Clinical Case Conference

Treating an Orthodox Jewish Woman With Obsessive-Compulsive Disorder: Maintaining Reproductive and Psychologic Stability in the Context of Normative Religious Rituals

Vivien K. Burt, M.D., Ph.D., and Maja Rudolph, M.D.

This report describes the complex issues involved in the treatment of comorbid obsessive-compulsive disorder (OCD) and major depression in an orthodox Jewish woman of childbearing age. Although much has been written about the use of medications to treat both of these conditions during pregnancy and the postpartum, this case highlights the need for sociocultural sensitivity on the part of the treating psychiatrist. This Orthodox Jewish woman clearly requested help in managing her conditions in a manner that would allow her to proceed with her plan to bear many children. She was concerned about achieving and maintaining clinical stability over the course of repeated pregnancies and postnatal periods, and she also emphasized her wish to remain healthy so that she could successfully mother her children. What is often viewed as a clinical problem from a purely psychopharmacological perspective was therefore more properly addressed comprehensively in the context of the patient's culture and religion. In this article we address issues such as family planning, obsessions and compulsions arising out of accepted community religious practices, premenstrual exacerbations, hyperemesis gravidarum, miscarriage, and family education regarding the risks and benefits of psychotropic use during pregnancy and nursing.

Received Sept. 22, 1999; revision received Dec. 7, 1999; accepted Dec. 9, 1999. From the Women's Life Center, UCLA Neuropsychiatric Institute and Hospital. Address reprint requests to Dr. Burt, Women's Life Center, UCLA Neuropsychiatric Institute, Suite 2337, 300 UCLA Medical Plaza, Los Angeles, CA 90095-6968; vburt@mednet.ucla.edu.

CASE PRESENTATION

Patient Description

Ana B. (a pseudonym) was a 26-year-old Orthodox Jewish woman who had been married 4 months before being seen at the UCLA Neuropsychiatric Institute and Hospital Women's Life Center. She worked as a sales representative for a computer software company. Ana had OCD and comorbid major depression. In view of her religious and cultural background, she planned to bear numerous children, and she requested stabilization of her condition during pregnancies and the intervening months. Ana also wished to be educated about the safety of psychopharmacological management of OCD and depression during pregnancy and the postpartum.

History of Present Illness

Ana's history of self-doubt dated back to age 7, when she first recalled being uncertain about adhering to many of the religious rituals normally associated with her community's cultural/religious beliefs. For example, many Orthodox Jews observe a waiting period of 6 hours between eating meat and dairy foods. Ana would carefully count the hours between eating a meat meal and a dairy meal, but she would later be beset with doubts about whether or not she had waited the religiously allowed number of hours. Such self-doubt extended into other religiously defined regulations, but for the most part she was able to refrain from any ritualistic behaviors. At the age of 18, Ana attended a girls' school in Israel and embarked on a course of chronic checking rituals. Thus, if she stopped at restaurants that served nonkosher food, she compulsively washed her hands repeatedly because she feared that she might have unintentionally touched some forbidden food, utensils, table, or countertop. She began to skip meals because she was afraid that she might contaminate her own food with nonkosher food products unknowingly carried on her hands. Other symptoms included habitually rechecking labels of food products to ensure that they were kosher. By the time she was 24 years old, her symptoms had progressed to the extent that she became afraid to eat and lost 25 lb over the course of 1 year. Other rituals included checking and rechecking locks and stove burners. Two years before her initial evaluation in the Women's Life Center, Ana was treated for OCD by a community psychiatrist, who gave her short (1–2-month) trials of fluoxetine (20 mg/day), clomipramine (100 mg/day), and sertraline (150 mg/day). In each case she achieved partial relief of her obsessive thinking and compulsions but ruminated about continuing to take medications for a prolonged time because she hoped one day to marry and have children and feared that she would rely on medication that she presumed would be unsafe in pregnancy. As a strictly Orthodox Jewish woman, Ana considered marriage and the bearing of children as major lifetime goals of paramount importance.

Ana met her husband-to-be, a successful independent entrepreneur, in an arranged meeting. She told him that she had OCD and that she was treated with medications that partially controlled her symptoms. He was very supportive, particularly because one of his siblings had OCD. At the time of

her marriage she had discontinued all medications. Two months after the marriage, however, her obsessions and compulsions returned and began to trouble her more than ever. She was unable to prepare any meals because of increasing self-doubt about contaminating utensils meant to be used for meat dishes with those reserved for dairy foods, and vice versa. For Ana, marriage added to the culturally normative rituals that further challenged her obsessive-compulsive tendencies.

After marriage, Orthodox Jewish men are prohibited from touching their wives during the time of menstruation or for 7 days thereafter. According to stipulated ritual, an Orthodox Jewish wife is responsible for ensuring that she is no longer exhibiting vaginal bleeding by swabbing herself carefully with a linen cloth for each of the 7 days following the overt cessation of the menstrual flow. It is only then, after a ritual bath (the Mikvah), that she and her husband are allowed to physically touch one another. Faced with this responsibility, Ana obsessed about whether there was a tinge of pink on her linen cloths. She checked the linen cloths repetitively and was unable to decide definitively that the menstrual flow had ceased. Ultimately, she consulted with her rabbi, who agreed to check the linen on a monthly basis and make the decision about whether or not she was free of blood. At work, she ruminated about making mistakes and checked her inventory lists repetitively in order to ensure that she did not forget any entries for each day's work. She began to isolate herself and spent many hours of each day and much of the weekends in bed. Ana also experienced premenstrual worsening of her depressive symptoms.

Ana's husband took responsibility for food preparation and household cleaning. However, as Ana's obsessions worsened she became increasingly depressed. Her symptoms included loss of appetite, hypersomnia, anergia, anhedonia, amotivation, passive suicidal ideation, and feelings of guilt for adding to her husband's responsibilities. She identified her religious conviction as the reason that she would never actually harm herself. Despite her husband's support, she was concerned that the viability of their marriage might be threatened as a consequence of her worsening condition.

Additional History

Ana was the younger of two daughters of Orthodox Jewish parents. Her mother had been diagnosed with depression and treated with clomipramine. Her sister had been in psychotherapy but had never been diagnosed formally with a psychiatric disorder. Ana described both of her parents as perfectionist. Both she and her sister were raised in a sheltered environment After Ana spent 1 year in the girls' school in Israel, she attended an East Coast college, where she received a bachelor's degree in political science. She remained on the East Coast after graduation in order to participate in her religious community's social circle as a prelude to meeting a potential mate. However, she found the social pressures to be overwhelming, and after several years she returned to Los Angeles, where she met her husband. She worked as a sales representative, with job responsibilities that included making daily site visits to shops and restaurants. She found the work tedious and stressful, particularly because she worried about making mistakes in her inventoried accounts and also becoming inadvertently contaminated during her visits to various food establishments.

Ana and her husband were married 1 year after they met, a rather long courtship for members of her religious community. As Ana explained this, "I am very much a part of the Orthodox community, but I also have a mind of my own, and I very much wanted to make sure that the match between us was a good one." When initially seen, Ana was using foam birth control, yet another testament to her determination to carefully move ahead with her life with foresight and planning. In this case, she was concerned about her OCD being so out of control that she might become pregnant at a time when her emotional instability might compromise the stability of the pregnancy or her own mental well-being.

Ana had never abused alcohol or illicit drugs. Baseline laboratory data were gathered, and all indexes (CBC, chemistry panel, liver function tests, and thyrotropin level) were normal. Her past medical history was unremarkable.

Mental Status Examination

When first seen, Ana was an attractive, cooperative 26-year-old woman appearing her stated age. In the fashion of members of her religious community, she wore a kerchief over her hair. She was alert, oriented, clear, logical, and coherent. Her thoughts were concerned with symptoms of OCD and related depression. Her thought process was focused, ordered, and logical. Her speech was rapid and pressured. She was moderately depressed and had a mildly agitated affect that was nevertheless full and appropriate to content. She described herself as increasingly helpless and felt overcome with guilt at the burden her symptoms were placing on her husband. She affirmed passive thoughts of wondering if life was worth living, but she denied any thoughts of actively harming herself. She was cognitively intact and had an excellent fund of knowledge, vocabulary, and memory (remote, recent, and immediate). There were no psychotic signs or symptoms. Ana's insight and judgment were excellent. She was aware that her symptoms were not normal, and she was motivated to do what was necessary to gain control of them. She also expressed the desire to be treated by a psychiatrist who would refrain from adverse judgment regarding the traditions, customs, and beliefs of her cultural and religious community.

Treatment Plan

The treatment plan was based on goals that Ana wished to achieve:

1. Symptom resolution. A combination of psychopharmacology and behavioral exposure therapy was selected. Ana clearly wanted to gain control of the symptoms that had so overwhelmed her and the marriage over the course of the past months. It was clear that Ana had as a primary goal the attainment of a balanced marital relationship with a sharing of domestic and career responsibilities.

2. Preparation for pregnancies, postpartum, and parenting. Ana saw as a major priority being the mother to a large family of children. She therefore wanted to prepare for her pregnancies in order to maximize their successful outcome and also wanted to increase the likelihood that she would feel emotionally able to take on this role.

We agreed on a course of combined pharmacotherapy and behavioral exposure therapy to aggressively treat the symptoms of OCD and secondary depression. Because of her discomfort about disclosing the religiously ritualistic aspects of her symptoms, Ana declined a referral to an intensive behavioral therapy program. Since her psychiatrist (V.K.B.) had prior experience in the use of behavioral exposure to treat OCD, it was agreed that both

pharmacotherapy and behavior therapy would be carried out under the direction of that physician. Upon symptom resolution or the achievement of significant improvement, Ana's medications would be tapered and stopped while she continued the cognitive behavioral regimen, to maintain improvement and stabilization of her condition while minimizing the likelihood of medication use during future pregnancies. Several conjoint sessions were planned to educate Ana's husband about the nature of OCD and depression and to review the alternative modalities available to treat these conditions. Ana and her husband would also be educated about clinical decision making, in case pharmacotherapy was needed to achieve symptom resolution during pregnancy and/or the postpartum.

Treatment Course

Prepregnancy regimen. Over the next 18 months Ana was treated with fluoxetine, at doses from 20 to 60 mg/day. She also underwent a modified regimen of intensive cognitive behavioral therapy. Ana purchased a copy of a layperson's book on the treatment of OCD (1), and much time was spent in therapy reviewing various techniques for postponing, interrupting, or interfering with her obsessions. She listed the situations that stimulated her obsessions and precipitated compulsive, repetitive behaviors. In addition to the situations already described, over the course of therapy additional obsessions and compulsions were revealed. Ana described her fear that she might be cheating cashiers when paying for purchases at the market; as a result, she would compulsively ask them to state and restate what she had paid when giving them money. As part of her monthly ritual washing in the Mikvah, she was required to submerge herself. Invariably she was unsure of having performed the correct number of immersions or having been fully submerged. She compulsively and repetitively washed fruits and vegetables in order to assure herself that they had not been contaminated with nonkosher foods when being handled by others in the market. Each week a goal was set for Ana to expose herself to one of these stressful situations for a limited but prescribed time and to repeat this exposure until she found herself "bored" by the exercise. She would then move on to another situation that stimulated her obsessions and compulsive behaviors, and she would practice desensitization exercises in similar fashion. In the session she was provided with utensils that had purposefully been contaminated with nonkosher food products, and she would be directed to handle these during the course of the session. She would then be asked to leave the office in order to wash her hands for not more than 60 seconds. Upon returning home, she purposefully refrained from washing her hands before participating in kitchen activities. Slowly, she found herself sharing household tasks with her husband. Religious rituals also became less stressful, and she was able to refrain from repetitions beyond those that were culturally required. Both Ana and her husband felt more hopeful and optimistic. Her husband felt included in the treatment process, and Ana felt less isolated. One year after the combination program of medication and behavioral exposure was instituted, the symptoms of OCD, while not completely resolved, were substantially improved. Although obsessions still occasionally intruded into her thoughts, she was able to refrain almost completely from checking rituals. She prepared foods in the kitchen, refrained from compulsive hand washing, and no longer doubted the results of her monthly linen inspection.

Ana and her husband decided that she was ready to attempt a trial taper of the fluoxetine. Over the 2 months following discontinuation of fluoxetine, Ana's symptoms returned. While she was more capable of controlling many of her compulsive responsive behaviors, she nevertheless reported a return of her obsessive thoughts and experienced a rising tension as she refrained from responding to these thoughts with compulsions. The depressive symptoms also returned. Since Ana and her husband had been educated about the data regarding the use of fluoxetine during pregnancy, the decision was made to reinstate this medication at a dose of 40 mg/day. One month after reinstatement of fluoxetine, Ana's OCD symptoms had once again dissipated considerably.

First pregnancy and postpartum. Three months after a return to her baseline response to combined treatment, at Ana's request a discussion was held with her obstetrician to apprise him of her diagnosis and the decision to continue medication management through pregnancy. He was also given a publication (2) that reviewed the literature on the use of psychotropic medications during pregnancy. One month after discontinuation of birth control use, Ana became pregnant. The pregnancy was remarkable for a sustained interval of hyperemesis gravidarum lasting 24 weeks. Over the first 20 gestational weeks, she experienced a weight loss of 10 lb. Intermittently Ana required intravenous hydration and nasogastric feeding in order to replenish fluids lost through emesis and to stabilize her nutritional status. Anxiety, agitation, irritability, tremulousness, shortness of breath, and palpitations characterized Ana's condition. Depressive symptoms emerged and appeared to be secondary to the unceasing nausea and anxiety. Attempts by the obstetrician to control the emesis with prochlorperazine and trimethobenzamide hydrochloride were minimally successful. During the 16th antepartum week, after consultation with the obstetrician Ana and her husband were seen again in a conjoint session to discuss the use of a benzodiazepine to control the anxiety and thus perhaps to remove one factor that might be responsible for the hyperemesis. The available data regarding the use of benzodiazepines at different points in pregnancy were reviewed (2, 3). Clonazepam was prescribed and titrated up to a maximum dose of 0.5 mg b.i.d., which Ana took intermittently as needed. By 18 weeks she began to gain weight, and the nasogastric tube was removed. Clonazepam was continued in diminishing doses until the 22nd week antepartum, when it was discontinued. As the hyperemesis and anxiety dissipated, the associated depression also resolved. The OCD symptoms were well controlled with fluoxetine, 20–40 mg/day.

At this point the benefits of breast-feeding to both mother and baby and the risks and benefits of fluoxetine use by nursing mothers (4–6) were reviewed with Ana and her husband. Ana elected not to breast-feed. Her reasons included uneasiness regarding the paucity of data on the subject and the fact that sleep deprivation exacerbated her OCD symptoms. A baby nurse was hired to assist in feedings over the first 10 postpartum days. At 39.5 weeks' gestation Ana delivered a healthy 7 lb 1 oz baby girl. After the initial 10-lb weight loss she had gained 18 lb, resulting in a net gain of 8 lb over her prepregnancy weight. The delivery was spontaneous and vaginal with no complications. Over the first 2 postpartum weeks Ana exhibited mood lability, intermittent tearfulness, and emotional hypersensitivity but

bonded well with her infant. She continued to take fluoxetine (20 mg/day), and her depression (or, more accurately, "postpartum blues") receded by 2.5 weeks postpartum.

Two months after the birth of her baby and 1 week before her first postpartum menses, Ana experienced a return of emotional hypersensitivity, depressed mood, and irritability. Her OCD symptoms remained mild and largely in the background. Over the next 2 months Ana experienced premenstrual irritability, moodiness, and worsening OCD. The fluoxetine dose was increased to 60 mg/day, with a definitive improvement of both premenstrual symptoms and OCD. At no time did either OCD or depression interfere with Ana's ability or desire to care for her baby. At this point Ana also resumed the use of foam birth control.

Second pregnancy and miscarriage. While still using foam contraception, at 5 months postpartum Ana became pregnant. At her request, the fluoxetine dose was reduced to 20 mg/day. Unlike Ana's first pregnancy, the second was not accompanied by nausea or vomiting. She did, however, experience occasional bouts of dysphoria interspersed with low-level symptoms of obsessions, which she was largely able to contain through a combination of medication and cognitive restructuring. Twelve weeks after her last menstrual period Ana learned that she had suffered a miscarriage involving twins. Dilation and curettage were performed. Symptoms of OCD, particularly an increase in the frequency of hand washing, returned and remained troublesome for 2 weeks. The fluoxetine dose was increased to 60 mg/day, which produced good control of her OCD symptoms.

Third and fourth pregnancies. Within 3 years of the miscarriage Ana became pregnant twice. As was the case with her first pregnancy, hyperemesis, anxiety, and depression marked both events. Clonazepam was added sparingly when necessary and relieved the anxiety and nausea. OCD symptoms were effectively maintained by fluoxetine at doses of 20–60 mg/day. In each case, an initial 2-week period of emotional hypersensitivity, depressive symptoms, obsessive thoughts, and increased frequency of rituals such as excessive hand washing characterized Ana's postpartum course. The fluoxetine dose was varied as needed and effectively resulted in the resolution of the OCD and depressive symptoms. As had happened after her first pregnancy, depression and irritability preceded Ana's initial postpartum menses. An effective treatment regimen was established whereby the fluoxetine dose was increased by 20 mg during the 5 premenstrual days and then maintained at a baseline dose on all other cycle days.

Ana delivered a second daughter, 7 lb 11 oz, and a son, 7 lb 7 oz, both by normal spontaneous deliveries after full terms of gestation. In follow-up appointments Ana was usually seen with one, two, or all of the children, with whom she had bonded very well. All three children were thriving and healthy. She resumed contraception and planned to become pregnant again at some future date.

DISCUSSION

Several case reports and studies indicate that pregnancy and the postpartum are times of increasing symptom severity for women with established diagnoses of OCD (7–9) and may also be risk periods for new-onset OCD (8, 10). In particular, the third trimester and the postpartum may be times of particularly increased risk for exacerbation of OCD (11). Furthermore, patients with OCD frequently have comorbid depressive syndromes, including major depression (12). It is therefore important that women with established OCD be provided with careful preconception counseling, including a discussion of the advisability of contraception until the psychiatric condition is stabilized. Treatment options, comprising both pharmacologic and psychotherapeutic regimens, should be discussed with the couple, and time should be allotted for questions. It is particularly helpful to provide the couple with a written summary of the treatment plan options, and care should be taken to justify each of the different options.

In the case of Ana B., the accepted standards of practice for treating a woman with OCD through prepregnancy stabilization, pregnancy, and the postpartum were complicated by the sociocultural norms of the patient and her family. For Orthodox Jewish families, childbearing represents a critical and sacred privilege and requirement. For Orthodox Jewish women, bearing numerous children is a most important goal. It is beneficial, therefore, if the caregiver is willing to understand and be sensitive to the norms of the religious community. It is not necessary for the clinician to be a practitioner of Orthodox Judaism or to be a member of the same religion; rather, what is useful is that the clinician be nonjudgmental and willing to learn about required religious rituals.

Learning about normative religious and cultural rituals while at the same time appreciating how these may be incorporated into the signs and symptoms of psychiatric illness is important for the treating psychiatrist. In the case of Ana B., many of the rituals involving religious practice, particularly those related to food and to cleansing in association with the menstrual cycle, presented particular difficulties. Ana's OCD symptoms invariably related directly to these rituals. However, Ana was intelligent, reflective, and highly motivated to achieve her goal of mothering a large family. She was an active and spirited participant in all aspects of the treatment.

Conjoint prepregnancy counseling, always desirable in discussions of treatment options, was particularly important in the case of Ana B. With inclusion of her husband, not only was information regarding treatment before, during, and after pregnancy shared, but an opportunity was provided for emphasizing that the lifestyle choices of this religious couple need not be compromised or threatened. Thus, although Orthodox Jews do not sanction birth control, contraception is generally permitted when the mother's health is at risk (13). After a discussion with their rabbi about the importance of psychiatric stabilization before pregnancy, rabbinical approval was granted for contraception. The entire case formulation and treatment plan was shared with Ana's obstetrician.

This case demonstrates how the practice of Orthodox Judaism provides a backdrop of beliefs and behaviors that affect the presentation of psychiatric symptoms. In another example of how religiously accepted practices may interact with psychiatric symptoms, observant Muslims engage in daily ritual cleansing before prayers, which are said five times daily and may repetitively recount phrases to deflect sacrilegious thoughts (14). The clinician who is unaware of religiously acceptable practices may mistake these behaviors as evidence of OCD or paranoid psychosis. Alternatively, it is important to be aware that symptoms of psychopathology may emerge in the context of religious rituals. Sensitive clinicians who learn and appreciate the nature, practice, and beliefs of patients who embrace religious and cultural lifestyles other than their own will be able

to distinguish normative beliefs and rituals from abnormal preoccupations and practices that are disabling and cause morbidity and dysfunction.

CONCLUSIONS

Educating prospective parents about the safety and advisability of alternative treatment options over the course of pregnancy and the postpartum allows for the establishment of an effective regimen in the context of a working alliance that incorporates parents, psychiatrist, obstetrician, and when appropriate, members of the clergy. As this case demonstrates, it is important also to understand and appreciate the sociocultural and dynamic personality constructs of both the patient and partner. Treating Ana was gratifying not only because she realized her two stated goals of maintaining psychiatric stability and successfully assuming her role as mother of a growing, emotionally healthy family. An added, unanticipated source of gratification was the shared respect that developed between clinician and patient. A successful treatment regimen was established because both openly acknowledged mutual misconceptions and deficits in knowledge about culture and religion. As a result, both were motivated to flexibly address clinical problems that were encountered over the course of four pregnancies and the birth of three healthy children.

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