

Case Report

Treatment of Anorexia Nervosa in an Ultra-Orthodox Adolescent Male

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Abstract

Objective: This unique case presents an opportunity to deepen the understanding of the etiology of anorexia nervosa in an ultra-orthodox 14-year-old adolescent. The boy arrived at our countryside clinic after a 1.5-year history of severe self imposed diet restrictions to control his weight and appearance, and a year of partial and full hospitalizations in psychiatric wards. The main objectives of the intervention were: to achieve nutritional rehabilitation, develop normal eating and self-care habits, eliminate bed-wetting, as well as challenge developmental issues and cultural discourses.

Method: 12-months of comprehensive intervention, which included: a weekly dietetic session, parental guidance or family therapy, interpersonal and narrative psychotherapy twice a week, and a clinical mentorship (two days per week). The boy's progress was assessed via interview, using EDEQ-17 for the assessment of eating disorder symptoms, DASS-21 for the assessment of self-regulation, and the Rosenberg scale for the assessment of self-esteem.

Results: After a year in our outpatient clinic, the boy regained normal eating habits and normal weight status. His EDEQ global score decreased from 4.1 to 0.9. His global DASS-21 score decreased from 38 (severe) to 7 (normal) indicating improvements in self-regulation and impulsiveness. Self-care and self-esteem were also significantly improved. Bed-wetting disappeared. He is currently fully functional in his community and attends a school that better accommodates him. The co-morbidity of eating disorders, obsessive-compulsive disorder (OCD), impulsiveness and anxieties as well as bed-wetting led to the decision to implement an intense and long-lasting intervention.

Discussion: The described case demonstrates the lack of suitability to function adequately in the ultra-orthodox community as a precursor for anorexia nervosa with compulsive features. The co-morbidity of eating disorders, OCD, depression, and bed-wetting worsened the course of his anorexia leading to an intensive and long-lasting intervention. As a result, the boy overcame his anxieties and developed skills, maturity, self-esteem and self-care in order to return to his community.

Keywords: Anorexia Nervosa; Orthodox; Bed-wetting; Anorexia Nervosa

1. Introduction

Despite limited research, empirical studies have demonstrated that religious and spiritual variables are important sociocultural contributors to the understanding of eating disorders and related conditions [1]. In the large and growing orthodox Jewish communities, reports on the prevalence of eating disorders are conflicting [2-4]. Eating disorders are less common among males across cultures, and specifically in ultra-orthodox communities [2].

The ultra-orthodox Jewish community is characterized by heavy restrictions on specific foods, as well as mass media exposure, sexual relationships, and more. Ultra-orthodox Jews tend to live in segregated neighborhoods. There is gender separation during the schooling process. All orthodox adolescent males are expected to fit the ideal stereotype of the ‘Jewish Yeshiva boy’ who enthusiastically studies Talmud. When they are 20-22 years old, they are expected to get married, often before they are emotionally ready. Anxieties and inner turmoil are the fate of adolescents that disappoint the family due to learning difficulties, weak or negative coping skills, and religion-related external motivation. Exposure of gender confusion may cause a family breakdown; thus, it is often denied [5]. Food is central to all Jewish cultural, ethnic and religious traditions; Food is paramount in the lives of the ultra-orthodox community, not only because of religious ritual practices, but also because of extremely large families to feed. In Israel, one-third (33.7%) of ultra-orthodox families have six or more children, compared to 3.4% of secular Jewish families [4].

Greater levels of religious orientation are generally associated with more positive mental and physical health outcomes among children [6]. Religion may serve as a protective factor against eating disorders among orthodox girls. Religious girls are less influenced by the Western society beauty models. Due to strict observance of religious traditions they do not need to control eating and weight as a means to handle pressures of adolescence [2]. Positive religious coping [7], spiritual wholeness, and attachment to God [8] are associated with better health outcomes.

However, religious orientation may also have a negative impact [9, 10]. Religious experiences that are associated with self-criticism [4], guilt, or anxiety may exacerbate general psychopathology [11] and eating disorder symptoms [12]. It is not surprising that anorexic behaviors may reflect a projection of religious features such as extremity, dominance of rituals and laws, self-criticism, fasting as a purification mechanism, repetition as a positive value in learning, and more.

Similar to secular adolescents with anorexia, orthodox adolescents may be susceptible to eating disorders in their attempts to avoid mental pain or deal with issues related to interpersonal conflicts. In the ultra-orthodox society, the failure to fit in with religious and societal norms may be a specific risk factor. Unlike girls, the problem is not adherence to the superwoman ideal and body dissatisfaction which are irrelevant [13], rather a failure to adhere to the Yeshiva career where the self-identity relies totally on studying and on family matters.

The described case demonstrates the dynamic of being unsuited to the ideal image of a Yeshiva boy, as a precursor for anorexia nervosa in ultra-orthodox males. To the best of our knowledge, this case report is among the first detailed publications about anorexia nervosa in an ultra-orthodox adolescent male.

2. Case Presentation

2.1 Demographics

This case report describes a 14-year-old adolescent, the third child of 36-year-old ultra-orthodox parents with six children. He lives in an ultra-orthodox family within an ultra-orthodox community. His mother works as a caretaker in a kindergarten and his father is a Kollel student, which means he divides all his time between the Yeshiva and his family. The Yeshiva takes care of the family's financial and spiritual needs.

2.2 History

The boy arrived at our clinic (Shahaf Eating Disorder Center) after a year of partial and full hospitalizations in eating disorder wards. He had a 1.5 year history of severe self-imposed diet restriction in order to control his weight and appearance - a rare phenomenon in his community. He was referred to our countryside clinic by his rabbi, who insisted it was time for him to return to his community and school, contrary to the recommendations of the inpatient ward's medical team. The diagnostic assessment that was sent to us reported low-range intellectual abilities. The assessment described his powerless, fragile and inferior self-perception, as opposed to the parents' perception of his high intellectual abilities and a future as a great Talmudic student. The assessment mentioned indirect communication and a tendency towards acting out his aggressive urges. Oppositional behaviors, obsession with food, and compulsive standing were also reported.

The boy's anorexia was developed after a bicycle accident which resulted in skipping school and synagogue, feelings of being bored and over-eating, and exacerbation of his social and learning difficulties. This led to deterioration in anxiety and impulsivity axes.

2.3 Symptoms at admission

Upon admission to our facility, the boy demonstrated a meticulous appearance with features of dandyism with weight 33 kg, height 1.41 meters, BMI- 16.6 - in the 21st percentile on the BMI-for-age curve, and the 2nd percentile on the stature-for-age curve. Blood pressure 96/62 mmHg and pulse rate 97. He reported eating six meals a day, according to the diet prescription given to him at the hospital. The diet included approximately 2000 calories. He

presented major obsessive-compulsive symptoms associated with the eating disorder, such as: selective eating, Neophobia, fat phobia, fear of weight re-gain, and compulsive standing.

He was diagnosed with Restrictive Anorexia Nervosa according to the DSM-5 criteria [14] and according to scores on the Eating Disorders Examination Questionnaire (EDE-Q) [15] using the Hebrew version [16]. His Global EDEQ scores at admission were 4.1 ± 2.5 with a Restraint subscale score of 6 ± 0.2 (Table 1). The Depression, Anxiety and Stress Scales (DASS-21) (17) indicated on severe depression (12 ± 1.6), severe anxiety (9 ± 1.3) and extremely severe stress 17 ± 1.1 (Table 1).

Our patient also reported regular uncontrolled bed-wetting interfering with psychosocial functioning (irregular school attendance, social difficulties, and disturbances in integrating into community activities). Any conversation about gender rituals was rejected with a childish tone.

Symptoms	Admission	6 months	12 months
Weight (Kg)	33	35	41
Height (m)	1.41	1.43	1.47
BMI	16.6	17.1	19
BMI percentile	21 st	21 st	52 nd
EDE-Q restraint	6 ± 0.2	2.75 ± 2.1	1.4 ± 1.7
EDE-Q eating concern	4.8 ± 2.7	2.2 ± 1.5	1 ± 1.2
EDE-Q shape concern	4.5 ± 1.7	2.75 ± 1.9	1.1 ± 0.6
EDE-Q weight concern	4.2 ± 1.8	1.4 ± 1.3	0.6 ± 0.9
EDE-Q Global Score	4 ± 2.5	1.9 ± 1.6	0.9 ± 1.0
DASS-21 Depression	12 ± 1.6	7 ± 1.0	4 ± 0.5
DASS-21 Anxiety	9 ± 1.3	3 ± 0.8	0 ± 0.3
DASS-21 Stress	17 ± 1.1	9 ± 0.8	3 ± 0.5

Note. EDE-Q17, Eating Disorder Examination Questionnaire. Normal Global values <4.5 ; DASS-21, Depression, Anxiety and Stress Scale. Normal values: Depression <4 ; Anxiety <3 ; Stress <7

Table 1: Symptomatology at baseline, 6 months, and 12-months (end of intensive treatment) follow up.

2.4 Treatment

The main objectives of the intervention were to achieve nutritional rehabilitation, develop normal eating and self-care habits, eliminate the obsessive-compulsive features, as well as improve the anxiety and stress components, the bed-wetting, and developmental issues. In this case, developmental issues refer to cultural and religious discourses that could not be communicated, and thus were conveyed via the severe disease. The comprehensive intervention included two weekly days at the clinic, nutrition counseling, interpersonal and narrative psychotherapy and clinical mentorship. Parental supervision and later family therapy was provided.

The gap between the parents' perception of the boy as having extraordinary intellectual abilities, and the boy's self-perception of himself as an incompetent, inferior, fragile, and worried boy in his community was targeted in various ways. The family therapist assisted his parents in acknowledging his difficulties and capabilities and accepting him as he is: and at the same time practicing firm parental authority when the boy faces difficulties with boundaries.

The dietitian provided psychoeducation, cognitive behavioral tools, and motivational enhancement strategies to assist the boy in regaining his independence. He was expected to: demonstrate self-care; set limits to his fears, stress, and aggressive urges that were projected upon eating and his body; and develop appropriate maturity. The clinical mentor helped him practice normal eating habits, assisting him in developing self-caring and compassion by treating the animals on the farm. Attention, rigidity, impulsivity and mature behavioral issues were addressed via collaboration between the boy and his clinical mentor in planning and building a house for hens. The boy himself expressed his wish to perform this project "in order to leave his fingerprint" on the out-patient clinic yard. During individual psychotherapy, he developed opposition towards the eating disorder and rebuttal of its demands. He monitored his self-control and self-discipline and set school-related objectives to address his wish to be integrated in his orthodox community.

3. Results

After a year in our outpatient clinic, the patient regained a normal weight status, normal eating habits, and self-care behaviors. He weighed 41 kg, his height measured 1.47 meters and his EDEQ scores were significantly reduced to normal values (Table 1). He no longer demonstrated eating disorder symptoms. Similar improvement was noted in DASS-21 (Table 1). His anxiety, self-esteem, and childish behaviors were significantly improved, and bed-wetting disappeared. We assumed that the success of the treatment stemmed from addressing the boy's unique needs and connecting him with nature, which helped him recognize his strengths. After the one-year intensive treatment, the patient continued with only dietetic follow-up meetings.

Following our recommendations, which were supported by the community's head rabbi, the boy enrolled in a school which teaches agriculture and animal management practices, as opposed to only Bible studies (as expected for a future Yeshiva student). It is very common in orthodox communities that the head rabbi is more person-centered and able to address the inability of certain vulnerable children to adhere to the community's strict track. They often recognize the need to adjust the track to the child and find a compromise appropriate to both the child and the community.

4. Discussion

We described a case of a 14-year-old ultra-orthodox boy with anorexia nervosa, obsessive compulsive behaviors, and bed-wetting. His sense of anxiety and inferiority, due to a function in the ultra-orthodox community, caused severe anorexia with compulsive features. The co-morbidity between the eating disorder, anxiety, impulsive components and bed-wetting led to an intensive and long-lasting intervention. The boy overcame his anxieties, developed skills, maturity, self-esteem, and self-care in order to return to his community.

The eating disorder was a means for coping with the large gap between his personal emotional, cognitive and social abilities and the ideal discourse of an ultra-orthodox boy. During the treatment he admitted to dandyism which is a negative characteristic in the ultra-orthodox community. His reported desire to purchase expensive shoes and watches, and wear elegant suits, ties and scarves contraindicated the rules of modesty which are imposed by his community. This dandiness may be part of his developmental process of individuation and a way to achieve a sense of uniqueness and superiority as well as part of gender issues, an idea which he waved away.

Latzer et al. suggested that negative religious coping is associated with negative mental and physical health outcomes [7]. However, religious symptoms are more likely an impetus to seek guidance from a Rabbi rather than a mental health expert in the ultra-orthodox communities. The ultra-orthodox society tends to avoid emotional conversations, and encourage suppression of strong desires and emotional challenges [18]. A famous religious proverb says “There is no hero like the one who suppresses his desires”. In ultra-orthodox communities, mental health problems still carry a severe stigma; thus there is often resistance to seeking psychological treatment to deal with emotional issues [19]. The exacerbation of the boy's hidden low self-esteem and difficulties (dependence, studying, setting boundaries, and social problems) may have been caused by, the associated guilt, anxiety, and shame of communicating difficulties in a straightforward manner, as suggested by Siltan and Fogel [12]. The reason his parents brought him into our clinic was primarily a way to release him from the psychiatric department which could harm his and his siblings' future potential marital matching chances [20].

We hypothesized that the gap between his low self-perception, immature personality, powerful urges, and his surroundings' denial of his difficulties, threatened the boy's individuality. He was preoccupied with his appearance to avoid exposing his weaknesses (dependence, uncontrolled desires, dandyism, lack of ability to achieve expectations in his ultra-orthodox community, and possible gender identity confusion). He had an immature personality and a complicated inner world that is not allowed to be exposed in the ultra-orthodox society. Moreover, in his community it is unacceptable to express a passion for animals and gardening. Such passion may only be expressed towards religious studies.

In this case report, self-imposed, long-lasting dieting was a symptom of anxiety, shame, low self-esteem, and a sense of unsuitability associated with failure to fit the ideal ultra-orthodox image. The avoidance of negative emotions and direct communication in this community, and the simultaneous occurrence of uncontrolled desires, may explain the rare appearance of these cases in treatment. In patients with eating disorders, fear of gaining weight and obesity is often related to unrealistic sociocultural messages regarding appearance, targeted at young adolescents [21]. The boy described in this case was not exposed to TV or mass media. When asked about his ideal male figure, he did not describe muscularity as expected by a typical 14-year-old. The fear of being obese may have been projection of the boy's inner fears of being incompetent in various fields exclusive to the community values. The epistemological gap between the reality in the country-side clinic and the boy ultra-orthodox family presented new paragraph major challenge for the therapists. The clinic had to remove pictures from the walls which were immodest in the parents'

view, and provide ultra-kosher food. Moreover, therapists often had to determine whether the reasons for certain rituals of the subject's behaviors were truly religious or manipulations of the eating disorder.

Current research is very limited with regards to anorexia nervosa in orthodox adolescent males. These occurrences may be rare, or simply unreported to avoid the shame associated with exposure of mental illness in ultra-orthodox families and the resulting difficulties to find an appropriate marital match for the family offspring.

5. Conclusion

Insufficient attention has been given to the reasons why males develop eating disorders. This case study suggests that eating disorders may emerge among ultra-orthodox adolescent males when they fail to fit the ideal religious stereotype, traditional roles, and their community discourses. Omission of religious rituals, a sense of loss of control of eating, uncontrolled urges, self-judgment, and unacceptability of natural tendencies may be precursors to restrictive rituals. Such rituals may provide a way to regain a sense of control, self-loyalty, and success in setting boundaries for the 'sinful' soul.

Consent

Written informed consent was obtained from the patient and his parents for publication of this case report.

Availability of Data and Materials

The datasets used during the current study are available from the corresponding author on reasonable request.

Authors' Contributions

MG wrote the first draft of the manuscript. ST was a major contributor in writing the manuscript. All authors read and approved the final manuscript.

Competing Interests

The authors declare that they have no competing interests.

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