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 ultraorthodox 14-year-old boy. 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, normal eating habits and self-care, eliminate bed-wetting, and challenge developmental issues as well as cultural discourses.

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

Results: After a year in our outpatient clinic, he regained normal eating habits and weight status. His EDEQ global score was reduced from 4.1 to 0.9. His global DAS 21 score decreased from 38 (sever) to 7 (normal) indicating improvements in self-regulation and impulsiveness. Self-care & self-esteem were also significantly improved. The 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 symptoms, impulsiveness and anxieties as well as bed-wetting demanded an intense and long-lasting intervention.

Discussion: The described case demonstrates the dynamic of being "unfit" for ideal functioning in the ultraorthodox community as a precursor for anorexia nervosa with compulsive features. The co-morbidity of eating disorders, OCD and depressive disorder & night wetting worsened the course of his anorexia and demanded an intensive and...
long-lasting intervention until the boy overcame his anxieties, developed skills, maturity, self-esteem and 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, conflicting reports describe the prevalence of eating disorders [2-4]. Eating disorders are less common among males across cultures, and specifically among ultraorthodox community [2].

The ultraorthodox Jewish community is characterized by heavy restrictions on specific foods, mass media exposure, sexual relationships, and more. Ultraorthodox Jews tend to live in segregated neighborhoods, separating genders during the schooling process. All orthodox adolescent males are expected to fit the ideal stereotype of the ‘Jewish Yeshiva boy” that enthusiastically studies Talmud, and when they are 20-22 yrs old, they are expected to get married - often before they are ready. Anxieties and inner turmoil are the fate of adolescents that disappoint the family due to learning difficulties, weak or negative coping skills, and external religion motivation. Those who face gender confusion know that their exposure might cause a family breakdown. Thus it is often denied [5]. Food is central to all Jewish cultural, ethnic and religious traditions; It is paramount in the lives of the ultraorthodox 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 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, due to the fact that religious girls are less influenced by the Western society beauty models, and due to strict observance of religious traditions they do not need to control eating and weight as a means to handle growing-up pressures of adolescence [2]. Positive religious coping [7], spiritual wholeness, and attachment to god [8] are associated with better health outcomes.

Even so, 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] as well as eating disorder symptoms [12]. It is not surprising that anorexic features and behaviors may reflect a projection of religious features such as extremity, dominance of rituals and laws, self-criticism, and fasting as a purification mechanism, repetition as a positive value in learning, and more. Orthodox adolescents may be captured by eating disorders, similar to secular boys and girls with anorexia, in their attempts to avoid mental pain or deal with issues related to interpersonal conflicts.
Orthodox males face loss of control of their body and their urges when entering adolescence, as found in girls. However, the pathogenesis and specific risk factors for eating disorders are unknown. In the ultraorthodox society, the failure to fit the society discourses 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 learning and family matters.

The described case demonstrates the dynamic of being "unfit" for the ideal image of a Yeshiva boy as a precursor for anorexia nervosa in ultraorthodox males. To the best of our knowledge, this is the first publication about anorexia nervosa of an ultra-orthodox adolescent male.

2. Case Presentation
2.1 Demographics
This case report is about a 14-year-old boy, the third child of 36-year-old ultraorthodox parents with six children. He lives in an ultra-orthodox family within an ultra-orthodox community. His mother works as a caretaker in 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 after a year of partial and full hospitalizations in eating disorder wards. He had a 1.5-year history of severe self-imposed diet restrictions 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. This was opposed to the recommendations of the inpatient ward's medical team. The diagnostic assessment that was sent to us reported low-range intellectual abilities. Powerless, fragile and inferior self-perception, as opposed to his parents’ perception of his high intellectual abilities and a future as a great Talmudic student, indirect communication and 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 was associated with skipping school and synagogue, feelings of being bored and eating a lot of sweets as well as the explosion of his social and learning difficulties which caused deterioration in the anxiety and impulsivity axis’s.

2.3 Symptoms at admission
At admission to our facility, he demonstrated a meticulous appearance with features of dandyism. He weighed 33 Kg, and his height was 1.41 meters. BMI=16.6- in the 21st percentile on the BMI-for-age curve, and in the 2nd percentile on the stature-for-age curve. His blood pressure was 96/62 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 EDE-Q scores at admission was $4.1 \pm 2.5$ with restraint subscale of $6 \pm 0.2$ (Table 1). The Depression, Anxiety and Stress Scales (DASS-21) (17) indicated on severe depression ($12 \pm 1.6$), severe anxiety ($9 \pm 1.3$) and extreme sever stress $17 \pm 1.1$ (Table 1).

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

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Admission</th>
<th>6 months</th>
<th>12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight (Kg)</td>
<td>33</td>
<td>35</td>
<td>41</td>
</tr>
<tr>
<td>Height (m)</td>
<td>1.41</td>
<td>1.43</td>
<td>1.47</td>
</tr>
<tr>
<td>BMI</td>
<td>16.6</td>
<td>17.1</td>
<td>19</td>
</tr>
<tr>
<td>BMI percentile</td>
<td>21&lt;sup&gt;st&lt;/sup&gt;</td>
<td>21&lt;sup&gt;st&lt;/sup&gt;</td>
<td>52&lt;sup&gt;nd&lt;/sup&gt;</td>
</tr>
<tr>
<td>EDE-Q restraint</td>
<td>$6 \pm 0.2$</td>
<td>$2.75 \pm 2.1$</td>
<td>$1.4 \pm 1.7$</td>
</tr>
<tr>
<td>EDE-Q eating concern</td>
<td>$4.8 \pm 2.7$</td>
<td>$2.2 \pm 1.5$</td>
<td>$1 \pm 1.2$</td>
</tr>
<tr>
<td>EDE-Q shape concern</td>
<td>$4.5 \pm 1.7$</td>
<td>$2.75 \pm 1.9$</td>
<td>$1.1 \pm 0.6$</td>
</tr>
<tr>
<td>EDE-Q weight concern</td>
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<td>$1.4 \pm 1.3$</td>
<td>$0.6 \pm 0.9$</td>
</tr>
<tr>
<td>EDE-Q Global Score</td>
<td>$4 \pm 2.5$</td>
<td>$1.9 \pm 1.6$</td>
<td>$0.9 \pm 1.0$</td>
</tr>
<tr>
<td>Dass-21 Depression</td>
<td>$12 \pm 1.6$</td>
<td>$7 \pm 1.0$</td>
<td>$4 \pm 0.5$</td>
</tr>
<tr>
<td>Dass-21 Anxiety</td>
<td>$9 \pm 1.3$</td>
<td>$3 \pm 0.8$</td>
<td>$0 \pm 0.3$</td>
</tr>
<tr>
<td>Dass-21 Stress</td>
<td>$17 \pm 1.1$</td>
<td>$9 \pm 0.8$</td>
<td>$3 \pm 0.5$</td>
</tr>
</tbody>
</table>

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, normal eating habits and self-care, eliminate the obsessive-compulsive features and improve the anxiety and stress components, the bed-wetting, and developmental issues. By developmental issue we refer to cultural and religious discourses that could not be spoken out and thus were communicated through the severe disease. The comprehensive intervention included two weekly days at the clinic, in which he received nutrition counseling, interpersonal and narrative psychotherapy and clinical mentorship. His parents were provided with parental supervision and later it turned into family therapy with the boy and sometimes with his siblings.
The gap between his parents’ perception who viewed him as having extraordinary intellectual abilities, and his own self-perception of being an incompetent, inferior, fragile, and a worried boy in his community was targeted in various ways. The family therapist assisted his parents to acknowledge his difficulties and abilities and to accept him as he is, and at the same time, when the boy faces difficulties with boundaries, insist on practicing firm parental authority.

The dietitian provided psychoeducation, cognitive behavioral tools, and motivational enhancement strategies to motivate the boy to regain his independence. He was expected to demonstrate self-care, ability to set limits to his fears, stress, and aggressive urges that were projected upon eating and his body, and to develop appropriate maturity. The clinical mentor helped him practice normal eating, as well as treating the animals in the farm, assisting him in developing a caring and compassionate attitude towards the animals and himself. Attention, rigidity, impulsivity and mature behavioral issues were addressed via collaboration between the boy and his clinical mentor while they were 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 the individual psychotherapy, he developed hostility towards the eating disorder and rebuttal its’ demands. He monitored his self-control and self-discipline and set objectives around school-related demands to address his wish (age-matched) to be related and as far as possible 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 was 1.47 and his EDEQ scores were significantly reduced to normal values (table 1) and no more demonstrated an eating disorder diagnosis. Similar improvement was noted in Dass 21 (Table 1). His anxiety, self-esteem, and childish behaviors were significantly improved. The bed-wetting disappeared. We assumed that the successes of the treatment stemmed from addressing the boy's unique needs and from connecting him with a nature which helped him to recognize his strengths.

Following our recommendations, which were supported by the community chief Rabbi, he registered to a school which involves agriculture and animal management practices, and not only bible studies (as expected from a future Yeshiva student). It is very common in these orthodox communities that the chief rabbi is more person-centered and able to see the inability of certain vulnerable children to adhere to the community strict track and the need to adjust the track to the child and find a compromise which the child and the community can live with. After the one-year intensive treatment he continued with only dietetic follow-up meetings.

4. Discussion
We described a case, in which a 14-year-old ultraorthodox boy, presenting Anorexia Nervosa, obsessive compulsive behaviors, and bed-wetting. His sense of anxiety and inferiority due to a failure to fit into the ideal functioning in the ultraorthodox community, caused severe Anorexia with compulsive features. The co-morbidity between the eating disorder, anxiety and impulsive components as well as bed-wetting demanded an intensive and long-lasting
intervention, after which the boy overcame his anxieties, developed skills, maturity, self-esteem, and self-care in order to return to his community.

The eating disorder provided distraction for coping with the large gap between his personal emotional, cognitive and social abilities and the discourse of the ideal ultraorthodox boy. During the treatment he admitted to favor dandiness which is a despicable characteristic in the ultraorthodox community. His reported desire to purchase expensive shoes and watches, wear elegant suits, ties and scarves contradicting the rules of modesty which are imposed on his community. This dandiness could be part of his individuation developmental process 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 more negative mental and physical health outcomes [7]. Still, religious symptoms are more likely to be brought for guidance to a Rabbi than a mental help expert in the ultra-orthodox communities. The ultraorthodox society tends to avoid emotional conversations, and encourages suppression of strong desires and hiding emotional challenges [18]. One of the famous religious proverbs says “There is no hero like the one who suppresses his desires”. In ultra-Orthodox circles mental health problems still carry a severe stigma thus there is often resistance to seeking psychological treatment to deal with emotional issues [19]. As suggested by Silton and Fogel, the associated guilt, anxiety, and shame of communicating his difficulties straightly, in order to keep his community relatedness, might be the reason for exacerbating his hidden low self-esteem and difficulties (dependence, learning, setting boundaries, social problems) [12]. The reason his parents brought him into our clinic was first of all a way to release him from the psychiatric department which could harm his and his siblings' future potential 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 authenticity. He was preoccupied with his appearance to show-off his abilities and to avoid exposing his weaknesses (dependence, uncontrolled desires, dandyism, lack of ability to achieve what is expected from a boy his age in his ultraorthodox community, and maybe gender identity issues). He had an immature personality, with a complicated inner world that is not allowed to be exposed in the ultraorthodox society. Moreover, in his community it is not common to express such positive attitudes towards animals and gardening. Such an attitude can be expressed only towards religious studies.

In this case, self-imposed, long-lasting dieting was the symptom of anxiety, shame, low self-esteem, and a sense of weirdness associated with failure to fit the ideal ultraorthodox image. The avoidance of the negative emotions and direct communication in this community, and at the same time the occurrence of uncontrolled desires, may explain the rare appearance of these cases in treatment. Fear of gaining weight and being obese in patients with eating disorders is often related to unrealistic sociocultural messages related to appearance targeted at young adolescents [21]. This boy is not exposed to TV or mass media and when asked about his ideal male figure, he did not describe it around muscularity as normal 15-year-old. boys might. It seems that in our patient, the fear of being obese was a projection of the boy's inner fears of being incompetent in various fields which are exclusive to the community.
values. The epistemological gap between the reality in the country-side clinic and the boy ultraorthodox family possessed a major challenge for the therapists. We had to remove from the wall those pictures which to the parents’ view were immodest, we had to come with modest clothes (long sleeves were mandatory although the heat) and we had to bring Ultra kosher food. Moreover, often we had to ask whether the “religious” reasons are truly religious or manipulations of the eating disorder.

Current research appears very limited with regards to anorexia nervosa in orthodox adolescent males. These occurrences may be rare, as well as simply not reported to avoid the shame associated with exposure of mental illness in those families and the resulting difficulties to find a decent pairing to 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 ultraorthodox adolescent males when they fail to fit the ideal stereotype as they are expected to according to the religion, traditional roles, and their community discourses. Omission of religious rituals, a sense of loss of control of eating, as well as attention to uncontrolled urges, to punitive self-judgments, and to lack of acceptance of different natural tendencies may be precursors to restrictive rituals as 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.

References


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