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Disordered eating & cultural diversity: A focus on Arab Muslim women in Israel

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ABSTRACT

Context: A dearth of data concerning eating problems among adult women from minority population groups leaves substantial knowledge gaps and constrains evidence-based interventions.
Objectives: To examine prevalence and predictors of disordered eating behaviors (DEB) among Arab Muslim women in Israel, whose eating behaviors have not been previously examined and to compare with second generation Israeli-born Jews of European heritage.
Design: Community-based study includes sub-samples of Arab Muslims and Israeli-born Jews. DEB is assessed with fourteen DSM-IV related symptoms. Hierarchical regressions examine influence of weight, self-criticism and psychological distress on DEB severity.
Results: Relatively high prevalence rates emerge for Muslims (27%) and Jews (20%), a nonsignificant difference. In contrast, regressions reveal substantially different predictor patterns. For Arab Muslims, weight has the strongest association; for Jews, weight is not significant while self-criticism is the strongest predictor. Explained variance also differs considerably: 45% for Muslims and 28% for Jews.
Conclusions: Surprising similarities and distinct differences underscore complex patterns of eating disturbances across culturally diverse groups. Culturally sensitive interventions are warranted along with more illuminating explanatory paradigms than 'one size fits all.'

1. Introduction

Culturally sensitive interventions for eating disturbances are constrained by a dearth of data (Cummins, Simmons, & Zane, 2005; Marcus, Bromberger, Wei, Brown, & Kravitz, 2007), especially for minority population groups. Despite the importance of sociocultural factors, our understanding remains "relatively rudimentary," (Cummins et al., 2005 p. 570) particularly with regard to adult women (Feinson, 2011). An opportunity to address this knowledge gap is provided by a first-ever, community-based study of adult Arab Muslim[1] women in Israel, whose eating behaviors have not been previously assessed. Prevalence and predictors of disordered eating behaviors (DEB) afford intriguing cross-cultural comparisons with second generation Israeli-born Jews of European heritage.

1.1. Background

The influence of sociocultural factors on eating problems is complex, fraught with inconsistent findings, and derived primarily from studies of young females (under age 25) (Feinson, 2011). A limited number of studies of young Arab Muslim women also contain mixed findings (Abdollahi & Mann, 2001; Latzer, Tzischinsky, & Geraisy, 2007; Nasser, 1986). Inconsistent findings suggest that exposure to westernized norms may be irrelevant for some eating disturbances, such as BED (Striegel-Moore et al., 2005). Indeed, some research is broadening the sociocultural agenda to include factors such as the subordinate status of women in patriarchal cultures (Douki, Ben Zineb, Nacef, & Halbreich, 2007), minority acculturation processes (Cachelin & Regan, 2006; Mussap, 2009), discrimination and poverty (Halperin-Kaddari & Yadgar, 2010; Striegel-Moore, Dohm, Pike, Wilfley, & Fairburn, 2002), major social transitions (Abu Baker, 2002; Al-Haj, 1995) and stresses from conflicting cultural demands (Haj-Yahia, 1995; Kuba & Harris, 2001; Pessate-Schubert, 2003).

Several important sociocultural factors are highlighted by focusing on Arab Muslim women in Israel, a deeply divided society in which almost one-fifth (18%) of the population are Arab citizens. In contrast to minority groups elsewhere, Arabs are not immigrants, but have lived in the country for centuries. They are predominantly Muslim (82%); their language is Arabic, not Hebrew, and their way of life

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[1] A number of terms describe the Arab population including Israeli Arabs, Palestinian Arabs, Palestinians, Palestinian-Arab citizens of Israel, and Arab Muslims, among others. All respondents in this study are Arab Muslims and that is the term that is used.

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tends to be semi-traditional compared to dominant Israeli culture (Smooha, 2010). A central aspect of Arabs' distinctive status is that as a "national minority" they are "…tied by language, culture, identity, history, collective memory, narratives, and loyalty to Palestinian nationalism and pan-Arabism" (Smooha, 2010 p. 7). These distinguishing characteristics contribute to making Arabs an "…inassimilable minority. Arabs do not intermarry with Jews. They want to keep their existence separate... The cornerstone of the separation is that of residential communities and schools, which affects 90% of the Arabs who live in Arab villages and towns" (Smooha, 2010 p. 7).

Accordingly, Muslim respondents in this study live in an Arab village on the outskirts of Jerusalem. Abu Ghosh, one of the only remaining Muslim villages in the area, is named for the Arab clan that settled in the area in the 16th century and its 5700 residents are direct descendants (Moshe, 2000). Abu Ghosh is a village with 13 restaurants that many Israeli Jews visit, especially on weekends, when most Jerusalem restaurants close for the Jewish Sabbath. Despite these contacts, Arab–Jewish relations generally have worsened since the 1995 assassination of Prime Minister Yitzhak Rabin with "a consistent trend of growth in the alienation, deprivation, and fears among the Arabs…" (Smooha, 2010 p. 18).

1.2. The present study

In addition, several other sociocultural factors are particularly relevant including the observation that Arab Muslim women "suffer from a three-tiered discrimination: as women in Israel, as Palestinians in Israel, and as women within the Palestinian community" (Halperin-Kaddari & Yadgar, 2010). Also, during the past three decades, Arab society has been undergoing a complex transition involving changes in women's status within the family and community. Despite increased education and work outside the home, "woman's role as mother and wife continues to be traditional and non-egalitarian" (Haj-Yahia, 1995 p. 439). Thus, forces encouraging modernization and those pulling families toward traditionalism are operating simultaneously, contributing to stresses and conflicts for women (Haj-Yahia, 1995). Finally, there is the issue of bi-cultural conflict that arises when the values, beliefs and practices of minority groups diverge from dominant cultural norms. Arab Muslim women may find comfort in food as they struggle with the conflicting demands of a bi-cultural existence (Kuba & Harris, 2001).

A unique opportunity to explore disordered eating and cultural diversity issues exists with a community-based study including two population groups: Arab Muslims, with roots dating back to the 16th century and second generation Israeli-born Jews of European heritage. High rates of disordered eating among Arab Muslim women might be expected due to sociocultural risk factors, including their status within a disadvantaged minority group and as subordinates within a patriarchal culture (Halperin-Kaddari & Yadgar, 2010). Additionally, Arab women's traditional roles within patriarchal families, including meal preparation for large families, may exacerbate eating problems. Alternatively, aspects of Arab Muslim culture may be protective and associated with reduced rates of disordered eating, including the rootedness of Arab communities and the stability provided by history, heritage identification, and deeply embedded religious rituals and traditions (Mussap, 2009).

2. Methods

2.1. Recruitment of respondents

A community-based sample was recruited randomly from primary health care clinics in Jerusalem and surrounding areas including Abu Ghosh. All instruments and protocols were reviewed and approved by the appropriate institutional review boards and the medical directors of all participating clinics. (For additional details, see (Feinson & Meir, 2012).)

2.2. Measures

2.2.1. Disordered Eating Behaviors—Screening Questionnaire (DEB-SQ)

The absence of adequately standardized instruments for assessing eating problems in multicultural, non-clinical samples of women across the life span (Kuba & Harris, 2001; Marcus et al., 2007) is particularly relevant to Israel (Latzer, Witztum, & Stein, 2008). Thus, an easily administered, culturally sensitive self-report questionnaire (SRQ), adapted from several widely-used instruments, was developed to assess 14 behaviors, more than half consistent with DSM-IV symptoms especially binge eating. Higher scores reflect more serious eating problems. The DEB is used categorically for descriptive statistics and in linear form for correlations and regressions (see Feinson & Meir, 2012).

2.2.2. Weight

Interviewees indicated if they were underweight (slightly or very) or overweight (slightly or very), a procedure consistent with numerous studies and sufficiently valid for epidemiological and survey studies (Striegel-Moore, Wilson, Wilfley, Elder, & Brownell, 1998).

2.2.3. Emotional well-being

Two aspects of emotional well-being are measured. A modified version of the Rosenberg Self-Esteem Scale (Rosenberg, 1979) reflects a more nuanced dimension of self-esteem, namely, self-criticism (CSS). Cronbach's alpha (standardized) is .733 with acceptable alphas for both population groups. Psychological distress is measured with the Brief Symptom Inventory (BSI), an 18 item questionnaire frequently used in epidemiological studies with well-established reliability and validity. Alpha reliability for this sample is .868 with similar alphas for population groups (data available upon request).

2.2.4. Socio-demographic variables

Two population groups include Arab Muslims ($n = 48$) and Israeli Jews ($n = 98$). Age groups conform to Central Bureau of Statistics categories. Socio-economic status is measured with single questions concerning years of education and income sufficiency.

2.3. Statistical analysis

Socio-demographic comparisons utilize Pearson's chi-square, Spearman's Rho and analysis of variance. Bivariate relationships are assessed using Pearson correlation coefficients for continuous variables and Spearman's Rho for categorical variables. Hierarchical regressions measure the contribution of three clinical correlates (weight, self-criticism, distress) to explaining DEB variance after controlling for demographic variables. DEB, CSS and BSI distress are normally distributed and used in their initial continuous form.

3. Results

3.1. Demographics

For the full community sample ($n = 567$) and two population sub-groups (Table 1a) reveals no significant group differences regarding age or income sufficiency. Arab Muslims are more likely than Jews to be married (68% vs. 49%, $p < .05$) and to have fewer years of education (12.2 vs. 14.6, $p < .001$).

3.2. Frequency distributions

3.2.1. Clinical correlates

Table 1b reveals that just under 20% of individuals in the community sample are obese with no significant differences between the two sub-groups. While a larger proportion of Arab Muslim respondents are highly self-critical (27% vs 16%), the difference is non-significant. In