aware that if the mother is admitted to the prison healthcare centre or an NHS hospital, arrangements will be made to hand her child to outside carers, except where the NHS hospital has an MBU.
- Encourage steps to get more sleep, eg rest during the day as much as possible; learn the art of cat napping.
- Encourage the woman to find some time for herself, eg 30 minutes for an uninterrupted bath.
- Encourage the woman to eat regularly even if she does not feel like it and to aim for a balanced diet including plentiful fluids.³ This is not the time to try and lose weight. If appropriate, advise a reduction in caffeine intake.⁴
- Identify someone the patient can confide in. Encourage her to seek practical and emotional help from others. Inform her about the role and availability of the prison healthcare team, the health visitor and any other support available. Support her in obtaining additional telephone calls to family and friends outside. If appropriate, discuss support for a possible application for a temporary licence (see also **Types of release on licence** on the disk). Give her a copy of *Coping with Depression*.

After improvement, plan with the patient the action to be taken if signs of relapse occur. As psychiatric morbidity remains high during the second postpartum year, regular follow-up and monitoring should continue.

Liaison and advice for the health visitor, MBU staff and other carers

Ask the mother's permission to discuss the following with the other staff caring for her. Inform her that you will only do this with her permission, except where there is a risk of harm to herself or others.

- Inform them of the outcome of the assessment of risk to the mother herself or the baby and discuss risk management, including the level of monitoring required. Discuss the location, including a shared room, if possible.
- The support of staff and family is an important element of treatment. Support to depressed women by caregivers may help the depression resolve more quickly.⁵ Discuss increasing the level of practical support to the mother, eg help with feeding and bathing the baby, institute a routine, arrange a break from the baby to allow sleep.
- Discuss ways they can support the mother (eg helping her break routine tasks down into manageable bits, praising her when she completes even a small task, avoiding additional stresses). Give them a copy of *Working with Mothers and Babies: The Psychological Aspects*.
- Inform staff of the likely impact of the illness on the mother's functioning (eg irritability and aggression can cause an increase in arguments between the mother and carers, and between the mother and their partner and family during visits). If possible, explain this to the patient's partner or family and encourage their additional patience and support for the mother.

Psychological treatments

Psychological treatments, where available, are often preferred to medication by women. Such therapy allows the woman to review her relationship with her baby, partner and family. The best evidence of effectiveness in the treatment of depression is available for cognitive-behavioural therapy and interpersonal therapy.⁶ Marital/couple and family therapy may have a particular role where there are problems in these relationships.⁷ Person-centred counselling by specially trained health visitors⁸ and psychodynamic psychotherapy⁹ may also be useful.

Professional and/or social support may also help postpartum depression.⁵ Parenting-training programmes may be helpful for mothers with mild depression or those recovering from more severe depression.¹⁰ Patients with chronic, relapsing depression may benefit more from cognitive-behavioural therapy (CBT) or a combination of CBT and antidepressants than from medication alone.^{11,12}

Medication

For advice about prescribing for depression, see the **Depression** guideline (page 47). In addition, check thyroid function and treat it if found to be abnormal.¹³

Choice of medication

- In general, non-sedating antidepressants (a tricyclic such as lofepramine or a selective serotonin re-uptake inhibitor [SSRI]) are preferred, especially if the mother is breast-feeding. If the woman cannot sleep, a sedative tricyclic (eg trazodone) may be used. If this is not sufficient, consider the use of hypnotics **in the short-term**, except where breast-feeding. If either type of sedating drug is used, provision must be made for adequate supervision of the baby.

If the patient is breast-feeding

- Decisions about safety are difficult: all psychotropic drugs pass into breast milk, and while concentrations are normally much lower than those that pass through the placenta during pregnancy, infants are poor metabolisers of drugs.
- All drugs should be avoided if the infant is premature or has renal, hepatic, cardiac or neurological impairment. The infant's renal and hepatic function should be checked before it is breast-fed by a mother who has been prescribed psychotropic medication.
- In general, older drugs are preferred, as more is known about their effects on the baby.¹⁴ Prefer tricyclic antidepressants (TCAs) (**except doxepin**). If SSRIs used, prefer those with short half-lives. **Avoid monoamine oxidase inhibitors (MAOIs) and lithium.**
- It is best to avoid sedating drugs and those with long half-lives.
- Avoid polypharmacy.
- If possible, give the drug as a single daily dose before the infant's longest sleep period. Breast-feeding should occur immediately before the dose is due. If possible, avoid breast-feeding when drug concentrations peak in milk where this is known (eg amitriptyline 1.5 hours, imipramine 1 hour).

- Monitor the infant for adverse effects, eg sedation, irritability. If these occur, take appropriate action (eg dose reduction, drug change, referral for advice).
- Treat the mother with the lowest effective dose as adverse effects in the infant are often dose-related.

Referral

Refer for weekly listening visits by a specially trained health visitor if the depression is mild and there is no significant suicide risk.⁸ Referral to the secondary mental-health services is advised:

- as an emergency if there is a significant risk of suicide or danger to the baby, or if there are psychotic symptoms, severe agitation or retardation with impaired food/fluid intake or
- as a non-emergency if:
 - significant depression persists despite treatment in primary care. Antidepressant therapy has failed if the patient remains symptomatic after a full course of treatment at an adequate dosage. If there is no clear improvement with the first drug, it should be changed to another class of drug
 - there is a history of severe depression, especially of bipolar disorder.

If drug or alcohol misuse is also a problem, see the guidelines for these disorders. If the mother has used alcohol or drugs during pregnancy, the baby will require close monitoring physically. There is increased risk of foetal alcohol syndrome, neonatal withdrawal syndrome and low birth weight. Problematic alcohol or drug use after pregnancy may reduce the parent's ability to provide adequate care for the infant due to unpredictable, inconsistent and ineffective patterns of behaviour.

Involve non-healthcare support (eg chaplain, counsellor, voluntary support group) in all other cases where symptoms persist, where the patient has a poor or non-existent support network, or where social or relationship problems are contributing to the depression.¹⁵

Severely depressed adolescents are difficult to assess and manage, and referral is recommended.

Throughcare and prerelease planning should include advice on services available to support mothers who have psychological problems and their babies (such as Homestart and Newpin, see below), as well as close liaison with medical and socialcare staff in the community (for more details, see **Managing the interface with the NHS and other agencies**, page 149).

Resources for patients and primary support groups

Association for Postnatal Illness: 020 7386 0868

145 Dawes Road, Fulham, London SW6 7EB (SAE needed)

(Can put you in touch with other mothers who have come through PND)

BM CRY-SIS: 020 7404 5011

London WC1N 3XX

(For parents of crying children)

Depression Alliance: 020 7633 0557
35 Westminster Bridge Road, London SE1 7JB
(National network of self-help groups for people experiencing depression)

Homestart UK: 0116 233 9955
2 Salisbury Road, Leicester LE1 7QR
(Volunteers offer support, friendship and practical support to young families with at least one child under 5 who are experiencing difficulties and stress)

Meet a Mum Association (MAMA): 020 8768 0123
26 Avenue Road, South Norwood, London SE25 4DX
(Self-help groups for pregnant women and mothers of small children)

Newpin: 020 7703 6326
Sutherland House, 35 Sutherland Square, London SE17 3EE
(Promotes the protection and preservation of mental health among parents and children. It supports families with emotional difficulties and mental distress)

National Childbirth Trust: 020 8992 8637
Alexandra House, Oldham Terrace, Acton, London W3 6NH
(Advice, support and counselling on all aspects of childbirth. Many local groups)

Pen Pal Project for Mothers in Prison: Tel: 001 805 967 7636; Fax: 001 805 967 0608; URL:
<http://www.chss.iup.edu/postpartum>
Jane Honikman, Founding Director and Coordinator, PSI, 927 N. Kellogg Avenue, Santa Barbara, CA 9311, USA. E-mail:
jhonikman@earthlink.com
(The US-based non-profit organisation Postpartum Support International [PSI] runs a support network for new mothers in prison often as the result of infanticide. Mothers write to each other)

Resource leaflet:
Coping with Depression

Books:
Erika Harvey. *The Element Guide to Postnatal Depression: Your Questions Answered*. Shaftesbury: Element, 1999
J Douglas, Richman N. *My Child Won't Sleep*. London: Penguin, 1988
Whiteford B, Polden M. *The Postnatal Exercise Book*. London: Penguin, 1992

- 1 O'Hara MW, Swain AM. Rates and risks of postpartum depression: a meta-analysis. *International Review of Psychiatry* 1996; 8: 37–54.
- 2 Kumar R. Postnatal mental illness: a transcultural perspective. *Social Psychiatry and Psychiatric Epidemiology* 1994; 29: 250–264.
- 3 Wallin M, Rissanen A. Food and mood: relationship between food, serotonin and affective disorders. *Acta Psychiatrica Scandinavica* 1994; 377 (Suppl): 36–40. (CV)
- 4 Greden JF. Anxiety or caffeinism: a diagnosis dilemma. *American Journal of Psychiatry* 1974; 131: 1089–1092. (AV)
- 5 Ray KL, Hodnett ED. Caregiver support for postpartum depression. Cochrane Library, Oxford 1998, issue 3. Update software.
- 6 Department of Health. *Treatment Choice in Psychological Therapies and Counselling*. London: Department of Health, 2001.
- 7 Sandberg JG, Johnson LN, Dermer SB *et al*. Demonstrated efficacy of models of marriage and family therapy: an update of Gurman, Kniskern and Pinsof's chart. *American Journal of Family Therapy* 1997; 25: 121–137.
- 8 Holden JM, Sagovsky R, Cox JL. Counselling in a general practice setting: controlled study of health visitors' intervention in treatment of postnatal depression. *British Medical Journal* 1989; 298: 223–226.
- 9 Murray L, Cooper PJ (eds). *Postpartum Depression and Child Development*. London: Guildford, 1997.
- 10 Barlow J, Coren E. Parent-training programmes for improving maternal psychosocial health. Cochrane Library, Oxford 2001, issue 1. Update software. States that parenting programmes may make a substantial contribution to the improvement of maternal psychosocial health. However, further research is required to identify whether this is so, irrespective of the level of pathology present in the mother.
- 11 Thase M, Greenhouse J, Frank E *et al*. Treatment of major depression with psychotherapy or psychotherapy-pharmacotherapy combinations. *Archives of General Psychiatry* 1997; 54: 1009–1015.
- 12 Evans M, Hollins S, De Rubeis R *et al*. Differential relapse following cognitive therapy and pharmacotherapy of depression. *Archives of General Psychiatry* 1992; 49: 802–808.
- 13 Harris B, Othman S, Davis JA *et al*. Association between postpartum thyroid dysfunction and thyroid antibodies and depression. *British Medical Journal* 1992; 305: 152–156.

- 14 Yoshida K, Kumar R. Breastfeeding and psychotropic drugs. *International Review of Psychiatry* 1996; 8: 117–124, as quoted in World Psychiatric Association. *Depressive Disorders in Physical Illness*. New York: NCM Publications, 1998.
- 15 Ostler KJ, Thompson C, Kinmonth ALK *et al*. Influence of socio-economic deprivation on the prevalence and outcome of depression in primary care: the Hampshire Depression Project. *British Journal of Psychiatry* 2001; 178:12–17.

Puerperal psychosis

See the **Acute psychosis** guideline. The information below consists only of supplementary information specific to puerperal psychosis.

Presenting complaints

The mother may have experienced extreme and labile emotional states (manic or depressed), abrupt-onset hallucinations, delusions or confusion.

Between 0.1 and 0.2% of newly delivered women suffer from a postpartum psychosis. Women with previous episodes of postpartum psychosis or bipolar disorder or who have had a family history of bipolar disorder are at very high risk,^{1,2} and where there has been a previous episode of bipolar disorder or postpartum psychosis planned psychiatric referral during pregnancy is advised.

Diagnostic features

Postnatal psychosis usually appears suddenly within 2 weeks of the birth.

- Marked mood swings: severely depressed or mixed/elated mood.
- Over-preoccupation or abnormal interaction with the baby.
- Severe anxiety or agitation.
- Perplexity and confusion.
- Suicidal and infanticidal ideation may occur (eg that the mother and baby would be better off dead).
- Less commonly, schizophrenia-like symptoms may occur (eg hallucinations such as hearing voices and experiencing strange smells or delusions, eg that the baby is evil).

Differential diagnosis

- Non-psychotic postnatal depression.
- Organic brain syndromes (eg consequent on infection, metabolic disturbance or haemorrhage).

Essential information for the patient and the primary support group

- Withdrawal, agitation, strange behaviour and thoughts are symptoms of the illness.
- The mother's mental state and symptoms will fluctuate daily.
- The prognosis for recovery from puerperal psychosis is very good.
- There is an increased risk of recurrence with further pregnancies.
- Medication is central to treatment and will help resolve the symptoms. Inform the mother about side-effects.
- In the acute stage, the illness will affect the mother's capacity to look after her baby:
 - A severely depressed mother may experience slowed movement and speech, a difficulty in concentrating and persistent exhaustion.
 - An agitated, manic mother may not be able to respond sensitively to her baby.
 - Mothers who have severe psychosis may experience suicidal thoughts or impulses to kill their baby. They may require someone with them at all times.
 - When the mother is less acutely ill but still recovering, she may require close supervision as her mental state may make her vulnerable to making dangerous errors of judgement, eg giving the baby feeds that are boiling hot.

Advice and support for the patient and the primary support group

- Ensure the safety of the patient, the baby and those caring for them. Postpartum psychosis in the acute stage (especially where delusions involve the baby) may necessitate separating the mother and baby until the mother's mental state has improved, unless adequate supervision and support is provided, usually in an in-patient Mother and Baby Unit (MBU). Contact the liaison social worker in accordance with prison child-protection procedures.
- The subjective experiences of a mother suffering from puerperal psychosis are bizarre and often terrifying. Avoid confrontation or criticism, unless it is necessary to prevent harmful or disruptive behaviour.
- Arrange support for the patient from carers and family to help her comply with treatment and, when appropriate, to re-establish sensitive mothering.

Referral

Refer **as an emergency** to the secondary mental-health services. It is essential that a mother suffering from postpartum psychosis is treated in a specialist psychiatric hospital, usually in an MBU.

Planned psychiatric referral is advised for women who have had a previous episode of puerperal psychosis and are pregnant again, as prophylactic interventions may significantly reduce the risk of recurrence. As the pattern of any subsequent relapse is remarkably similar to the original illness, it is essential that there is continued psychiatric monitoring, especially around the expected time of onset of the illness.

Medication

Medication for postpartum psychosis will vary according to the clinical picture (depressive, schizophrenic, manic, mixed) and should be prescribed by a specialist. If diagnosis is clear, however, and there is a delay in specialist consultation, commence antipsychotic medication acutely to manage disturbed behaviour or severe distress (see **Acute psychosis**, page 11).

If the patient is breast-feeding, consider the following.

- Decisions about safety are complex: all psychotropic drugs pass into breast milk, and while concentrations are normally much lower than those that pass through the placenta during pregnancy, infants are poor metabolisers of drugs.
- All drugs should be avoided if the infant is premature or has renal, hepatic, cardiac or neurological impairment. The infant's renal and hepatic function should be checked before it is breast-fed by a mother who is prescribed psychotropic medication.
- In general, older drugs are preferred, as more is known about their effects on the baby.³ **Avoid monoamine oxidase inhibitors (MAOIs), lithium and clozapine.**
- As a general rule, the mother should not breast-feed if she requires a dose of haloperidol > 20 mg day⁻¹ or chlorpromazine > 200 mg day⁻¹.
- Monitor the infant for adverse effects, eg sedation, irritability. If these occur take appropriate action (eg dose reduction, drug change, referral for advice).
- Treat the mother with the lowest effective dose as adverse effects in the infant are often dose-related.
- It is best to avoid sedating drugs and drugs with long half-lives.
- Avoid polypharmacy.
- If possible, give the drug as a single daily dose before the infant's longest sleep period. Breast-feeding should occur immediately before the dose is due. If possible, avoid breast-feeding when drug concentrations peak in milk where this is known (eg chlorpromazine 2 hours after oral administration).

Resources for patients and primary support groups

See the organisations listed under **Postnatal depressive disorder** (page 134)

¹ Kendell RE, Chalmers JC, Platz C. Epidemiology of puerperal psychoses. *British Journal of Psychiatry* 1989; 150: 662–673.

² Marks MN, Wieck A, Checkly SA, Kumar R. Contribution of psychological and social factors to psychiatric and non psychiatric relapse after childbirth in women with previous histories of affective disorder. *Journal of Affective Disorders* 1992; 29: 253–264.

³ Yoshida K, Kumar R. Breastfeeding and psychotropic drugs. *International Reviews in Psychiatry* 1996; 8: 117–124, as quoted in World Psychiatric Association. *Depressive Disorders in Physical Illness*. NCM Publications New York, 1998.

Problems with the mother–baby relationship

The quality of the relationship between a mother and her baby influences the child's emotional, cognitive and physical development. It is important, therefore, that staff look out for and try to ameliorate problems in the mother–baby relationship.

Why mothers may have problems

- A woman who has herself experienced poor parenting or who has spent some or most of her childhood in Local Authority care may have limited parenting skills.
- A person who has suffered poor or abusive parenting herself is more likely to be neglectful or abusive of her own children.
- A woman may develop postnatal depression, which has an impact on her ability to respond emotionally to her baby (see the **Postnatal disorders** guideline, page 134).
- A woman may have mental-health problems for other reasons.
- A woman who gives birth while imprisoned does not have access to her partner, family or friends for emotional and practical support as non-imprisoned women do.
- The experience of pregnancy and childbirth may bring back (possibly painful) memories and feelings from a woman's own childhood. She may feel more than usually hurt and needy.

Diagnostic features

Signs that the mother–baby relationship is at risk

The mother can show any of the following.

- Irritable with the baby most of the time.
- Avoids holding and looking at the baby.
- Repeatedly unresponsive to crying or obvious distress.
- Does not show any pleasure in the baby over time.
- Does not handle the baby in a gentle or tender way.
- Repeatedly over-stimulates the baby, eg vigorous and prolonged games with a very young baby.
- Makes repeated critical remarks towards or about the baby.
- Attributes malicious intent to the baby, eg believes that the baby deliberately cries to annoy her or to get attention that it does not need.

A lack of sensitivity to the baby's signals, if it continues over time, results in the baby becoming increasingly withdrawn. When the mother's response is repeatedly unexpected and inappropriate (eg sometimes hostile, sometimes ignoring the baby, sometimes loving, but with no pattern to the responses), the baby becomes confused and eventually avoids his/her mother and other people — not responding to them. If this goes on for a long period, the child grows up to have problems with attention, concentration and behaviour.

Differential diagnosis

- 'Maternity blues' / 'baby blues'.
- If there are significant symptoms of depression (see the **Depression** guideline, page 47).
- Anxiety states (see **Panic disorder** and **Mixed anxiety and depression**, pages 67 and 33).
- **Puerperal psychosis** (page 141) where avoidance of a baby is related to delusional beliefs (eg that the baby is evil or dangerous).
- Faltering growth or failure to thrive. Only a very small minority of babies have faltering growth because of abuse or neglect.^{1,2} However, mothers may feel an acute sense of failure if they cannot ensure adequate food for their child, especially if they have been told by medical staff that there is nothing wrong physically with their child. The mother may feel that it has been implied that she is a bad mother. This can greatly increase the stress and anxiety felt by the mother. Refer to health visitor in the first instance. The Children's Society publishes useful information on this topic (see **Resources Directory** page 316).

Disorders of the mother–baby relationship often coexist with depression and anxiety states.

Essential information for the patient and the primary support group

- Feelings of love for the baby do not appear immediately and automatically. For many women, it can take weeks or even months to develop closeness and mothering feelings.
- Learning to care for a new baby is hard and tiring work. Mothering takes time to learn.
- Crying is a communication that means the baby needs the mother. It is not hostile.

Advice and support for the patient and the primary support group

- Sympathise with the stress of being the mother of a young child.
- Demonstrate how to respond when the baby is upset or wants to play.
- Encourage the mother to find some time for herself (eg 30 minutes for an uninterrupted bath).
- Encourage her to get enough sleep, eg rest during the day as much as is possible and learn the art of cat napping.
- Do not criticise the mother directly. This will undermine her confidence and self-esteem still further. Try phrases like: ‘Some mothers find that ... works well’; ‘All babies are different. Why don’t you try ... or ... and see if it works for you?’ Encourage her to experiment with ways of satisfying the baby. Praise her.
- Try not to take sides against the partner or baby when the mother is critical of them.
- Encourage the mother to identify and take up anything that helps her feel good about herself (eg art, exercise, education) or that will help her get a job or social contacts when she is released.
- Encourage the mother to attend parenting classes, if available.
- Arrange a follow-up appointment to monitor the problem and the effect on the child.

Liaison and advice with MBU officers and other staff

Seek patient permission to do the following.

- Discuss with Mother and Baby Unit (MBU) officers and nursery nurses the provision of practical help for the mother, eg help with feeding and bathing the baby, instituting a routine, a break from the baby to allow sleep.
- Inform them that good social support can lessen the stress of the early years of motherhood even in vulnerable women. This means that staff in prison can be important to the health of the mother and the long-term emotional health of the baby.
- Consider setting up a befriending scheme whereby older and more experienced mothers from the community pair up with and support mothers in the MBU. This will help relieve pressure on staff and can be a very helpful resource for the mothers. A local Volunteer Bureau, Council for Voluntary Service, Mothers’ Union or National Childbirth Trust branch may be willing to help with this (see **Resources** below).
- Consider setting up an education and support group for MBU officers, nursery nurses and other staff to help deal with the stress of managing difficult or distressed mothers. For example, a monthly group session could be arranged with in-house and outside speakers that discusses topics such as normal child development and how to manage particular problems. The health visitor may be able to suggest suitable outside speakers.

Medication

Medication is only appropriate for comorbid disorders, eg depression, panic (see the relevant guideline).

Referral

- Refer to the health visitor for routine support and monitoring.
- Refer to the general adult psychiatrist if an underlying or comorbid severe mental disorder (eg psychosis or severe depression or anxiety) is suspected in the mother.
- Refer to the child and adolescent psychiatrist for advice if you are unsure about whether the mother–baby relationship is damaging to the baby.
- Parenting programmes have been shown to make a significant contribution to the psychosocial health (eg self-esteem, mood, stress) of mothers in general.³

Child protection

If signs of poor mother–baby attachment continue for more than a month or do not resolve when a mental disorder is treated and the quality of the relationship is deteriorating, discuss your concerns with the mother, involve the liaison social worker in accordance with prison child-protection procedures and explore obtaining further support for the mother and baby (see **Child protection**, page 276).

Resources for mothers and primary support groups

Association for Postnatal Illness: 020 7386 0868

145 Dawes Road, Fulham, London SW6 7EB (SAE needed)

(Can put you in touch with other mothers who have come through PND)

BM CRY-SIS: 020 7404 5011

London WC1N 3XX

(For parents of crying children)

Council for Voluntary Service (CVS): 0114 278 6636 (find via the National Association of Councils for Voluntary Service)

(Most local areas have a CVS that coordinates and supports local voluntary organisations. Some have a Volunteer Bureau [see below] as part of their organisation)

Depression Alliance: 020 7633 0557

35 Westminster Bridge Road, London SE1 7JB

(National network of self-help groups for people experiencing depression)

Meet a Mum Association (MAMA): 020 8768 0123

26 Avenue Road, South Norwood, London SE25 4DX

(Self-help groups for pregnant women and mothers of small children)

National Childbirth Trust: 020 8992 8637

Alexandra House, Oldham Terrace, Acton, London W3 6NH

(Advice, support and counselling on all aspects of childbirth. Many local groups)

Pen Pal Project for Mothers in Prison: Tel: 001 805 967 7636; Fax: 001 805 967 0608; URL:

<http://www.chss.iup.edu/postpartum>

Jane Honikman, Founding Director and Coordinator, PSI, 927 N. Kellogg Avenue, Santa Barbara, CA 9311, USA. E-mail: jhonikman@earthlink.com

(The US-based non-profit organisation Postpartum Support International (PSI) runs a support network for new mothers in prison often as the result of infanticide. Mothers write to each other)

Volunteer Bureau: (see the telephone directory or local library reference section)

(Most local areas have a Volunteer Bureau that recruits volunteers and matches them with organisations that need volunteers)

Resource leaflet:

Coping with Depression

Books:

Erika Harvey. *The Element Guide to Postnatal Depression: Your Questions Answered*. Shaftesbury: Element, 1999

J Douglas, Richman N. *My Child Won't Sleep*. London: Penguin, 1988

Whiteford B, Polden M. *The Postnatal Exercise Book*. London: Penguin, 1992

Faltering Growth — Taking the Failure Out of Failure to Thrive and My Child Still Won't Eat. Available from: The Children's Society, Edward Rudolf House, Margery Street, London WC1X 0JL. Tel: 020 7841 4400;

URL: <http://www.the-childrens-society.org.uk>

- 1 Boddy J, Skuse D. Annotation: the process of parenting in failure to thrive. *Journal of Child Psychology and Psychiatry* 1994; 35: 401-424.
- 2 Wright C, Talbot E. Screening for failure to thrive — what are we looking for? *Child Care Health and Development* 1996; 22: 223-234.
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