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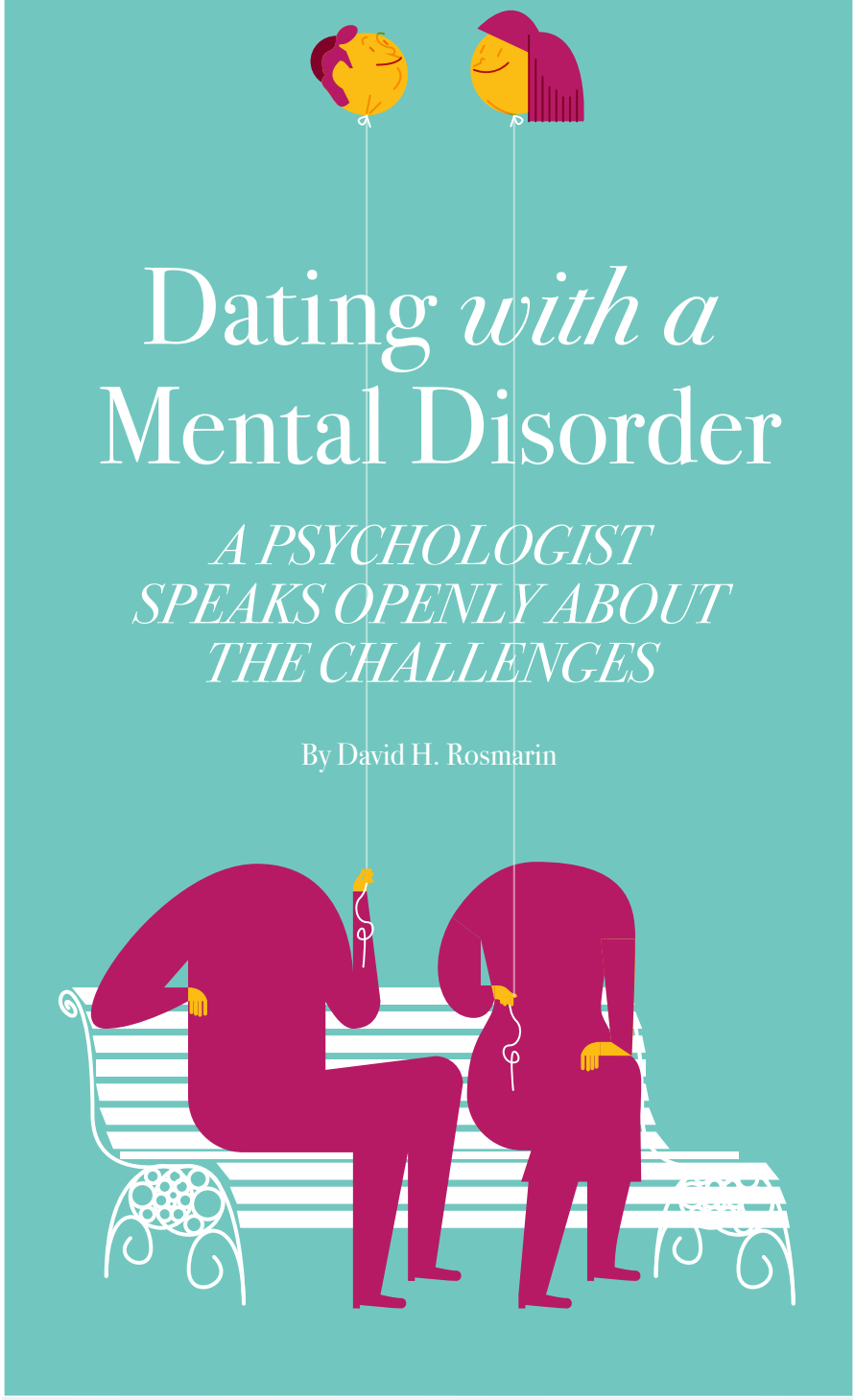
Dating *with a* Mental Disorder

A PSYCHOLOGIST SPEAKS OPENLY ABOUT THE CHALLENGES

By David H. Rosmarin



Mrs. Shoshana Reiss[1] called my office in a panic. Her twenty-two-year old daughter Adina had recently begun dating Simcha, a wonderful and kindhearted young man. Things were off to a great start and Adina was already thinking about the next step, but on the fourth date Simcha dropped a bomb: He disclosed that he suffers from obsessive-compulsive disorder (OCD), for which he receives both regular psychotherapy and medication. As Mrs. Reiss spoke with my patient care coordinator, her fears started to settle, but she had a number of serious questions, such as: Is Adina signing up for a life of turmoil by getting married to Simcha? Will he be able to take care of her, despite his OCD? How will Simcha handle the inherent stressors of Orthodox Jewish family life, such as raising children and the financial demands of paying tuition? Will his children inherit a genetic risk for OCD? What should Adina do? Should she call it off?

As a mental health professional who works within the Orthodox community, I receive these and other questions very frequently. This is no surprise, considering the high base rates of mental health concerns. According to the National Institute of Mental Health, nearly one in five American adults suffers from a full-blown anxiety disorder *in every given year*, and more than two in five will experience an anxiety disorder at some point over their lifespan. Of these cases, more than one in five can be classified as *severe*, meaning that the symptoms lead to a substantial impact on functioning and/or suicidality. And that's just anxiety. If we add mood disorders (e.g., depression), obsessive-compulsive and related disorders, psychotic disorders,

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substance use and other disorders, the yearly base rates climb close to 50 percent. Granted, those figures are for the general population and not Orthodox Jews, and some data seems to suggest that our community fares somewhat better in terms of mental health. For example, in a recent study I conducted with my close colleague Dr. Steven Pirutinsky with over 400 Jewish adults from the United States and Canada, 21 percent of Orthodox Jews[2] were taking psychiatric medications versus 29 percent of individuals outside the community.[3] Nevertheless, rates of mental disorders are alarmingly high, both in terms of prevalence and severity.

Most people know that mental disorders can create "significant distress and impairment" for those who suffer. The ubiquitous *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the American Psychiatric Association's bible of psychopathology, tells us so. But what is discussed far less in the (secular) scientific and clinical literature is the extent to which mental health concerns can impact family life. In any collectivistic or family-centric culture, mental disorders don't just affect the individual but also his or her surrounding social and family systems. And the reality is that Orthodox Jewish culture is far more family-centered than general Western culture. While a supportive family can be one of the most important psychosocial buffers against mental disorders, Orthodox Jewish family life is inherently hectic and often stressful. This creates a ripe context for mental disorders to become debilitating, while simultaneously generating higher stakes for many people. Orthodox Jews depend on each other, so when an individual suffers, his family and community suffer as well.

Therefore, it makes a lot of sense that many Orthodox Jews are asking questions about dating with mental disorders. Mental health issues are abundant, and they can impact family functioning. As such, people rightfully want to know: Can individuals with mental disorders have happy and fulfilling family lives according to conventional Orthodox Jewish standards? Are mental disorders preventable? When they do occur, are they treatable? How common is relapse after successful treatment? How much stress can individuals with mental disorders take before falling into old patterns? Does marrying an individual with a mental disorder create a genetic risk for future generations? Most of all: Should the Orthodox community be more vigilant about mental disorders when it comes to marriage? Should we screen out prospective candidates based on their mental health and that of their families? Should one call it off if he finds out that a prospective partner has a mental health problem?

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Fortunately, the past two decades have seen a substantial shift across all mental health disciplines (e.g., psychiatry, psychology, social work, counseling) towards evidence-based practice, in which clinicians ground their approaches upon empirical findings from systematic research studies, as opposed to intuition or anecdotes. Consistent with this trend, all of the above questions have been addressed by clinical science, to varying degrees. From my vantage point, the current data suggests there are two main factors to consider when addressing issues of mental health and marriage: (1) Whether the individual can access high-quality, evidence-based care such as cognitive-behavioral or dialectical behavior therapy, and (2) Whether the individual is willing to do whatever is necessary to live the best life possible. In other words: *While some mental health conditions may pose more risk to family life than others, when individuals have access to high-quality care and are willing to do whatever it takes to move forward, there is typically no major cause for concern. By contrast, even in "light" cases where people have access to care, when individuals are unwilling to acknowledge their need for help or cooperate with recommendations, the result is often a never-ending burden on family life.*

I will never forget Devora, a single Orthodox female in her late twenties who came to my office with such significant anxiety that she was almost homebound. Devora experienced unrelenting panic attacks, often more than five in a single day, and the last time she ran an errand for her parents at the local grocer, she felt so anxious that she was convinced she would go crazy. And so, Devora initially stopped going to supermarkets, and then she started avoiding the mall, and gradually her world got smaller and smaller because of anxiety, to the point that she could only travel to and from the school in which she worked. Needless to say, Devora's panic was wreaking havoc on her prospects for marriage. Aside from her extreme shame and concerns that she would never find someone who woud accept her, Devora had not been on a date in over a year out of fear that she might have a panic attack and go insane. Despite her symptom severity and impairment, Devora did extremely well in treatment because she accepted her need for treatment, she was highly motivated, and she was

willing to comply with everything that was asked of her. Devora's therapist used a behavior therapy approach called "exposure" to help her face her fears head on. Devora was encouraged to stop avoiding anxiety-provoking situations, and even to engage in activities that would cause her to have a panic attack. Devora pushed herself relentlessly through each stage of treatment, and when she had setbacks she got back on course and pushed herself again. Just six months later, Devora was not only panic-free, but fully functional in her day-to-day life. Three months later Devora started dating, and six months thereafter she was engaged to a sweet and responsible young man who accepted her just as she had hoped for.

In another case, a brilliant and extremely hardworking twenty-two-year old yeshivah student named Binyomin came to my office with an even more complicated situation. He described active perceptual distortions known as auditory hallucinations in which he would hear things that were not truly real. This seemed to be the onset of a very serious mental health condition known as schizophrenia, and so my clinical team was concerned for Binyomin's future. However, we found him to be highly willing to accept his diagnosis and do whatever was necessary to move forward with his life. Working with Binyomin's psychiatrist (who prescribed a low dose of an antipsychotic medication called Risperdal), as well as his parents and *rosh yeshivah*, we encouraged him to stop pushing himself to the brink in learning, to take regular walking breaks every single day, to remain socially engaged even when he felt like isolating, and to completely stay away from alcohol. We also taught Binyomin the basics of mindfulness meditation (which is commonly used in cognitive-behavioral therapy) and we encouraged him to simply observe his hallucinations nonjudgmentally, and to accept them without trying to rid them from his mind. Binyomin struggled to stop pushing himself in learning, and at times his stress level waxed too high and his hallucinations increased. But over the course of a year or so, Binyomin learned to accept his hallucinations and the limits of his stress tolerance, even though this required giving up on some of his dreams. It has now been nearly three years since we first saw Binyomin, and his functioning has not been impaired by his ongoing occasional hallucinations. Given his acceptance and willingness, I have no hesitations about him getting married.

In other situations, however, things have not worked out well. A few years ago, Yaakov, a married man in his mid-thirties came to my office with fairly mild OCD, as well as

some depression. Yaakov's wife had pressured him to go for treatment, since he was starting to avoid contact with his children due to his fears of contamination, and he would sometimes engage in handwashing compulsions prior to spending time with them. Yaakov's clinician provided him and his wife with basic information about OCD and depression, particularly the primacy of behavior therapy ("exposure") in treating the condition. Yaakov would need to face his obsessive fears, such as spending time with his children without decontaminating himself. We worked with Yaakov for several weeks, scaling down treatment to manageable, bite-sized chunks with low-level targets that were fully within his capabilities. But Yaakov was not willing to face the music or engage in treatment using this approach. Over the next four years, Yaakov and his wife bounced around from therapist to therapist, and from psychiatrist to psychiatrist, using all sorts of "treatments" and medications that were neither supported by evidence nor effective. In the end, his anxiety worsened to the point that he ended up in an inpatient psychiatric ward, and his divorce is now pending.

The above cases are consistent with current thinking in clinical science: Treatability in mental health is largely a function of access to high-quality evidence-based care and willingness on the part of the patient to do whatever it takes to get better. Furthermore, present severity or impact of an individual's symptoms is often a poor predictor of the future course of the disorder. Some individuals suffer severely, but their unrelenting desire to get better and willingness to comply with the demands of treatment pull them through, and they remain mentally healthy for life. By contrast, other individuals suffer with low levels of distress but experience a gradual decline over time because they refuse to acknowledge their need for help, or because they don't have the courage and strength to do what it takes to get better.

Clinical science has also taught us that while genetic explanations of mental disorders are commonly held by the general public, the empirical bases for such accounts are much lower than most believe to be the case. Briefly, few genetic risk loci have been identified for the most common concerns, including major depression, anxiety disorders, alcohol/substance use disorders, and obsessive-compulsive related disorders. Furthermore, genetic explanations are oversimplistic; the field of epigenetics has taught us that even schizophrenia and bipolar I disorder[4] are not "brain diseases," but rather they occur only when biological vulnerabilities interact with complex environmental and behavioral factors. In other words, genetic risks can be turned on or off, depending on life stressors and how one responds to such stressors. To make matters even more complicated, mental disorders are commonly misdiagnosed. For example, bipolar I is often better accounted for by bipolar II and/or borderline personality disorder, which have poor genetic bases. Thus, while advances in genomic research are important for the field at large, there are typically more important issues to consider when it comes to marriage and family life.

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Taking things one step further, it's up to each individual to decide whether he or she wishes to date someone who has a diagnosis. But the reality is that the statistical majority of Americans experience a bona fide, full-fledged mental disorder at some point over their lifespan, and our community is not far behind. Furthermore, don't *all* human beings grapple at times with common non-diagnostic issues, such as conceit, anger, passive-aggression, bossiness, social awkwardness, disorganization, and the like? Therefore, it's clear to me that avoiding all forms of emotional and behavioral concerns within marriage is unlikely in this day and age.

And so, in speaking with Mrs. Reiss, I asked her two questions: (1) Does Simcha have the financial and other resources to get high-quality, evidence-based treatment? And more importantly (2) Is Simcha willing to do whatever is necessary to make sure that his OCD doesn't impact his relationship with Adina and their family? I noted that Simcha's timely disclosure to Adina about his condition and the fact that he was already in treatment were likely good indicators, since they suggested that he is willing to acknowledge his issues and get the help he needs. In the end, Adina and Simcha did get married, and while their future is uncertain, one thing seems assured: Ultimately, the success of their marriage will not be determined by the presence or absence of mental disorders, but rather by their ability and courage to overcome emotional struggles. ■

Notes

1. All names and identifying details in this article have been changed to protect privacy.
2. 19 percent of the individuals were raised Orthodox (*frum* from birth) and 27 percent of the individuals were raised non-Orthodox (*ba'alei teshuvah*).
3. It is possible that this finding indicates less willingness among Orthodox Jews to take medications vs. lower incidence of mental disorders.
4. These two disorders have higher genetic risk than other conditions.