Mothers with Severe Psychiatric Illness and their newborns: a hospital-based model of perinatal consultation

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ZERO TO THREE Corner

Women with severe psychiatric illness face numerous risks and challenges during pregnancy and as parents. Mental health professionals can help these mothers and their infants by supporting the attachment relationship and by providing the external supports that are necessary for successful parenting. In this article from the Zero to Three Journal (Vol.29, No.5), the authors describe a hospital-based intervention in Geneva, Switzerland, and contrast the stories of two mothers with schizophrenic illness in terms of the risks and resilience of each mother in her capacity to care for her infant.

Women with severe psychiatric illness, such as schizophrenia, experience increased risks and vulnerability during pregnancy and the postpartum period. The risks are particularly high if the woman has had to stop taking her stabilizing medications because of the risks to the baby and if she lacks sufficient social supports (Miller, 1997). A recent epidemiologic study of over 1 million live births in Denmark over a 25 year period supported the theory that women with psychotic disorders are at substantially higher risk for perinatal loss and morbidity (King-Hele et al., 2009) than are women without psychotic disorders. This increased risk was not necessarily due to their psychiatric illness itself but rather to psychosocial impairment that is associated with chronic psychiatric illness and that results in insufficient prenatal care, unstable living conditions, and lack of integration into social support networks including a medical home (King-Hele et al., 2009). In addition, women with chronic psychotic disorders are more prone to lead unhealthy lifestyles that often involve nicotine dependence, poor nutrition, and greater risk for violence exposure (Hauck, Rock, Jackiewicz, & Jablensky, 2008).

The problem is not as rare as one might hope. Every year in the U.S., 4,100 to 8,200 women experience postpartum psychosis. New onset psychosis during the peripartum period is most commonly associated with bipolar disorder (Sharma & Mazmanian, 2003). Careful evaluation, diagnosis, and treatment of maternal psychiatric illness together with family planning counseling prior to any conception would be optimal in an ideal world. In reality, this is often not possible. And so, preventive intervention and sensitive alliance-building with psychiatrically ill parents, baby, and other caregivers from the first moments of presentation is paramount to provide the newborn with the opportunity for optimal development (Hauck et al., 2008).

At the University Hospitals of Geneva, we foster alliances between infants and their parents, medical staff and parents, and medical staff and infants with a developmentally and relationally focused perspective. These human bonds are the most precious, yet vulnerable lifelines for mothers, many of whom who have experienced disturbed attachments, abandonment, violence, lack of social support, or immigration stress. Because these women often feel abandoned and burdened, if not menaced, by the world around them, it is hard to let their own babies connect to them, even though those babies are hardwired to try (Stern, 1985). In addition to these social risk factors, chronic psychiatric illness may involve psychosis (i.e., loss of reality testing, thought disorder, gross disturbances in affective responsivity, poor social functioning), medications to treat their psychosis and other difficulties, and the potential side effects of those medications. Given these vulnerabilities and risks, women with psychiatric illness face enormous challenges to succeeding as parents in a complex urban society (Hipwell, Goossens, Melhuish, & Kumar., 2000).

For women with severe psychopathology, a key part of the treatment involves recognizing their capacities and their desires, however ambivalent, to form relationships that can at the least reduce stress, and at best, save lives (Schechter & Willheim, 2009). Another component of treatment involves helping to contemplate and interpret their baby's communication. It is important to note that this psychotherapeutic work is distinct from child protective services and should be clearly presented as such. This is to say that we as clinicians attempt whenever possible to maintain a therapeutic alliance with mothers that holds their and their baby's perspectives in mind while not neglecting safety issues. To maintain this longer-term investment in the mother and baby's well-being, we recommend that a separate team of mental health/child protection specialists, whose job it is to report over the short-term to the family court system directly, do a distinct forensic evaluation to determine whether parental rights should be upheld, suspended pending observation, or terminated. At times, we do find it essential to offer our clinical opinions one way or the other to the forensic evaluators. When this is necessary, as it often is, we often have one member of our team who is known to the mother discuss this frankly but sensitively with her, with an attempt to ally with her fundamental wishes to keep her child alive and protected from danger. Another member of our team known to the mother remains available should the mother decide that the therapist who spoke with the forensic evaluators can no longer be trusted. This is an advantage in working

in therapist-pairs with these families. We also try to continue our therapeutic work beyond the time when court decisions are made—which itself is often a period of enormous stress for parents, extended family, and baby. If a mother and baby are separated, often one member of the therapist-pair will continue to follow the baby in her new setting and the other, will work with mother on issues of separation, loss, and planning for her own future.

In order to assess an infant–parent relationship at high risk, it is important to try to elicit the strengths and capacities of the parent and infant, and the family's internal and external supports over multiple visits. The discovery of mother and baby's ability to form a loving attachment is a treasure to guard. But the ability to form a loving attachment within a structured hospital setting does not necessarily mean that a psychiatrically ill parent will be able to manage without a substantial network of resources upon discharge. Her baby may even need to be placed, temporarily or permanently, in a child protective center and/or foster family (Hipwell et al., 2000). Our work involves establishment of a sense of continuity and coherence in the lives of psychiatrically vulnerable mothers and the thoughtful integration of multiple points of view by members of various professional disciplines: the obstetric team, social workers, mental health professionals, pediatricians, nurses speech/occupational/physical therapists, vocational skills educators, and others.

In situations when termination of parental rights seems imperative, we again want to emphasize that it is still beneficial to work with parents and infant to prevent subsequent tragedies. Indeed, parents often "replace" a removed child, and many infants grow up with the scars of adverse early experiences in the child protective system. The efforts of the mental health professional , whether or not the parent remains active in the daily life of the child, should include mental health outreach, family planning, and violence prevention/safety planning as important treatment goals (Miller, 1997) Working with foster parents and their infants, and assessing their tolerance of an ongoing relationship between the child and biological mother when she is stable, can optimize the subsequent development of the child (Marshall, Reeb, Fox, Nelson, & Zeanah, 2008). To illustrate, we present below two contrasting situations involving mothers with chronic disabling psychiatric conditions.

Raiza and Yousef

In the Maternity Hospital, the neonatal staff requested an evaluation of a mother–baby relationship 1 day postpartum because of the staff's concern regarding the mother's erratic behavior. Nurses had noticed that Raiza, a 44-year-old Algerian woman, had appeared to be overly intrusive with her baby boy, Yousef, one moment, and very "odd" and elusive to the staff the next. Yousef was placed on the Developmental Pediatrics Unit pending further evaluation. A colleague in the adult psychiatry liaison service diagnosed Raiza with schizoaffective disorder, a form of psychotic disorder typified by delusions, hallucinations, profound ambivalence, mood swings, and erratic behaviour. Raiza had been stable for several years without any treatment—yet to maintain this level of functioning, she had a very routinized life with little social contact. She was on long-term disability and had a city-appointed case-manager to manage her finances. Behind inconsistent interaction with hospital staff was clear mistrust to the point of "paranoia." Raiza at certain points believed that the Swiss medical system was robbing African mothers of their children to make the children "Swiss" and work for the "white people." She denied any mental illness or need for treatment.

Raiza was not married to Yousef's father, Boris, who was an illegal immigrant and did not speak the local French language. Yousef is the only child of this couple, but Raiza had previously had an 11-year-old son out of a relationship with a man who had long since disappeared from her life. Boris had three children living in war-torn Bosnia whom he had left behind to seek political refuge in Geneva. The couple knew each other for less than 1 year. The pregnancy, while unexpected, went well despite the fact that mother had completely avoided obstetric care.

Raiza had been painfully rejected by her family for having had her first child as a single-mother and so moved to Geneva. Raiza remained guarded about her family. Yet she suggested that she had nothing good to say about her parents or siblings. A history of verbal and possibly physical abuse was suspected but never completely confirmed by Raiza.

She was hospitalized at the main psychiatric hospital in Geneva when her older son was only 2 years old. At that time, she was diagnosed as having a schizophrenic disorder. Raiza was assigned a case-manager, and this older son was given to his father who at that point assumed full-custody and legal guardianship, and the son had weekend visits with Raiza.

During meetings with the multidisciplinary team, Raiza had consistently appeared to be easily irritated, often talking nonstop without taking a breath, and showing signs of physical agitation that caused her to leap up from her chair, dramatically leave the room, and then return. She tended to jump from one subject to another often with vague, idiosyncratic references that were difficult to follow despite her excellent command of the French language. In the relation to Yousef, she seemed to confuse herself with Yousef, speaking of dry skin and lathering her own arms and face with skin cream but also applying it to Yousef's behind and legs tin such large quantities that a white visible layer that oozed from the diaper. At times, it appeared that she forgot about her baby, relinquished eye contact with him, and focused with his nurses only on her own grievances.

And yet at other moments Raiza clearly had a capacity to share an admiring glance with her baby, speak sweetly to him, or sing him a song. However, she described Yousef (i.e., "her mental representations of him") with a paucity of detail, and with no regard for his individuality: "What can I say of him… he is a baby and all babies that age are alike." She also described Yousef via attributions that one would normally apply to the description of an older child: "He is a wise young man—he knows what you are all up to." She had a definite idea that was unmovable regarding her baby. When we tried to introduce a bit of curiosity about him, she was not curious with us. It was as if the discovery of her baby from any other perspective was too threatening.

Another worry among hospital staff was the sudden panicked thoughts Raiza could have about her baby. A nurse could be talking with her calmly when suddenly the sleeping Yousef's gurgle would be interpreted by Raiza as evidence that he was suffocating. She would jostle him and hoist him up in her arms abruptly to make sure he could breathe, startling him and making him cry. When we tried to reflect with Raiza on these moments, she denied that she had really thought he would die, saying, "He was waking up and I just wanted to help him by holding him." We understood but did not interpret to Raiza that these incidents likely marked Raiza's own sense of suffocation by her baby's needs and the closeness he required.

Ten days postpartum, Raiza became increasingly anxious about why the Developmental Pediatrics Unit would not let her take her baby home if he was not physically sick. After not visiting all day, Raiza showed up in the evening on the unit and abruptly took Yousef out of his bassinet. She covered him in a blanket and stormed out of the unit. When the nurses tried to stop her, she screamed loudly in a threatening way at them. As Boris approached her to keep the elevator door open so she would have more time to talk to the nurses, she shoved him back and pulled the door closed. Hospital security was called but could not arrive quickly enough, and the mother disappeared into the night with the baby. The staff called the police and an adult psychiatrist to make an at-home crisis evaluation. At the time of the assessment, Raiza was calm and Yousef, sleeping, remained unharmed. Raiza reported that if police said that Yousef must go back to the hospital, she trusted that there was a real medical reason for it. She allowed the police to remove the baby and was not brought to the hospital herself. It was as if Raiza had been reassured by the police intervention and remained calm.

Following this event, Yousef was moved directly in front of the nurse's station and monitored when his mother visited. Raiza seemed more compliant with nursing requests and apologized for her rash judgment. Nevertheless, after a day or two, she again began to resist nursing suggestions that her baby might be crying for reasons other than hunger—even as she could keep her baby on her breast for exceedingly long periods, beyond nutritive sucking. She also had the need to awaken her baby to change him and lather his bottom with diaper cream.

By the third day following the police event, Raiza again seemed mistrustful of the nursing staff and easily irritated. Yousef was more dysregulated, hypervigilant, and frequently spitting up due to excessive feeding. The pediatricians limited visiting hours to allow time for Yousef's own sleep and feeding rhythms to develop without Raiza's intrusion. Raiza seemed more organized and focused on Yousef when she visited. As with the limitations imposed by the police, she seemed to rise to the challenge during the briefer visits. She, nevertheless, continued to deny any difficulties and refused psychiatric care even though this was a condition for increasing her visiting hours.

A law guardian was appointed for Yousef by Child Protective Services, to whom a report had been made when Raiza took Yousef from the hospital against medical advice. Meetings between this law guardian and Raiza ended with Child Protective Services deciding to place Yousef in foster care and terminate Raiza's parental rights. During the multidisciplinary meeting at which this decision was announced, Raiza hurled insults at the medical staff, became agitated, got up to leave, and then sat down again spontaneously and remained quiet and preoccupied, muttering to herself.

It was painful for us as parents to see Raiza's suffering in these circumstances. The countertransference was one of guilt, as we if we indeed had done exactly what Raiza feared. We felt helpless for lack of our capacity to appeal to logic or for this parent to exercise insight and invoke problem solving. Using this awareness of our own reaction to her, we reassured Raiza in this intense and disorganizing suffering that we understood how much she loved her baby and that we would do everything possible to help her maintain a link with Yousef no matter what the outcome would be.

Boris meanwhile, was in a precarious social situation since he was in Switzerland illegally. He visited often at first, with an attitude of total support for Raiza (perhaps either with ignorance of or denial of the degree of her psychiatric disturbance and thus colluding with her in the denial of her pathology). But after Raiza shoved him and took Yousef out of the hospital as nurses pleaded with her, he little by little showed understanding of Raiza's difficulties and, simultaneously, greater estrangement from her. At the same time, he too had a strong tendency to mistrust the medical staff and remained angry and abrupt. He seemed unaware that his temper was intimidating. He refused categorically that the baby should be placed out of his care—even though in Switzerland he had no paternal rights as an illegal immigrant with no proof of paternity. He threatened members of the medical team, causing security to be called when he visited. The presence of the the security officers in response to both parents' behaviour made them more hypervigilant and suspicious of the medical team's intentions. However, Raiza remained responsive to limits set—almost as if she had been reassured by the presence of security; while Boris tended to become agitated and provocative with guards and staff alike. Not surprisingly, the day Yousef was transferred to the Child Protective Services residence, the parents separated, and the residence's staff reported that Boris made no further visits to Yousef.

Yousef was placed in an attachment-sensitive center that is meant for temporary shelter, but in fact becomes often a placement for several months. Raiza did not show up for her outpatient visits with us. Follow-up at Yousef's shelter indicated that Raiza had visited initially on a sporadic basis but stopped after several weeks and that Yousef was waiting adoption.

As a postscript to this story, 2 months later Raiza was wandering around the lobby of the Children's Hospital one morning appearing agitated and lost. She was hardly recognizable, with a new hair color and style, wearing large glamorous sunglasses and fashionable, flowing, and colorful, if not somewhat mismatched clothes. She approached Dr. Schechter saying, "Doctor, I am so glad to see you… I don't know where my baby is. I heard he was adopted but they tell me nothing. I just want to know where he is and that he is safe." She proudly pulled out her cell phone and showed Yousef's picture. "This is the last picture I have… see that he can sit by himself now! He is so handsome, no?" Just as Raiza had disappeared, she had reappeared in a new guise and engaged the doctor to cope with her loss, receive confirmation that she had produced a lovely child, and to assist her communication with the city social services department so that she could find out that her baby was indeed in safe hands without compromising the foster family's right to maintain anonymity.

Rose and Europa

A local gynecologist worried that this Italian-immigrant mother whom we shall call Rose had presented for care in her 22nd week of pregnancy. A midwife noted that she seemed "odd and hard to follow." The gynecologist referred Rose for evaluation by the Adult Psychiatry Consult-Liaison Unit at the Maternity Hospital, which led to Rose's immediate hospitalization where she remained until the delivery. After an uncomplicated birth, her baby girl, Europa, was hospitalized in the Developmental Pediatrics Unit. Rose returned to the Adult Psychiatry Inpatient Unit.

We learned that Rose's own mother suffered from a psychiatric illness that required intermittent hospitalization. However, Rose had very positive early and consistent contact with her maternal grandmother until she was an adolescent and began to "have fun with boys." Rose herself had never worked. She was 34-years-old. Despite a history of multiple sexual pursuits since age 14, she denied

physical or sexual abuse. She did not know with any certainty the identity of Europa's father.

We observed that during visits with her daughter Rose appeared adjusted, attentive to Europa's signals, respectful of her sleep rhythms and feeding needs. The pediatric nurses noted that Rose was very careful with her daughter during bathtime, speaking and singing appropriately to her little girl throughout. Europa was a quiet baby who cried when hungry but calmed quickly in Rose's arms. When awake, Rose appreciated her attentiveness.

Rose, in contrast to Raiza, idealized her daughter and saw herself in her daughter. Yet Rose was also able to see her daughter as an individual: She was delighted to discover Europa's face, and to acknowledge that her daughter was nonetheless unique. Rose said, "She has her mother's feet but her hands are all her own."

During the second postpartum week, Rose awakened on the psychiatric ward crying for the nurse. She told staff that she "had nightmares that Europa is crying and calling for [me] but [I] cannot get there… [I] cannot tell her it will be all right." We viewed this as further evidence of an evolving attachment—of what Winnicott called " primary maternal preoccupation" (Winnicott, 1956/1958, p. 300) even though mother and daughter were not allowed to sleep in the same room. Staff decided to bring Europa's crib over to Rose's ward. The nightmares stopped. Europa woke up twice per night to feed and fell quickly asleep again along with her mother.

One concern that remained was that Rose continued to wonder whether in fact she might have produced Europa without a father because she did not know who the father was. During the pregnancy Rose had said that a man she passed on the street on the way to her obstetric appointment might have been the father, but after Europa's birth Rose said that maybe she "alone conceived the baby like the Madonna." This statement was made despite the fact that Rose was taking anti-psychotic medication, and as with many such women, sacrificing breastfeeding to do so.

On the positive side, Rose seemed to rally and become more organized when she spoke about her baby than when she spoke about her own life history. In particular, Rose disorganized around discussion of her tendency to fall in love quickly, passionately, and prolifically with a number of men whom she did not know well, thereby placing herself and her baby at considerable danger. Despite the hurdles of coming to accept that Europa had a father but that the father would likely never recognize Europa as his child (and that Rose would likely not recognize the father by appearance!), 2½ months of mother–baby hospitalization allowed us to build a very positive and reciprocal alliance with Rose and Europa. In contrast to the case of Raiza and Yousef, Rose accepted that "something was not right with her mind" (officially termed "schizoaffective disorder"). She thus gladly accepted psychiatric follow-up for herself and dyadic psychotherapy, home visitation, and case management with a law guardian in the interest of Europa. Until a suitable housing arrangement could be found for Rose in a supervised living facility, she allowed Europa to move to the same attachment-sensitive child protective unit where Yousef had been sent. Yet Rose maintained daily regular contact and demonstrated that she could keep her own mental health appointments. We thus felt confident that Europa and Rose would benefit from the best each could contribute to their mutually satisfying relationship. In addition, we believed that Rose and Europa's emerging attachment would lay the foundation for openness to subsequent attachments with others such as case managers, early childhood staff, or mental health professionals, who would further nurture and enrich Rose and Europa's development as a new family..

What do each of these vignettes teach us?

As infant specialists, we are relationship-based and attachment-focused. We understand the potential effects of protection and risk conferred by a particular attachment relationship (Coates & Schechter, 2004). And, in fact, psychiatric patients often have histories of interpersonal violent trauma, as in the case of Raiza, with compromised early attachment. Such a background often predicts a mistrust of caregivers, medical or otherwise. Yet, when we hear that a mother has paranoid schizophrenia, schizoaffective disorder, bipolar disorder, or has a "severe personality disorder," do we sometimes assume, based on a worst-case scenario stereotype, that an infant and mother with such difficulties are best separated? Indeed, the case of Rose and Europa illustrates that a psychotic mother with supports in place can fulfill her infant daughter's developmental needs sensitively and enjoy her own maternal competence.

This is not to say that we should ignore the elevated risk and perinatal stress implicit in becoming a mother while having one of these chronic disabling psychiatric conditions. Rather, we hope that we can learn to see what prevents Raiza and Yousef from developing a good-enough attachment despite the external supports and constraints that are imposed. And we hope that we can learn to se see what permits Rose and Europa, despite the mother's significant psychiatric morbidity, to maintain a loving attachment and make the most use of external supports and constraints that are imposed. Rose's lack of judgment in her relationships with men poses a risk for Europa in terms of potential trauma such as sexual abuse. And yet, Rose is able to accept that, for this reason, it may be best not to live alone with her baby at this time—while still maintaining a positive relationship with her under the guidance and supervision of professionals.

A secure attachment to her maternal grandmother surely provided a foundation for Rose to accept and make use of help and to pass this appreciation of human relationships on to Europa even as a newborn. In contrast, Raiza's early deprivation, and repeated trauma in the context of having no secure attachment, together with the particular nature of her subsequent psychopathology, prevented her from working with others and with Yousef for their mutual benefit.

Another very common and unfortunate fear for prospective adoptive parents of infants such as Yousef is that these babies may share the schizophrenic or bipolar genetics of their parents. As much as the complexity of modern medical science seems to bring us toward greater uncertainty rather than less, one helpful trend is the realization that caregiving environments matter very much and that genetics are not the only determinants of behavior (Caspi et al., 2003; Meaney & Szyf, 2005). The genetic risk of developing schizophrenia in adoptees whose biological mothers had schizophrenic-spectrum disorders compared to a control group of adoptees of nonschizophrenic mothers was slightly elevated but not statistically significant in a large Finnish epidemiologic study (Tienari et al., 2003).

For mothers such as Raiza and Rose, it is to the greatest advantage to their infants and subsequent generations to reduce their burden of stress during and following pregnancy because stress as been shown to play a role in the vulnerability to and exacerbation of at least some schizophrenic-spectrum disorders (Corcoran, Mujica-Parodi, Yale, Leitman, & Malaspina, 2002; Malaspina et al., 2008). Infant mental health specialists need to further research the effects of

our preventive interventions in terms of reducing toxic stress, improving outcomes, and interrupting cycles of trauma and psychiatric illness. The development of inpatient mother–baby units and transitional programs that provide support upon discharge and that are staffed by infant mental health experts, can play a crucial role in an cost effective and successful intervention for the benefit of all concerned (Hipwell et al., 2000).

Acknowledgments

The authors wish to thank Professor François Ansermet and the staff of the University Hospitals of Geneva and of Piccolo for their unwavering support of the work described in this article. We also wish to thank the patient–families, including those anonymously described in this paper, for what they have often so poignantly taught us about their experiences, needs, wishes, and fears.

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