Drowning in Plain Sight

LITHIUM SAVED MY LIFE," SAID LISA TO HER PSYCHIATRIST. Yet when she told him that she was pregnant, he said, "Of course, you can’t take medicine while you’re pregnant. Maybe we can give you Haldol, but even that wouldn’t be safe." Images flashed through Lisa’s mind of the chaos and self-destruction she felt before she started taking lithium. Yet here was the physician she had known and trusted for years. She took comfort in his certainty that stopping her medicine was the right thing to do. In her mind she challenged herself to be a good mother and to put her own needs second. She stopped her meds—doctor’s orders.

Without lithium, Lisa began to feel a rising agitation that made it impossible to sleep or think. The thought of her manic episode seven years ago terrified her. This is how it had begun—the sleepless nights and frenetic energy that led to desperate efforts to quell the agitation. The drinking helped back then, but what could she do now that she was pregnant? How could she keep going for seven more months until the baby came? Drinking was so tempting but seemed unsafe. In her irrationally rational mind, she imagined a more acceptable solution—driving into a tree.

The image of her bloody, mangled body stunned her into awareness. She felt shame and fear, but forced herself to go to the hospital, a place to which she swore she would never return. She went in her clinic work clothes so that the emergency department staff could see that she was a health care professional and not a patient like Andrea Yates—the Texas mother with postpartum depression and psychosis who drowned her five kids. Yet when she was admitted to the psychiatry unit, this was the welcome she received from the inpatient psychiatrist: “We can’t give you any medicine. If you want to take lithium again, you can talk to your outpatient psychiatrist, but we can’t give it to you in the hospital—too many risks in pregnancy. You can decide to take it, but that’s up to you.” This was the extent of the risk-benefit discussion about lithium with Lisa. Her psychiatrist quickly jumped to the conclusion that the risks of lithium outweighed the risks of withholding it even without attempting to quantify the risks. With so many competing demands, busy physicians are vulnerable to make snap judgments based on instinct and incomplete evidence. As Kahneman and others have described, intuitive errors oc-

lithium was dangerous in all pregnancies rather than pausing to consider available reproductive safety data about lithium and the specifics about Lisa’s situation.

After Lisa was discharged, I saw her for an initial consultation in the perinatal psychiatry clinic where I work. She told me about this devastating experience in the hospital in which she was turned away without help. “I was desperate, but the doctor in the hospital said my medicine could hurt the baby. I didn’t know what to do.” As she spoke an image passed through my mind. I pictured her drowning—screaming, bobbing up and down in the water, arms flailing. Men and women in white coats were standing on the dock beside her and dispassionately jotting down notes about her gestational age and fetal heart tones. One physician finally noticed that she was panicked and drowning. He conferred with his colleagues, who crossed their arms and furrowed their brows as they considered her dilemma. She screamed at them: “Help me! I’m drowning!” They turned to her and called out: “Hang in there. Just seven more months until you deliver.”

Lisa and I talked about the risks associated with first-trimester use of lithium, including Ebstein’s anomaly, a rare heart defect that is estimated to occur in 1 in 2000 (0.05%) to 1 in 1000 (0.1%) lithium-exposed pregnancies. I told Lisa that although lithium increases the risk for this condition, the absolute risk is very low because the baseline risk is extremely low. We then considered other medication options for bipolar disorder and their risks in pregnancy, including valproic acid, which has a 5% to 10% risk of neural tube defects and other craniofacial and cardiovascular abnormalities; lamotrigine, which has had conflicting reports of increased risk of oral cleft in some reports but not in others; and the second-generation antipsychotics, which have much more limited reproductive safety data compared with lithium. As Lisa and I discussed different treatment options, we also considered the risks of avoiding medication. We talked about the high risk of relapse in pregnant women with bipolar disorder who discontinue lithium. I also described the growing evidence that prenatal stress affects fetal brain development and sets the stage for later social and emotional problems in children. Beyond these distant concerns lay even more concrete and immediate risks such as relapsing with alcohol, hurting herself, and further alienating her husband, who bore the brunt of her moodiness. Surely this was not an acceptable prelude to bringing home a new-
born. Also with her worsening depression, how could she possibly connect with her baby? In her agitated state, she had withdrawn from friends and family to avoid lashing out at some unsuspecting person. How could she tolerate a baby’s crying? Escalating mood symptoms in pregnancy, financial strain, limited social support—these are all risk factors for postpartum depression or, in her case, postpartum depression or mania. Weighed against this highly probable scenario, the risks of restarting lithium paled in comparison.

Together Lisa and I decided that the safest choice was to restart her lithium, shore up her social supports, engage her husband in treatment decisions, and start psychotherapy. While titrating her lithium, we also started a medication to curb her agitation and help her sleep through the night—something she hadn’t done in months. I told her that the health of her pregnancy was completely tied to her own physical and emotional health and that by stabilizing on lithium she was taking steps to being the best mother she can be.

Would a physician tell a pregnant woman with epilepsy “Stop your meds and ride out the seizures until you deliver”? Are the medications of pregnant women with mental illness somehow more “optional”? Despite the known risks of maternal mental illness and the accumulating reproductive safety data on antidepressants and other psychiatric medications, pregnant women with recurrent mood disorders like Lisa are often told by health care professionals to avoid medication. Late-night television ads from lawyers fire up the fear of prescribing psychiatric meds: “Do you have a baby with a congenital defect? Were you taking an antidepressant during your pregnancy? You are entitled to cash. Call now!” As a perinatal psychiatry I am an open target for these lawsuits. But what can I live with: a lawsuit or a lawsuit or a lawsuit or a lawsuit or a lawsuit—what do we think will happen to their babies?

Lisa quickly stabilized on lithium and took it through-out the remainder of her pregnancy. She recently gave birth to a healthy baby boy who was lovingly welcomed by his mother. Lisa felt very supported by a community of family and friends that she had retreated from earlier in her pregnancy and then later sought out and embraced. When I saw Lisa tenderly cooing and gazing at her baby at our last appointment, I remembered the image of her drowning while her health care team stood by and watched. Her well-intentioned physicians carefully tried to protect the pregnancy without protecting the mother. If health care professionals let mothers with depression and other forms of mental illness drown, what do we think will happen to their babies?

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Many health care professionals told Lisa that she had to choose between her own health and her baby’s health. She and I reframed the challenge as one of reducing shared risks to herself and her baby—the risks of medication as well as the risks of untreated bipolar disorder. I told her what she instinctively knew all along—that if she relapses with alcohol or hurts herself with either self-neglect or a suicide attempt, her pregnancy and her baby’s health will suffer. It’s not an either/or; it’s a both/and.

Who advocates for the babies? When a mother is struggling to get through the day, what is a baby’s experience of her as a caregiver? She may be there physically, but as she struggles to contain her overwhelming emotions, she is preoccupied and not attuned to her baby’s needs. Furthermore, if the baby is born with fetal alcohol syndrome, could a lawyer make a case for malpractice by the physician who failed to treat the bipolar illness that set the mother up to drink?