



Holy anorexia: Eating disorders symptomatology and religiosity among Muslim women in the United Arab Emirates

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ABSTRACT

There is a substantial body of literature reporting a negative association between religiosity and psychiatric symptoms. In the context of eating disorders, however, this relationship appears to be reversed. The few studies exploring the relationship between religiosity and eating disorders have mostly focused on the Judeo-Christian religious traditions in Western nations. The present study examines this relationship among Muslim college women from the United Arab Emirates (UAE). All participants ($N = 1069$) independently completed the religious commitment inventory (RCI-10) and the eating attitudes test (EAT-26). As hypothesised, there was a positive association between religiosity and eating disorders symptoms. Furthermore, those scoring above the EAT-26 cut-off reported significantly greater levels of religiosity. These findings suggest that heightened religiosity among young Emirati women may represent a vulnerability factor for eating disorders. Preventative initiatives in the UAE should consider focusing on religiosity.

1. Introduction

All of the world's major religions advocate eating in moderation and promulgate some form of dietary restrictions. Fasting, for instance, is a religious practice in Islam, Judaism and several Christian denominations (Gerber et al., 2015). Early case reports of psychogenic self-starvation tend to implicate excessive religiosity as a central feature of the phenomenon. Morton (2004) alludes to a form of anorexia nervosa in the medical literature dating back to 300 A.D., when ascetics reportedly starved themselves to death engaging in religiously motivated acts of renunciation.

Within Roman Catholicism, drawing on the writings of the desert fathers, gluttony was considered one of the seven cardinal sins. Gluttony's corresponding heavenly virtue was abstinence (Lyman, 1989). Extreme abstinence (e.g. prolonged celibacy and fasting) is characteristic of a number of case studies that have, retrospectively, been described as anorexia mirabilis or holy anorexia (Bell, 1985). These cases, centring on pious women from the European medieval period, depict individuals who ostensibly renounce the world and engage in religious self-starvation. As one commentator describes it, "overcoming the flesh to achieve a triumph of the soul" (Nasser, 1997). Perhaps the best known of these holy anorexics is Catherine of Sienna, who is described as adopting an unusually extreme regime of abstinence/self-starvation and is also reported to have engaged in

frequent bouts of self-induced vomiting (Bell, 1985). Catherine's regular self-starvation resulted in emaciation and arguably contributed to her death at the relatively young age of thirty-three (Pitcock, 2014).

A significant difference, however, between the anorexic presentations of late antiquity and the European medieval period, is the absence of any discourse concerning an obsessive fear of weight gain (Huline-Dickens, 2000). Brumberg eloquently argues that:

"...in the earlier era (13th to 16th centuries) control of appetite was linked to piety and belief;...the modern anorectic strives for perfection in terms of society's ideal of physical rather than spiritual beauty."

(Brumberg, 1988 p.7)

Anorexia's apparent shifting symptomatology has been explained with reference to the idea of pathoplasticity. This is the argument that anorexia's content and prevalence are profoundly influenced by prevailing sociocultural pressures (Russell, 1985). Much research has explored the centrality of weight phobia (see Habermas, 1996) and body image disturbance to the contemporary condition (see Legenbauer et al., 2014 for review). Far less attention, however, has been paid to examining the extent that religiosity may or may not continue to play a role.

There is a fairly broad consensus that religiosity is a multi-dimensional construct. Concerning the specific content of the multiple dimensions, however, there is far less agreement (Pargament, 1997).

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Consequently, attempts to measure religiosity vary broadly within the literature. In a seminal work in this area, Allport and Ross (1967) distinguished two broad religious orientations, namely, extrinsic and intrinsic religiosity. Extrinsic religiosity is defined as religious behaviour as a means to achieve some self-serving end, such as self-esteem or popularity. Conversely, intrinsic religiosity is viewed as an end in and of itself, a means to spiritual development or strengthening one's relationship with a deity (Hunter and Merrill, 2013). These ideas were operationalized as a self-report measure known as the religious orientation scale, the scale, its revisions and derivatives, remain widely used. An alternative, but similarly multifactorial, approach to religiosity, is that Glock and Stark (1966) who identified five dimensions of religious commitment: experiential, ideological, ritualistic, intellectual and consequential. Numerous other conceptualizations and related psychometrics exist (for review see Park, 2002). Despite this heterogeneity of conceptualization and measurement, most definitions and measures of religiosity capture something of the following three factors. (1) A sense of belonging to a particular denomination or creed. (2) The personal importance of religion/spirituality to the individual. (3) A level of commitment to praxis, for example, attendance at communal worship or observing obligatory fasts (Miller et al., 2012).

In the general context of psychopathology, religiosity – as broadly defined above – has consistently been found to be associated with better mental health status (Dew et al., 2008). More specifically, in the context of major depressive disorder, a meta-analysis spanning 147 independent studies, including a total of 98,975 participants, found a statistically significant inverse relationship between religiosity (variously defined and measured) and depression (Smith et al., 2003). Furthermore, a 10-year prospective longitudinal study found that baseline religiosity (assessed using a simple three-item self-report measure) was associated with a reduced risk of later-life depressive episodes, particularly for those deemed at high-risk based on having a parent with a history of depression (Miller et al., 2012). Beyond depression, studies exploring substance-related disorders also suggest a protective role for religiosity. A review of the religiosity-substance abuse literature concluded that the majority of well-conducted studies report lower levels of substance related disorders with rising levels of religiosity (Moreira-Almeida et al., 2006). In a multi-faith study of 1837 Lebanese university students, it was found that alcohol use among Muslims, Christians and Druze, was inversely related to religiosity across the different faith groups (Ghandour et al., 2009).

The few empirical studies that have explored religiosity in the context of anorexia nervosa have tended to find that eating disorders symptoms are associated with greater religiosity. A study was undertaken among anorexia nervosa patients ($N = 851$), finding that weight loss was positively associated with the degree of importance individuals placed on their religion (Joughin et al., 1992). Similarly, a demographic analysis undertaken in North America among participants diagnosed with either anorexia or bulimia nervosa ($N = 252$) found higher rates of self-reported religious identification (Judaism and Catholicism) among patients, compared with rates occurring in the general population (Sykes et al., 1988). In a smaller scale study, including an explicit measure of religiosity (based on a subset of religion related items from the Minnesota Multiphasic Personality Inventory), Wilbur and Colligan (1981) found that participants diagnosed with anorexia nervosa ($N = 34$) had significantly higher religiosity scores than their psychiatric control group counterparts. Another study, this time among German patients, also found a significant positive association between religiosity (as determined by self-reported denominational affiliation) and eating disorders (Jacoby, 1993). There are, however, at least two studies that report the opposite pattern. Doumit et al. (2015) found that intrinsic religiosity, measured using the religious orientation scale-revised (Gorsuch and McPherson, 1989), was significantly inversely associated with vulnerability to eating disorders among a multi-confessional sample of young women from Lebanon ($N = 949$). Similarly, this inverse relationship was also observed among Jewish middle school

girls in Israel ($N = 320$), where greater religiosity was associated with lower rates of eating-disorders symptoms (Latzer et al., 2007). Furthermore, and most recently, a prospective nationwide study ($N = 2825$) failed to find any significant overall association between religiosity (assessed using the religious fundamentalism scale from the Minnesota Multiphasic Personality Inventory) and anorexia nervosa among young Finnish women (Sipila et al., 2017). Among other factors, Sipila et al. suggest that Finland is largely a Protestant nation that has rapidly secularised, resulting in a “moderate Protestant Christian religiosity” (p. 412), where fasting and asceticism are rare. They go on to suggest that other religious and cultural contexts may, indeed, identify religiosity as a risk-factor for Anorexia (Sipila et al., 2017).

Further research exploring the interplay between religiosity and eating psychopathology is required. The somewhat equivocal findings to date may reflect methodological or population (clinical vs. non-clinical) differences. Equally, they could reflect differences related to the societies or religious traditions within which the studies were undertaken. To date, no study has explored the relationship between religiosity and eating psychopathology among any of the Muslim communities of the Arabian Gulf region (Bahrain, Oman, Kuwait, Qatar, Saudi Arabia and the United Arab Emirates).

The Arabian Gulf region is home to Islam's two holiest sites, and the official religion of all the Gulf States is Islam. In addition to state-level religious commitment, personal religiosity (belonging to, valuing and practicing an Islamic religious tradition) appears to be relatively high across the Gulf States too. For example, in a comparative cross-cultural study exploring aspects of religiosity among similarly aged Kuwaiti and US university students, Kuwaiti students reported significantly higher scores on a measure of intrinsic religious motivation (Abdel-Khalek and Lester, 2009). Furthermore, across the Gulf States, religious practice, to varying degrees, is woven into the fabric of modern daily life; for example, workplaces, educational institutions, shopping malls and even petrol stations will all have prayer rooms. On Fridays, Islam's holy day, the streets in many Gulf neighbourhoods become congested with people attending congregational prayers at local Mosques. Regular religious practice is unequivocally an important and widespread phenomenon in contemporary Arabian Gulf societies (Thomas, 2014). The relatively widespread religious practice in the Gulf States heightens the importance of exploring the relationships between psychopathology and religiosity in these nations.

The present study investigates the relationship between eating disorders symptoms and religiosity among college women, all of whom are Muslims and citizens of The United Arab Emirates (UAE). The UAE was formed as a federation of seven autonomous states in 1971, and due to the commercial exploitation of the nation's large reserves of oil and gas, it has experienced unprecedentedly rapid socio-economic development (WHO, 2006). These rapid developments are thought to have given rise to acculturation among the youth, which in turn is viewed as contributing to an increased prevalence of eating disorders (Eapen et al., 2006). Previous research exploring eating pathology among the UAE's citizens (Emiratis), unequivocally reports relatively high rates of eating disorders symptomatology. For example, using the EAT-26, a widely applied eating disorder screening tool, one study found that 25% of participants (college women) scored above the screening cut-off (Thomas et al., 2010). Several other studies confirm these relatively high levels of eating disorders symptomatology among Emirati females (O'Hara et al., 2016; Schulte and Thomas, 2013; Thomas, 2014). In the present study, based on previously mentioned findings in other nations, it is hypothesised that heightened Islamic religiosity will be associated with elevated levels of eating disorders symptomatology among Emirati college women. In line with Miller et al. (2012)'s broad conceptualization of religiosity, Islamic religiosity in the present study is defined as: (1) a sense of belonging to the Islamic faith, (2) a level of personal importance attached to Islam by the individual, and (3) a level of commitment to praxis, for example, performing Salah (formal prayer, undertaken 5 times each day).

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