

Postpartum Hospitalization of Psychotic Parents With Their Infant: A Case Study

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Abstract: *Background:* Parents with mental illness are at risk for exacerbations during the postpartum period. The management of family members needing concurrent psychiatric hospitalization is unclear. This article describes the advantages and difficulties of a family hospitalization, focusing on the splitting processes in the staff and the use of “couple ego functions.” *Data:* A couple, simultaneously psychotic after the sequential births of two children, were hospitalized separately after the birth of the first child, and simultaneously in the same room after the birth of the second child. *Results:* The hospitalization of the couple with their infant led to a shorter, less stressful hospitalization, and strengthened the functioning of the family unit. *Conclusions:* Simultaneous hospitalization of family members is feasible and may lead to better clinical results.

Introduction

In the summer of 1996, a family — father, mother and baby — were hospitalized in one room in our psychiatric open ward. The parents, married for several years prior to the index hospitalization, are both psychiatric patients, with long periods in hospital in their past.

This novel step for our ward caused much consternation in the ward and out of it. It grew out of the experience in conjoint hospitalization of mothers and babies acquired in Eitanim Hospital since the early 1970s (1-3).

The birth of a child is a stressful event in any family. Family members are under individual stress while the dynamics of the family interactions change. Mothers deal with anxiety about increased responsibility, the fear of a defective child, and the grief for their lost young body. The changes taking place are perceived as originating from the baby, leading to aggressive and even infanticidal thoughts (4).

Postpartum psychiatric morbidity has received much attention in the literature. For the mother the postpartum period carries a greatly increased risk of psychiatric morbidity. Women with prior histories of psychiatric illness have been consistently reported to have higher rates of postpartum psychiatric morbid-

ity than the general population. Especially at risk are women suffering from bipolar disorder (5). In a prospective study of women with psychotic disorders, 24% of those with schizophrenia became actually psychotic within 6 months after having a baby (6).

In some parts of the world mother and baby units offer psychiatric hospitalization for the mother in which she may keep her baby with her in the hospital. The mother and baby units serve to prevent the disruption in the infant's attachment by maintaining the mother-infant dyad (7). The mother learns from the nursing staff, who act as “surrogate mothers,” how to hold, feed, play with and bathe the baby (2).

Fathers also exhibit psychopathology associated with the birth of their child. Male psychopathology after delivery can range from somatization (Couvade syndrome) (8) to depression (9, 10) and postpartum psychosis (11). In male bipolar patients, both new and recurrent psychotic episodes coinciding with pregnancy and birth in their partners have been documented (12). There is also a report of a new psychosis in a man occurring as the family adopts a baby (13). The extent that pregnancy, childbirth and puerperal mental illness in a wife are risk factors for recurrence or onset of psychosis in mentally ill fathers is unknown.

There have been several reports of psychiatric

* Shmuel Maizel died shortly before publication of this paper. His obituary appears on page 66.

morbidity in postnatal couples. Spouses of postpartum depressed women are far more depressed and anxious than spouses of well women, reaching clinical significance in almost 50% of the men (14-16).

The phenomenon of assortative mating creates many situations in which both partners are acutely ill after a birth in the family. Conjoint hospitalization of two family members with psychiatric disorders is rare in the literature. Family members who are simultaneously ill are usually separated, perhaps related to the recommendation in *folie imposee* that the two family members be separated (17). There is one report of a couple, the male diagnosed as schizophrenia and the female with behavioral problems due to mental retardation, hospitalized conjointly in the same room with clinical improvement (18). The mother and baby psychiatric units mentioned above evolved from a wish to protect the mother-baby dyad from the effects of separation. One mother and baby unit, in Norway, hospitalized the well father with the ill mother in order to preserve the family unit and its functioning (19). In France, as part of child psychiatry (20), parents are often hospitalized with their disordered children, and postpartum disordered women are hospitalized with their infants, siblings and husband (21). In these cases, the mother-baby units and the family hospitalizations, only one family member is ill. We have not found discussions or case reports of the management decisions in hospitalizing postpartum psychotic parents together or separately in the literature.

Case History

The Father

Abraham is diagnosed as suffering from schizoaffective disorder. Now in his late 40s, he was born in North Africa into a religious family and emigrated to Israel when he was 8 years old. Abraham was a normal child without any special problems. After 10 years of schooling he stopped attending school and was drafted into the army. He had many difficulties with discipline in the army and was discharged prematurely. After the army he tried to work but changed his place of work many times. He was involved in using and dealing in drugs. His first hos-

pitalization was at the age of 24 in a catatonic state with symptoms of autism, negativism and waxy flexibility. From age 24 to 35 he was hospitalized more than 20 times, spending in total more than 4 years in hospital. He suffered manic episodes with psychotic features, depressive episodes with psychotic features and psychotic states without affective symptoms. In manic states he was usually admitted under court orders after committing criminal offenses. Abraham was treated for long periods of time with various antipsychotic drugs including long-acting medications, combinations of mood stabilizers and ECT. About age 35, he became more religiously observant, stopped dealing in drugs and started to work/study at a yeshiva. From age 35 until the birth of his first child he was stable under ambulatory treatment with lithium and carbamazepine with antipsychotics added during exacerbations. When 42 years old, he married Sara in an arranged marriage. The two exacerbations that necessitated hospitalization occurred after the births of his two children.

The Mother

Sara suffers from paranoid schizophrenia. Now in her early 30s, she is the second of seven children born in Israel to a religious Sephardic family. In her childhood Sara is described as a normal child, social and active but weak in school performance. She did not matriculate but continued after high school in a training school for kindergarten teachers. She could not find a steady job and did not get along with her father. She then left home and began living in the streets of Tel Aviv until she was located by welfare. Her first psychiatric hospitalization occurred at the age of 22 when strange behavior was noticed — grimacing and talking to herself, and referring to herself as an angel. From the acute ward she was transferred to a rehabilitation ward where she was described on admittance as very passive, with a flat affect and hebephrenic features. She did fairly well and after approximately two years in the rehabilitation ward transferred to a protected flat. She met Abraham through an arranged match, married him and began working as a print-setter in a protected work environment. She continued follow up and medications — haloperidol decanoate 100 mg/month. The second hospitalization was during her first pregnancy.

The first child

During her first pregnancy, Sara's maintenance medication had been discontinued. Her mental condition slowly deteriorated until she required hospitalization in her seventh month. She was hospitalized (her second hospitalization) with ideas of reference, and a delusion that she was not pregnant. She refused to eat or drink and had to be given fluids IV. Medication was restarted leading to a rapid improvement in her condition. She was discharged prior to the birth to her home. In the general hospital during labor, the medication was discontinued. Although she received medication again after about three days, Sara returned to the psychiatric hospital seven days after the birth, refusing to eat and drink and reporting auditory hallucinations — a man and a woman discussing her and planning to harm her. She was hospitalized with her infant (third hospitalization) in the mother-baby unit.

Abraham was against the mother-baby hospitalization. He took the baby from the hospital and left it with his relatives and disappeared. Sara stayed in hospital with her family's encouragement. After staff engaged in reaching out, Abraham returned with the baby, participated in family therapy and accepted the conjoint hospitalization as a way to teach Sara how to take care of the baby and protect and encourage the emotional bond between Sara and the baby. After about two months in hospital, Sara was released home after she had demonstrated her ability to take care of the baby. A month after she returned to the couple's home, Abraham was hospitalized with a manic psychosis with paranoid ideation about his wife and her parents. Abraham was admitted onto the closed ward. Sara returned to the mother-baby unit (fourth hospitalization), because she felt unable to care for the baby adequately alone, but probably to be near Abraham, on whom we had seen a strong dependence. Abraham again resisted Sara's conjoint hospitalization. He managed to leave the hospital and called threatening to kill the caretakers of Sara and her child. He then disappeared and was located after a month in the United States. At this point it seemed as if the family unit had totally disintegrated. After Abraham left, Sara left the hospital for a shelter until she returned to her apartment when Abraham returned from the U.S. and initiated contact with her.

In this time period we noticed a seesaw effect in the couple with each partner assuming the sick role. When Sara could not endure the distance from her husband and came to hospital, Abraham immediately left.

The couple continued follow-up at our outpatient clinic and, with the help and accompaniment of the welfare services, brought up their daughter. The child was under special supervision by the local well baby clinic, and developed well according to her age. Sara returned to the printshop, and Abraham continued at the yeshiva.

The second child

Four years after the birth of the first child, the couple both developed psychotic exacerbations around the birth of their second, planned child — a boy. Sara was admitted to the general hospital for a planned caesarean section. For a month prior to the birth Sara had been more passive than usual and had voiced delusions of reference with auditory hallucinations. When Sara was admitted to the general hospital Abraham stopped his medication. During the caesarean section Sara also underwent a planned salpingotomy with the couple's rabbi's permission in accordance with the wishes of both Sara and Abraham. The first indication of Abraham's developing manic state was the large lavish party he arranged for the son's circumcision ceremony (brit). After the ceremony Abraham stopped sleeping at night, left the apartment and began to wander the streets. He was brought to the hospital by the family's social worker after Sara alerted her to his condition. On admission he was euphoric, and had ideas of reference and delusions of grandeur: God had been signaling to him, through the movement of cats and dogs, that he was a special envoy of God.

Sara came to the hospital (fifth hospitalization) three days later (the baby was eleven days old) in a psychotic exacerbation with delusions of reference and somatic delusions. She felt her body had been altered and something had been taken from her body — most probably the baby. She was fairly sure that the baby she was caring for was indeed her child but was very aggrieved it had been removed from her body.

The clinical state of the parents required hospitalization. In the mother-baby unit, all mothers who are

capable of being on the open ward are accepted with their babies (3). In this case the father's clinical state was appropriate for the open ward. Neither parent represented a danger for the infant. We decided to admit them together to the same ward and into the same room with their baby. The daughter, now four, stayed with an aunt who had taken her in when Abraham became manic.

Both parents agreed to be hospitalized with the baby, in the same room. The decision to house them in the same room came from our understanding of the events surrounding the birth of the first child. We had understood that the couple had reacted psychotically to the presence of the child in the couple's "space." In their illness they sought to redefine the couple's balance, but disintegrated in the process. Therefore, we decided to put them together — the ward was to be a container for the couple, their illness and their individual needs. Thus contained they would, we hoped, be able to work out a new balance. They would also stay closer to the normative model of a couple. They were to be treated pharmacologically, with individual psychotherapeutic treatments, couple therapy and family therapy with the four-year-old. The pharmacological and psychotherapeutic treatments were to be administered by one doctor each. It seemed important to give them separate doctors to allow each to have their individual needs addressed. In addition they were to participate in all routine ward activities including groups and occupational therapy.

The decision to house them in the same room was taken in the first staff meeting on the day Sara was admitted. The nursing staff was much against the idea because it seemed to them immodest — the couple would be able to have sexual relations, and this would be disruptive for ward relationships — a cause for envy from the other patients. In the general uproar about the couple's physical intimacy it was overlooked that in the immediate period after birth sexual relations are prohibited by Jewish halacha (Nida). It took a lot of conviction on the part of the senior staff to convince the nursing staff.

During the first night Abraham tried repeatedly to find a different room to sleep in, claiming the baby's crying was disturbing him. This was interpreted by the medical staff as a wish to escape his responsibilities and the family unit and by the nursing

staff as a confirmation that the couple should have separate rooms.

During the early part of the hospitalization Abraham went back and forth from the ward to the city, "running errands" for the couple. Sara stayed in the hospital taking care of the baby in a mechanical fashion.

Abraham was treated with carbamazepine 800 mg/day (9.4 µg/ml), lithium 1500 mg/day (0.75 mEq/L) and clonidine 40 mg/day. Sara received haloperidol 5 mg/day, haloperidol decanoate 100 mg/month and biperiden 2 mg/day.

Both patients projected the sickness onto the other — Abraham declaring that Sara was ill and should stay in hospital while he was just here to help her and would do so by running the errands. Sara was capable of seeing Abraham's behavior as an illness but also saw his behavior as a means to escape her and demanded that the staff curtail his absences.

Apart from the split with the nursing staff, another split appeared among the staff treating the family. The female doctor assigned to Sara felt that Abraham was clearly manic and his doctor should control him — raise his lithium and curtail his absences. The male doctor retorted that Abraham was in wonderful shape, and that the demand that Abraham be physically present by his wife and participate in the physical care of the baby was a female and feministic plot against Abraham's active manhood. Sara's doctor replied that the current division of labor, whether or not socially justified, was not going to help this couple because Sara would not assume full care of the baby unless she was adequately supported by Abraham. The family therapist complained that in the absence of Abraham no family work on the division of labor and support was possible.

At this point it was recognized that a serious split and a concordant identification (22) as a part of counter-transference had occurred in the staff. It was then decided that regular meetings between the family's caretakers would be held once a week. At the first of these meetings the following was decided: Sara was to have one afternoon a week free when Abraham was to take care of the baby. Abraham and Sara were to show up for family sessions.

In the couple's sessions the family dynamics became clear. Abraham was translating his fear that

Sara would leave him into hyperactive doing while Sara responded to her feeling of being abandoned by becoming totally unemotional and lapsing into her passivity. In the family sessions the emphasis was on concrete organization of their stay in hospital and at home. Through concrete planning, the couple's potential space was structured, utilizing each partner's ego functions that were still functional. Thus they planned their future time together within the limits of yeshiva, work, kindergarten and baby care, mapping out their new role assignments. Their emotional demands were voiced through the concrete requests — Sara's demand that Abraham take the initiative in the family was expressed by asking him to take her out to more family occasions and religious meetings, and her fear that Abraham would receive all the daughter's affection by insisting that Sara be the one to pick the girl up from the kindergarten. Abraham voiced his fear of the changes in the family than might lead to his loss of Sara's attention when he remarked that no more babies would be due after the tubal ligation. In the family sessions it was understood that Abraham had asked for the tubal ligation due to his fears of abandonment by Sara.

The family was in the hospital for about one month after which they went home for long weekends. Both Abraham and Sara adapted to the new limits placed and eagerly came to family therapy once there was acknowledgement of their individual needs in the sessions.

The split with the nursing staff was diminished after the split process between the therapists was recognized and acknowledged (23).

The family was discharged after both the parents had significant clinical improvement. Their coping skills, both in the couple and as individuals, were markedly increased — mainly their ability to communicate about the various decisions they had to take. They were in the hospital for a total of two months.

The staff had to meet severe obstacles overcoming the anxiety of the community therapists and their own anxiety to return the expanded family to the community. The anxiety among staff was voiced as anxiety about the baby's physical care and about the daughter's developmental status. After the family pediatrician and the kindergarten psychologist were consulted regarding the normal development of the

daughter, and the baby's physical and mental development was assessed by the pediatrician, the staff's anxiety diminished significantly. Before discharge we arranged with the community welfare office that the baby should have day care from the age of six months and the daughter would continue in the kindergarten. A mental health visitor came to see the family once a day for the first month at home and once a week for three months.

When the family returned to the community, the staff, nursing and medical, experienced a sense of relief and pride in the functioning of the family and the staff.

Discussion

Both parents present clear vulnerability to pregnancy and birth and twice reacted with psychotic exacerbation. Twice, Sara showed more vulnerability by becoming actively psychotic both during the pregnancy and after the birth, while Abraham became overtly psychotic only in the postpartum period. The decision to admit them together evolved from the understanding that the couple's prior hospitalization after the birth of the first child had caused the disintegration of the whole family.

Fatherhood and motherhood are complementary processes that evolve within the culturally established family structure to safeguard the physical and emotional development of the child (24). By hospitalizing both parents together with a second child, thus preserving the family structure, we hoped to prevent deeper psychotic regression, primitive manipulating of each other, and chaos. We now realize that by keeping them together, both parents received the role of "sick" and were able in the mutual space preserved by keeping them in the same room to reach a new balance that enabled them to return to the community as a functioning family, keeping their children and offering them proper care. In the ward, each was able to voice his needs from the other and receive equal attention as a patient and as part of the couple. Had they been separated we feel that the individual needs as a patient would most likely have been met, but the redefinition of the couple needed to accommodate the new child would not have been accomplished. They would have remained at the mercy of their fears, which would have weakened

their ego functioning and led to destructive acts toward each other.

As a functioning family, they had a defined order of the day: morning schedule, childcare, work and so on. These "couple functions" are analogous to the maternal ego functions that we feel we utilize in the conjoint mother and baby hospitalization. The emphasis on the concrete planning of the couple's time together is analogous to the work with the mother on the care of the baby through which we approach the mother-baby bond.

In this presentation, we have concentrated on the management decision about conjoint hospitalization of the psychotic parents and its ramifications on the staff processes, and neglected for brevity and clarity's sake, to elaborate the work on the mother, father and baby ties.

Follow-up

Eight years after the conjoint hospitalization the family is doing well and the parents are raising their children in their home. The children are healthy and are pupils in grades appropriate for their age. Abraham and Sara are both in stable remission, and have had no hospitalizations or active psychotic episodes. They are ambulatory outpatients, and cooperate well with the treatment. The same doctor sees them separately once a month. Surprisingly, Abraham now recognizes his elevated moods and requests help when this occurs. Abraham continues as a handyman and student at the yeshiva — the same lifestyle he had. Sara has had no further deterioration and continues to work in the same protected work environment.

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