

“A Full Stomach”: Culturally Sensitive Diagnosis of Eating Disorders among Ethiopian Adolescents in Israel

Rinat Grundman Shem-Tov, MA,¹ Eynat Zubery, PhD,¹ Noa Loevy Hecht, MA,¹ and Yael Latzer, DSc,^{2,3}

¹ *Eating Disorders Treatment and Research Unit, Hanotrim Clinic, Ra'anana, Shalvata Mental Health Center, Clalit Health Services, Israel*

² *Faculty of Social Welfare and Health Sciences, University of Haifa, Haifa, Israel*

³ *Eating Disorders Institution, Psychiatric Division, Rambam Medical Center, Haifa, Israel*

ABSTRACT

In recent decades there has been a significant increase in the prevalence of eating disorders among non-Western populations. This article aims to address unique socio-cultural issues regarding the procedure and dilemmas of the diagnosis process of eating disorders among Ethiopian adolescents in Israel. We will discuss cultural aspects relating to the perception of the disease and the circumstantial contexts relating to this population, such as the process of immigration, integration into Israeli society and issues related to identity and trauma.

Diagnostic dilemmas relating to the differences between traditional vs Western perceptions of the illness will be discussed. For illustration, two case studies will be presented. In the discussion, a culturally-sensitive diagnostic model is proposed. Based on Cultural Formulation Interview, this model assumes that the observation of clinical cases from different cultural backgrounds cannot be achieved solely through a western diagnostic prism. Rather, we suggest that the diagnostic process should continue throughout the entire therapeutic process.

conomic backgrounds within industrialized Western countries. This perception has changed over the years due to reports indicating a rise in the prevalence of EDs among minority groups and other non-Western populations (1, 2). A key explanation for these changes is the process of Westernization, characterized by industrialization, urbanization, globalization, and increased exposure to Western cultural messages associated with the thin ideal as a model for beauty, success and excellence (3). Another major risk factor for the development of EDs in women is being part of a “culture in transition” (4). Moreover, immigration, especially from a non-Western country to a Western country, is considered a life event that increases the risk of psychological distress and mental disorders among vulnerable individuals. This can result from related adjustment problems in the familial and social support systems, exposure to an unfamiliar cultural and physical environment, prejudice, discrimination and decreased socio-economic status (5). Eating disorders are one of the possible expressions of that psychological distress (6). In addition, a strong connection between EDs and trauma has also been documented (7, 8). However, there is evidence in the scientific literature which indicates various forms of ED expression among different cultural groups (9). This phenomenon could have a significant impact on the process and accuracy of the diagnosis.

The State of Israel is in essence an immigrant state, as Jews from all over the world have and continue to settle based upon the Law of Return. Over the past four decades, many thousands of Ethiopian Jews immigrated to Israel, a journey that has been fraught with numerous difficulties for many of them. These difficulties often persist after arrival in Israel and become expressed as

INTRODUCTION

Over the years, eating disorders (EDs) have been described as “culture-bound syndromes” that afflict primarily white, adolescent or young adult females of upper socioeco-

Address for Correspondence: ✉ Rinat Grundman Shem-Tov, Shalvata Mental Health Center, Hanotrim Clinic, Ra'anana 4356020, Israel
📧 rinat.grundman@gmail.com

socio-cultural and economic difficulties among immigrants and subsequent generations. Consequently, some Ethiopian immigrants may develop physical and mental illness as a result of or as a way to cope with stress (10). However, the process of diagnosis and treatment of these illnesses, especially mental health conditions, is often laden with many challenges. These challenges are primarily a product of varying manifestations of distress and cultural differences related to the perception of health and illness in the culture of origin and the receptive Western culture (11).

The purpose of this article is to describe and discuss a clinical picture of eating and feeding disorders among Ethiopian adolescents in Israel according to the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (12). We will discuss possible connections between the symptoms presented and specific stressful situations, such as immigration to Israel and absorption in Israeli society. Through two diagnostic cases studies, we will address the background of the diseases, their various forms of expression and their perceptions in both Western and traditional cultural languages. We will propose an integrative, culturally-sensitive model to diagnose and treat eating and feeding disorders among Ethiopian adolescents. We aim to show how it is essential to continue the diagnostic process throughout all stages of treatment, not only at the onset. This model can also be applied to patients from other cultural backgrounds.

THE ETHIOPIAN POPULATION IN ISRAEL

The immigration of Ethiopian Jews to Israel took place in three main waves between 1980 and 2010. The first wave of immigration in 1985, dubbed "Operation Moses," brought 10,000 immigrants. Many were forced to flee in secret due to economic and political crises and crossed by foot from Ethiopia to Sudan, where they waited in refugee camps for an extended period before immigration to Israel (10). The story of the Ethiopian immigration in this wave is unique and involves instances of strength, bravery and initiative, alongside with physical and mental trauma, mortality and sexual and physical injuries (13).

The second wave of immigration in 1991, dubbed "Operation Solomon," brought about 20,000 immigrants to Israel. These immigrants were flown in straight from Addis Ababa. The third wave was called the unification wave, as many of the incoming immigrants already had relatives living in the country. It brought some 80,000 immigrants between 1995 and 2010. Most of the immi-

grants in this wave were called Falash Mura or converted Jews, as they or their ancestors had left Judaism. Therefore, they waited years for approval from state immigration authorities (10). Currently, the Ethiopian population in Israel stands at about 141,000 people, 39% of whom were born in Israel. The population is considered relatively young compared to other population segments in Israel (14). In general, despite differences between the various waves of immigration, many experienced socio-economic and immersion struggles primarily due to the gap between their country of origin and Israeli culture, language difficulties, lack of professional skills and ethnic rejection. Therefore, the process of integration was characterized by major difficulties (15) and a high percentage of the community requires welfare (16). Regarding the family unit, 89% of Ethiopians tend to marry within their demographic. The rate of single parent families stands at 29%, which is twice the rate of those born in Israel. The divorce rate is higher at 16 compared with 9 cases per 1,000 in the Jewish population (14). There is a higher expected rate of incidence of domestic violence in comparison to the Israeli population, particularly the murder of women by their partners (15). Furthermore, older members of the community, over 20 years in Israel, still experience significant financial problems, housing problems and difficulties arising from cultural differences and discrimination (17, 18). This population in transition is required to cope with daily existential and stressful situations, alongside complex questions related to a sense of belonging and identity.

HEALTH AND ILLNESS IN THE ETHIOPIAN CULTURAL VIEW

According to many non-Western perceptions, sickness is understood as an amalgam of body, mind, spirit, family, community and location (19). In Ethiopia, the concept of medicine is traditionally rooted in nature and does not differentiate between mental and physical ailments. According to this perspective, factors associated with social forces (such as jealousy), natural forces (food, sunlight and cold), and supernatural forces (possession and the devil) are all intertwined and contribute to illness. Causes for diseases are usually "external" and circumstantial such as conflicts between the individual and the individual's relationship with supernatural powers (11). The transition to Israel confronts Ethiopian immigrants with Western-oriented health care services and perceptions that has led to the use of integrated medical services

and traditional medicine alongside Western practices (20). Thus, awareness of traditional concepts of illness and the cultural codes associated with them are both vital to understanding how the patient and their family interpret the patient's condition and treatment options in a Western-oriented health care setting.

THE ETHIOPIAN POPULATION AND MENTAL HEALTH

In the Ethiopian tradition and language, mental illnesses are perceived and divided into three groups: psychotic states (“*yeamero bishita*” – mental illness, “*ebd*” – chronic insanity, “*bescet*” – temporary psychosis, and “*qaws*” – delirious episodes), neurotic conditions (“*hazen*” – depression/grief, “*firhat*” – phobias, “*chinkel*” – fear/anxiety, “*menetket*” – stress, nervousness) and personality disorders (“*kutu*” – a person susceptible to frustration, “*nacnacca*” – a person who complains chronically, “*tlawawac*” – a person without stability or character whose mood changes rapidly, and “*tataratari*” – a very suspicious person) (21). However, when referring to Western medical services, mental distress often tends to be expressed and understood in a typical somatic and metaphorical manner (11). This somatization is considered one of the most common forms of psychological stress among immigrants. Additionally, although no clear physical pathological findings are found, there is a tendency to attribute the symptoms to physical illness and seek medical help for them (22). Moreover, somatization is one of the leading reasons for under-diagnosis and under-treatment of mental disorders among immigrants from different cultural backgrounds in primary and secondary medical services (23). A study conducted by Youngmann et al. (11) showed that Ethiopian immigrants tend to somatize emotional problems, complaining mainly about the heart, head and abdomen, and describing burning sensations, tingling, heaviness, weakness or numbness. Ben-Ezer (24) also describes a high prevalence of gastrointestinal and eating symptoms as a particularly common form of somatic expression among this population. An example of this is the phenomenon of “*zar*,” rooted in Ethiopian culture as one of the main causes of many physical and mental diseases. This phenomenon is perceived as an evil spirit takeover of the person, which is inherited or due to a violation of a norm and is expressed in morbid behavior. One of the more familiar physical manifestations of this phenomenon is abdominal pain called “*kureynya*,” which may be the main complaint at the time of referral (20). Hence, the Western therapist's lack of familiarity with the

phenomenon of “*zar*” and its forms of expression may make the process of diagnosis and treatment difficult. This may also contribute to the patient's feeling that the therapist does not really understand his problem, thus harming the patient's trust and cooperation with the treatment. Indeed, in practice, the members of this community who suffer from mental illness often prefer to approach traditional healers rather than mental health professionals. Only a relatively small number of Ethiopian Israelis suffering from mental distress are willing to receive treatment in mental health clinics compared to immigrants from the former Soviet Union and native-born Israelis (25).

As for eating disorders, a decade ago there were no reports of Ethiopians adolescents turning to clinics for eating disorders (6, 26). From the author's clinical experience, only few Ethiopian female cases were referred with the possibility of having an eating disorder. One possible explanation for the few referrals may be related to a low prevalence of eating disorders among this minority group. This explanation is supported by epidemiological research on other ethnic minority groups in Western-oriented countries around the world (27, 28). Another explanation may be related to the different help seeking characteristics for mental health services in this population. This may include the fear of stigmatization for getting help, the lack of knowledge about the healthcare system in general and eating disorders in particular, and under diagnosis.

In this article, the diagnostic dilemmas related to eating disorders among Ethiopian adolescents who were referred to EDs centers are addressed. The details of the case descriptions are blurred and the names are fictitious. It is important to note that both of them continued to use the Ethiopian name given to them at birth. In the discussion, a diagnostic model throughout the intervention process is presented that may contribute to understanding the symptoms of eating and feeding disorders in this population.

THE DIAGNOSIS DILEMMAS OF REBECCA - CASE STUDY 1:

Rebecca is an adolescent female of Ethiopian descent in the twelfth grade who attends a boarding school. She was referred to the EDs Center by a social worker at her boarding school because of restrictive eating accompanied by stomach pains and daily induced vomiting that led her to lose 7 kilograms in a short period of time and amenorrhea for at least 3 months. She would vomit after eating specific foods, which according to her understanding was related to her pain. She avoided the dining hall due to nausea, and as result she subsisted on a limited diet consisting of milk,

vegetables and fruit. This complaint started a year ago, but until then her eating habits were normal without any problem. When she was first admitted to the ED clinic, her weight was 45 kilograms with a BMI of 17.5.

Prior to her admission to the ED clinic, Rebecca was sent to a general family practitioner and underwent numerous medical examinations. No pathological result was identified for her stomach pain. The counselor from her boarding school then assumed that maybe her pain was related to a phenomenon common among girls of Ethiopian descent that there is discomfort around the Israeli diet that does not include many of the ingredients typically found in Ethiopian cuisine. It was found that when she went home, she would complain about the pain as well and avoided many ingredients at home too.

The assumption at the beginning was clear that she may have *anorexia nervosa binge-purge* type. Neither the social worker nor the patient reported on body dissatisfaction or drive for thinness, eliminating the *anorexia nervosa* diagnosis.

In the assessment phase, it was discovered that she wanted to study at a boarding school as she felt it would allow her to integrate more fully into Israeli society. She also noted that her class consisted of a combination of Israelis and Ethiopians. She was a very good student.

From the initial evaluation, it was clear that these were somatic symptoms that were being expressed emotionally and not as disruptive body perception. This clinical picture is appropriate to assess for Avoidant/Restrictive Food Intake Disorder (A/R-FID) according to the DSM-5.

In accordance with our consultation with a psychiatrist who is an expert regarding the Ethiopian population, emphasis was placed on the evaluation and continued treatment of Rebecca's stomach pains and her experience regarding them. It became clearer that culturally-sensitive diagnosis and understanding should be continued into the therapy phase. Rebecca responded with excitement and gratitude regarding the willingness to better understand her suffering. The stomach pain was described in detail: "Suddenly, there was a sharp pain in my stomach, something was moving from side to side, a stabbing-like feeling and then, a sense of release."

Additional investigation revealed that Rebecca's aunt underwent the same phenomenon when she was growing up. She became more aware and every time she visited her aunt, Rebecca would check the aunts' cooking tendencies and her eating patterns. She would share what she noted during her visits during treatment. ("Her home is the place I feel the most comfortable eating in and I don't feel

bothered by anything there.") A picture surfaced of a child born in Ethiopia to young parents who was raised by her aunt (mother's sister) from birth as she had no children of her own. When she was six years old, her aunt's family moved to Israel and, as a result, she moved back to her parents' home. It was only at this point that she learned that her aunt was not her real mother. Despite not being raised by her parents during her formative years, Rebecca established a good relationship with her biological parents. At the age of ten, she moved to Israel along with her biological parents and renewed her relationship with her aunt. It was also revealed at this point that Rebecca belonged to the Falash Mura, an Ethiopian sect whose Jewish identity in Israel is considered questionable. As a result, she immigrated to Israel with a sense that she didn't belong – both to her family and to the Jewish people. This was further combined with the additional issue of her identity as an adolescent in general and as an Ethiopian female adolescent, who tried to integrate into the new society and be accepted the Israeli peer group. Furthermore, Rebecca uses an Ethiopian dialect in which her parents are not proficient, which resulted in arguments regarding the way she speaks. Prior to treatment, she had not spoken about any of her past or present issues with anyone at any point. Throughout treatment, Rebecca's ability to express herself at boarding school was also brought up, her confidence in her Ethiopian identity and as a leader became stronger and she found herself defending the rights of the "Ethiopian girls" group at the school. She conducted a lesson on Ethiopia for girls in her class, which helped her view the girls as less threatening, and even interested. She was also able to discuss with her family how growing up with her aunt influenced her at home.

After a year in treatment, the vomiting and dizziness ceased. She continued to be treated to expand her dietary options and returned to the weight she had two years prior. Rebecca described having occasional stomach aches but the fortitude which she had developed through treatment enabled her to continue to function. Rebecca completed the twelfth grade.

Our team looked for a framework to better prepare Ethiopian youth for the army (army service is considered central to acceptance in Israeli society). This framework includes preparation for tests to facilitate the army's matching process of enlistees of Ethiopian descent to suitable positions (the IDF claims that this population receives low scores on entrance exams as they do not allow for cultural factors and, as a result, do not reveal the true abilities and intelligence level of this popula-

tion). Currently, Rebecca is serving successfully in the army in a position of her choosing and is not exhibiting any symptoms.

By using the culturally-sensitive diagnosis process throughout all phases, it was clear that the picture was not anorexia nervosa, but rather R-FID that was related to stressors such as: her acculturation to Israeli society in general and the boarding school in particular, her desire to be successful, her struggle with her identity and her wish to fit in.

THE DIAGNOSIS DILEMMAS OF SARAH - CASE STUDY 2:

Sarah was 15 years old and a tenth grader of Ethiopian descent when she was referred to treatment by the staff at the boarding school she attended for being underweight (she has a BMI of 17 at admittance). She lost weight dramatically a few months prior to her referral, she used laxatives, had binge eating and purging behavior, and exercised compulsively (daily 15 km runs). She was also preoccupied with her appearance, her body and her weight. In addition to her eating problems, she had somatic syndromes such as claiming she was asthmatic and using an inhaler; however, a pulmonary specialist indicated that she did not meet any of the markers for this illness. She would feel dizzy and faint, as well as suffer from headaches and various physical ailments. An extensive medical evaluation and a neurological examination that she completed prior to the referral came back with no findings.

Sarah's symptoms revealed a picture of anorexia nervosa binge-purge type according to DSM-5.

Sarah's illness process: At age 12, Sarah weighed 70 kilograms and her older brothers used to tease her. As a result, she began to restrict her eating and lost 18 kilograms within three months.

Sarah was hospitalized under a mandatory order at a psychiatric hospital. Sarah said: "How can I explain to my mother that I have an ED? There isn't a word for this in Amharic."

Thereafter, when she was stabilized she insisted on going to boarding school. In spite of the fact that the treatment staff and boarding school considered her home an unsafe place, Sarah wasn't willing to give up on her role in her mother's home and she insisted on going home for every school vacation. However, after she had once again drastically lost weight after returning to school following spring vacation at home, it was decided that in order to prevent this cycle from occurring during the summer vacation, Sarah would be hospitalized in the

eating disorders unit instead. Sarah was fully compliant while hospitalized and received medical treatment for the first time, in addition to the ongoing psychological counseling. She was able to maintain the progress that she had made during her hospitalization in the summer, even after returning to school and treatment at our center.

Sarah was an excellent student, highly intelligent and similar to Rebecca initiated studying at a boarding school in order to attain greater academic achievement. She emphasized that she also chose to study at a boarding school out of a desire to "save her home."

Sarah's immigration process: Sarah's family immigrated to Israel as part of Operation Solomon. Her family's integration into Israeli society was described as difficult and her parents do not speak Hebrew. She is the fifth among seven children in her family who were fathered by four different men. Her mother was married to each at one point (the first husband was murdered in Ethiopia and the second physically abused the mother). Sarah's biological father, who was her mother's third husband, left the family when she was a baby and her mother always told her that he denied he was her father. Sarah subsequently viewed the fourth husband as her father. Sarah also shared that throughout the years she assisted her mother in navigating Israeli bureaucracy.

Given the immigration process, her family's history in Ethiopia and her family's background, it was also suggested to consider the possibility of diagnosis of PTSD or complex post-traumatic disorder (CPTSD) (29) in the evaluation process and treat them accordingly.

During one of the school vacations, Sarah came to the EDs Center with her mother for the first time. Because her mother does not speak Hebrew, Sarah translated the treatment team's words for her. As a result, it was an unpleasant experience. Sarah felt angry that she had to be her mother's "translator" and pass along what was being said in a credible fashion instead of just being her mother's daughter and patient at the Center. Following this encounter, we decided to bring a translator to our Center. The meeting with her mother and the translator was considered a turning point. Sarah finally was able to act the role of the daughter alone, and was able to experience having her mother receive information from our team regarding eating disorders like every other daughter that came to the clinic. This provided guidance for Sarah's mother regarding Sarah's difficulties and needs.

During the treatment process, a connection was revealed between the appearance of her symptoms and a crisis between her mother and the fourth husband.

Sarah took on the role as the intermediary and witnessed violence between them. During this period, Sarah began to exhibit a decline in temperament and in her studies, and began to vomit and use laxatives.

From this point, there was a significant improvement regarding Sarah's visits home and in how her brothers treated her. A significant process occurred in the construction of trust and progress between our Center along with the boarding school and counselors. In addition, processing the loss of a home and the meeting of different worlds made it possible to strengthen the bond with her mother. Sarah was able to find more adaptive coping skills and was able to raise a variety of potential solutions to the complex situation she was facing at home. Not once did she say during psychological treatment regarding her mother, "this is something you can't understand, it's a cultural matter...You can't say it to my mother...It's considered crazy in our culture...you need to understand that my eating disorder embarrassed my family."

The ability to discuss these topics allowed Sarah to feel less lonely regarding the issues that burdened her and to experience her anger towards her mother and her brothers in a more integrative manner within the new world in which she is now living. Gradually, her symptoms declined.

Although the illness process took more than four years, and despite the symptoms, her quick recovery after the culturally-sensitive treatment process (the involvement of her mother during the treatment) raised the question whether Sarah indeed suffered from genuine AN. Another theory is that it was a psychosomatic presentation and reaction to the stressful life events she experienced along with her effort to adjust to the new culture and to cope with her adolescence as an addition transition period. This course is not typical of anorexia nervosa in most cases. In this case the ability to talk about the conflict and express her fears and frustrations enable her to feel better and the symptoms subsided within short period.

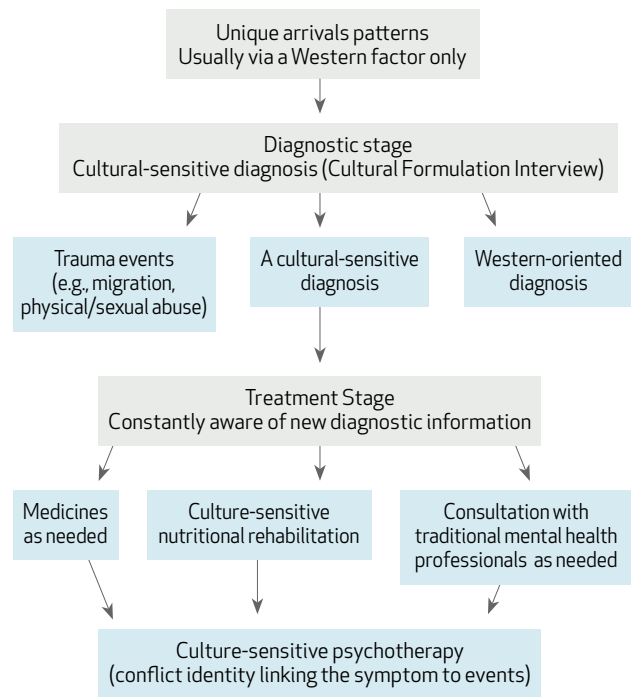
DISCUSSION

Eating Disorders from an Ethiopian perspective and perception were described by Ben-Ezer as "eating arrest." This phenomenon is commonly liable to be interpreted incorrectly as the expression of anorexia nervosa (24). According to Ben-Ezer, in order to understand this type of eating disorder, it is necessary to know the identity of the "Ethiopian stomach." This perspective states that emotions reside in the stomach, not in the heart, and exist in layers,

whereby the topmost layer is the emotional layer that is experienced in the present. In addition, the previously described tendency of restraint and "keeping things inside the stomach" regarding difficulties and emotions, can be accompanied by "active forgetfulness." This describes the attempt to deflect knowledge from the problem, which allows the individual to experience the "layers" of happiness and joy at the same time that they are undergoing these difficulties. Therefore, during times of hardship or crisis, it is customary to say "the stomach is full" of the troubles and problems of life, something which can also be expressed through the lack of the ability to eat.

From this understanding along with the theoretical background presented above, supported by two case studies, a culturally-sensitive diagnosis model emerged and will be presented and discussed. The proposed model will attempt to show a culturally-sensitive process which aims to improve the intervention process, starting from the referral period through the diagnosis that is prolonged throughout the treatment phase. Furthermore, this integrative model may contribute to the understanding of patients coming from other traditional backgrounds who seek treatment for mental problems from Western-oriented health systems (30, 31) (see Figure 1).

Figure 1. A culturally-sensitive integrative model for the diagnosis of Ethiopian origin adolescents in eating disorder centers in Israel



As highlighted by the suggested model, the first stage relates to the help-seeking characteristics of this population. According to the authors' clinical experience, most of the referrals to ED centers come from family practitioners, pediatricians or family members. In the case of Ethiopian adolescents, they tend to have different help seeking characteristics and tend to be underdiagnosed or misdiagnosed because of different culturally-oriented perception and presentation of the symptoms, and or as a result of fear of stigma. However, some patients will be referred by clinicians who are more aware of culturally-sensitive problems. For example, the girls presented in both case studies were referred by the social workers at their boarding schools. In Sarah's case (case study 2), prior to her integration into the boarding school, she suffered from being underweight and repeating complaints of severe stomach-aches. During this period, her mother brought her twice to the emergency room at a general hospital. The first time, she was hospitalized in the pediatric department for medical examination to eliminate the medical problem, and at the second time Sarah was involuntarily committed to a psychiatric hospital. In both cases the diagnosis was not clear. There was no way her mother would know where to take her for treatment in Israel, and it was also impossible for her to communicate with the medical staff because of the language barrier. It was only when she entered boarding school that she was referred to a center that specialized in the treatment of EDs that were related more to her complaint and problem.

The second stage describes the diagnostic phase that initially included a three-level, culturally-sensitive interview:

1. **Western-oriented diagnosis:** Diagnosis of EDs according to the DSM-5 (12) or ICD-10 (32).
2. **Cultural formulation interview (CFI)** (33): A culturally-sensitive interview based on the principles of understanding symptoms and treating them in light of the relative cultural context.
3. **Screening for the possibility of post-traumatic disorders, PTSD or CPTSD diagnosis that may relate to:** the adaptation to a new culture in Israel, dealing with significant loss or destruction (family members, frameworks and cultural), frequent occurrences of physical and sexual violence are some of the risk factors for CPTSD among migrating populations, in particular among Ethiopian females, and/or among patients suffering from eating disorders (7, 8).

CULTURAL FORMULATION INTERVIEW (CFI)

The purpose behind developing the Cultural Formulation (CF) of the diagnosis that appears in DSM-IV (34) was to give a culturally-sensitive narrative context to the therapist or physician working with a patient from a different cultural background. Through this lens, they could see the effects of the culture on different aspects of the clinical encounter. In the DSM-5 (33), an interview called the Cultural Formulation Interview (CFI) was included. The CFI consists of 16 open-ended questions for the use of a clinician during the intake. The purpose of the CFI is to gather information about how the culture works in order to understand specific aspects of the clinical picture presented by the patient (33). It provides insights into cultural aspects of the pathology presented in the diagnostic phase, through the collecting of information that might be influencing the diagnosis and therapy later.

This interview, of which one of the authors of this article (Noa Levy Hecht) was part of its initial development, was based on four categories that appear in the initial Cultural Formulation (35). Their goal was to allow the patients to be able to acknowledge their cultural origins in the initial interview. The rationale behind this change was the creation of a framework addressing cultural aspects in the diagnosis, as current diagnostic tools did not take into account the existing cultural differences in any society and their impact on the individual's psychopathology (36).

THE CFI FRAMEWORK RELATES TO FOUR MAIN PRINCIPLES:

1. **The cultural identity of the individual:** This emphasizes the importance of reflecting on the patient's original identity and his new assumed identity that resulted from moving to a new country. Within this mix of identities, the creation of a new self-identity can be added as a significant developmental stage in self-formulation, especially during adolescence. The conflict between different identities impacts the clinical manifestation and, as a result, should be considered during the diagnosis process.
2. **The cultural explanation as it relates to the individual's disease:** In this section, the diagnostician will try to better understand the description of the disease and its conceptualization through the original culture of the individual. It is also necessary to note the material expression of the symptoms and treatment in the original culture. As such, the importance of inquiring about

specific ritualistic treatments that may have been used in the patient's original culture should be emphasized (alternative medicine, shamans), as well as grieving rituals regarding people or cultural loss (37, 38).

3. Measurement of the impact of cultural factors on the individual ability to function: This framework examines the level of social support of the individual, how the individual is accepted and functions in this society (age, sex, status), and difficulties regarding the individual's new social position in the host society, such as economic situation, losses and discrimination.

4. Cultural elements between diagnostician and patient: This measures the impact of cultural differences and discrepancies in social and cultural status between the diagnostician and the patient during diagnosis and treatment sessions. These include differences and discrepancies related to language, trust and empathy.

Research measuring the effect of CF and CFI show that attention to culture can substantially improve diagnostic accuracy and reduce the over-diagnosis for psychosis among ethnocultural minorities. In addition the clinicians reported improvement in communication, reduced diagnostic and treatment errors and clarification of cultural aspects of transference and countertransference (36).

In the cases presented, the culturally-sensitive interview and the special attention given to cultural aspects in the diagnosis process enable insights into the pathology presented and thus clarify the diagnosis and help in the subsequent treatment process. A preliminary inquiry into Rebecca's stomach issues clarified and made it possible for her therapists to understand the importance of the use of stomach pains and disruptive eating as a way for Rebecca to express her distress by using a familiar language that was used by her aunt and her family. The ability to explore these issues in the therapy (based on the preliminary information), allowed her to freely examine her identities and sense of belonging. This understanding enabled Rebecca to start searching for new ways to interact with her new world. She gave a lecture on the Ethiopian community and protested against the isolation of Ethiopian girls in classes. The steps that Rebecca took were acknowledged by the school administration. The legitimization that Rebecca received from being able to freely reflect on her difficulties, in particular, through her original cultural lens, allowed her to better handle her stomach aches and understand them in a different way, as well as to taste different foods and to better adjust later to her military service.

In Sarah's case, when the therapist decided to invite her mother to visit the ED center alongside a translator, this action accommodated Sarah's basic need to be understood by us and by her mother and facilitated the essential communication between mothers and therapists of an adolescent who is younger than 18 for treatment. This resulted in additional progress in her emotional and symptomatic situation along with her improved ability to cope with difficulties at home and in school. Sarah felt as though she became herself again and began resuming her place at home, her place among her peer group as an adolescent and her place in the new culture as a new immigrant dealing with identity, separation, and acculturation.

INTEGRATIVE DISCUSSION ON THE QUESTION OF DIAGNOSIS

According to the DSM-5, Rebecca's situation was characterized by disruptive eating, weight loss and amenorrhea. Additionally, the vomiting was not initiated in order to lose weight but rather to ease her stomach aches. The clinical picture, according to the DSM-5, matches the diagnosis of Avoidant/Restrictive Food Intake Disorder (A/R-FID) (12). Furthermore, following an extensive interview, it was understood that the stomach aches and avoidant eating were the result of social stress expressed through somatization as described by Ben-Ezer (24). It was also understood that the woman responsible for raising Rebecca, her aunt, had exhibited similar behavior. This understanding was one of the keys to understand her pathology.

Sarah's case shared some similarities with Rebecca's case. Sarah was referred to the ED center due to significant weight loss and binge-purge behavior. She was preoccupied with body shape and fear of gaining weight. According to DSM-5 she met the diagnostic criteria for anorexia nervosa binge-purge type. However, despite fulfilling the DSM diagnostic criteria, further cultural information was needed in order to better understand her symptoms, which in turn led to a breakthrough in treatment. Sarah's mother turned to an Ethiopian therapist for help after Sarah stopped eating and drinking for a few days. Greater exploration showed that Sarah performed this syndrome occasionally in situations of distress. It was understood that Sarah was convinced that her mother was trying to hurt her due to their complex relationship. This explanation matched Ben-Ezer's description of "eating disorders" (24) emphasizing that weight loss is not necessarily related to body distortion but rather to some other culturally sensitive

explanation. This understanding led to a breakthrough in treatment and showed a slight different manifestation of AN presented in the DSM. This deeper understanding enabled us to approach therapy uniquely.

In both cases, although overcoming the illness took a few years, and despite the ED symptoms, their fast recovery after the culturally sensitive diagnosis process using the CFI (understanding the cultural and familial meaning of stomach ache in Rebecca's case and the involvement of the mother in the treatment in Sara's case) raised the question whether Sarah and Rebecca indeed suffered from genuine AN or A/R-FID. Another possibility is that their symptoms were a psychosomatic presentation and reaction to the stressful life events they experienced along with their efforts to adjust to the new culture and cope with their adolescents. This course is not typical of anorexia nervosa in most cases. In both cases the ability to talk about the conflicts and express the fears and frustration enabled them to feel better and the symptoms subsided within relatively short period of time.

THE DIAGNOSIS PROCESS DURING THE TREATMENT STAGE

In this article we explore the therapy phase only in terms of the diagnosis process. It is important to understand how the diagnostic data is collected and worked with in a continuing manner throughout the therapy phase. This is true in any treatment process however special attention should be given when treating individuals coming from a different culture. The greater the gap between western and nonwestern perspectives, the greater the attention and awareness needed by the therapist.

The therapist should be constantly aware of the possible hidden information in the encounter: things the therapist is not aware of and the patient even thinks are not relevant.

Culturally-sensitive diagnosis in EDs should be attributed to various stages in the treatment process. The first intervention focuses on nutrition rehabilitation. The therapist should take into account the cultural dietary differences and try to assess whether the symptoms and the behavior relate to those differences rather than to ED presentation, presented by avoiding or restricting food (see Rebecca's case). In addition to the medical treatment in these cases, the involvement and support of religious figures is needed in order to better understand the symptoms (see Rebecca and Sarah cases). During the second stage, a culturally-sensitive diagnosis should be continued along with psychotherapy. It is important to consider

the conflicting identities, trauma caused by the patient's journey to Israel, difficulties in adjusting to a new culture and additional traumatic events that the patient might have experienced over their lifetime. The last stage of treatment deals with rehabilitation and strengthening a patient's ability to cope and function on a daily life. It is important to touch on issues relating to transition, grief, and the symptom narrative from the patient's perspective.

This understanding and culturally-sensitive diagnosis process allowed the treatment staff to better comprehend the problem in a cultural context, and thus to provide better treatment accordingly.

CONCLUSION

The purpose of the paper was to present a culturally-sensitive diagnostic model through the story of two young females of Ethiopian background with symptoms of eating disorders. It illustrates the importance of culturally-sensitive observation during the various diagnostic stages while treating mental disorders, in general, and eating disorders in particular. Furthermore, it highlights the importance of utilizing this integrative model with any patient who comes from a collectivist traditional oriented culture and lives in a modern, Western-oriented and individualistic society.

As Israel is a country composed of many different cultures and religions, it is important for educators, treatment teams, social workers and additional health care workers to acquire a deeper knowledge of this field as they are often on the front line, referring patients from this sector to eating disorder centers.

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