



Disordered eating and complexities of cultural origin: A focus on Jews from Muslim countries

Marjorie C. Feinson*, Adi Meir

Falk Institute for Behavioral Health Studies, Kfar Shaul, Givat Shaul, Jerusalem, Israel

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ABSTRACT

Context: A dearth of data concerning eating problems among adult women from diverse cultural origins leaves substantial knowledge gaps and constrains evidence-based interventions.

Objective: To examine prevalence and predictors of disordered eating behaviors (DEB) among adult Jewish women (21+) from distinct cultural origins.

Design: Community-based study includes 175 Israelis born to parents from Muslim countries (aka Sephardic) and 108 second generation Israelis mostly of European ancestry. DEB assessed with DSM-IV related symptoms. Hierarchical regressions examine influence of weight, self-criticism and psychological distress on DEB severity.

Results: Despite similar exposure to Israel's westernized norms, substantial group differences emerge. Considerably lower rate of DEB found among respondents of Sephardic origin (11.4%, 19.4%, $p < .05$); regressions reveal dissimilar patterns of clinical predictors.

Conclusions: Community cohesiveness and deeply-rooted cultural and religious traditions may be protective for Israelis of Sephardic origin. Additional research is needed to clarify cultural influences and enhance culturally sensitive interventions for multicultural populations.

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1. Introduction

Our understanding of cultural influences on eating problems remains 'relatively rudimentary,' especially regarding adult women. In contrast to numerous cultural studies of young females (under age 25), (Cummins, Simmons, & Zane, 2005; Feinson, 2011) there is a dearth of empirical evidence concerning adults, leaving significant knowledge gaps and constraining evidence-based interventions (Le Grange, Stone, & Brownell, 1998; Marcus, Bromberger, Wei, Brown, & Kravitz, 2007; Striegel-Moore & Cachelin, 2001). Moreover, there are inconsistent findings concerning culture's contribution to anorexia nervosa (AN) and bulimia nervosa (BN) (Keel & Klump, 2003). With regard to binge eating behaviors (e.g. BED), there are relatively few studies (Cummins et al., 2005). Emerging evidence, however, suggests that "...the amount of exposure to white social norms may be irrelevant for an understanding of risk for BED." (Striegel-Moore et al., 2005).

1.1. Cultural origin and eating problems—an Israeli study

A study of Israeli high school girls sheds light on some of the cultural complexities (Neumark-Sztainer, Palti, & Butler, 1995). Substantial weight concerns were found among students, regardless of cultural

background¹ leading researchers to consider Israel's predominantly westernized culture sufficiently strong to override students' ethnic differences. In contrast, mothers differed according to cultural origin; those born in westernized countries had greater weight and shape concerns compared to mothers from North African or Middle Eastern countries.

1.2. The present study

The influence of cultural factors on eating problems is complex and unresolved. An opportunity for exploring cultural issues exists with a demographically diverse sample of adult women in Israel (age 21 to 80). Large waves of immigration since Israel's founding in 1948 provide an invaluable milieu for exploring the issues. In this analysis, prevalence and predictors of disordered eating behaviors (DEB) for two culturally distinct groups with comparable exposure to Israel's westernized norms are explored. One group (Sephardic) has roots in North Africa and the Middle East, in Muslim countries² considered more traditional and less influenced by westernized

¹ Although 97% of the students were born in Israel, their cultural background was assessed according to mother's birthplace.

² The Sephardic group also includes respondents born in Muslim countries who immigrated to Israel as young children. Detailed analyses revealed that these respondents lived in Israel more than 75% of their lives. Because of similarities with first generation Israelis of Sephardic origin and long exposure to Israeli culture (i.e. language, education etc.), the two groups are combined and referred to as respondents of Sephardic origin.

* Corresponding author. Tel.: +972 2 6513395; fax: +972 2 6513292.
E-mail address: Falk1@012.net.il (M.C. Feinson).

norms than European-American countries and Israel. Another cultural group consists of second generation Israeli-born Jews whose families immigrated to Palestine from Europe and Russia during the late 19th and early 20th centuries.³

More eating problems among Sephardic respondents might be expected due to many hardships, both as minorities in Muslim countries and in Israel (Cohen & Leon, 2008; Datan, Antonovsky, & Maoz, 1981). Also, women's traditional roles within patriarchal families, (Datan et al., 1981) including constant meal preparation for large families, may exacerbate disordered eating. Alternatively, aspects of Sephardic life may be protective and associated with fewer disordered eating behaviors (DEB). Among these are a stable family environments associated with deeply rooted religious rituals and Sephardic traditions.

2. Methods

2.1. Recruitment of respondents

Interviewees were recruited from primary care clinics in Jerusalem and surrounding suburban neighborhoods. Under Israel's system of universal health care, neighborhood clinics provide services without charge, thus eliminating economic considerations and producing relatively high utilization rates (Cwikel, Zilber, Feinson, & Lerner, 2008; Yishai, 1992). Many clinic visits are not for medical treatment, but for prescription refills, referral forms, accompanying children and family members, etc. This results in respondents more reflective of a community sample than a treated patient population. Indeed, a majority of interviewees reported no medical treatment for health conditions during the prior year.

All women entering the clinics age 21+ were invited to complete a short (3–5 min), self-report screening questionnaire (DEB-SQ) in Hebrew, Russian or English. A final question solicited participation in a 30–40 min telephone interview. All research protocols were approved by appropriate institutional review boards and medical directors of participating clinics. Overall, 1194 women completed screening questionnaires, 811 agreed to be interviewed and 567 interviews were completed.

2.2. Measures

2.2.1. Disordered eating behaviors-screening questionnaire (DEB-SQ)

Self-report screening questionnaires (SRQs) are considered effective research instruments when clinical diagnoses are not required (Le Grange, Louw, Breen, & Katzman, 2004). In the absence of standardized assessment tools with documented utility for a multiethnic sample of women (Marcus et al., 2007), an easily administered, self-report screening questionnaire with 14 DSM-IV-related symptoms (particularly binge eating) was developed for this study (Feinson & Meir, 2011). Three DEB categories reflect number and frequency of symptoms: serious DEB, with answers of 'often' or 'always' to one-third of 14 symptoms, suggests threshold conditions; 'considerable' DEB includes answers of 'sometimes' or 'often' to one-third of symptoms and suggests sub-threshold conditions; 'minimal' DEB includes answers of 'rarely' or 'never.'⁴ DEB alpha reliability is .795 with similar alphas for cultural groups.

2.2.2. Weight

To assess weight by telephone, interviewees were asked if they were a healthy weight for their age and height. Those answering 'no' specified underweight (very, slightly) or overweight (very, slightly) and were categorized accordingly.⁵ Since obesity is consistently underestimated by self-report (Engstrom, Paterson, Doherty, Trabulsi, & Speer, 2003;

³ While all PBI respondents are second-generation Israelis, some respondents may have grandparents from other than Central European countries.

⁴ Researchers have observed no sharp demarcation between full syndrome and sub-threshold groups.

⁵ The few underweight respondents are included in the healthy weight group.

Gillum & Sempes, 2005), our findings undoubtedly under-estimate the true prevalence as well.

2.2.3. Emotional well-being

Two related aspects of emotional well-being are measured: self-criticism and psychological distress. A modified version of the Rosenberg Self-Esteem scale (Rosenberg, 1979) adapted for this study reflects a more nuanced dimension, namely, self criticism (e.g. feeling critical of yourself, not good enough, much of what you do is inadequate, etc.) with three response categories (most of the time, sometimes, rarely). Higher scores reflect more self-criticism. Psychological distress is measured with the Brief Symptom Inventory (BSI), an 18-item questionnaire with well-established reliability and validity (Derogatis, 2000). (Additional information for all measures available upon request.)

2.2.4. Socio-demographic variables

Cultural origin group is defined according to parents' birthplace. Women born in Israel to parents from North African or Middle Eastern countries are respondents of Sephardic origin (PBA/S: Parents Born Abroad/Sephardic origin).² Women born in Israel to Israeli-born parents are second generation Israelis of European ancestry (PBI: Parents Born in Israel).³ One item assesses income sufficiency: Does the family income (total income of all family members) cover most of the basic daily needs and expenses (food, rent, clothing, transportation, etc.)? Three response categories (does not cover most expenses; covers part, covers all or most) classify respondents accordingly. Age and education groups conform to categories of Israel's Central Bureau of Statistics. Regarding marital status, widowed and divorced respondents are considered previously married.

2.3. Statistical analyses

Socio-demographic comparisons are examined using Pearson's chi-square and t-tests. Correlations are calculated using Pearson's *r* for continuous and Spearman's rho for ordinal variables. Hierarchical regressions for the full sample and two cultural groups predict DEB severity by entering three clinical variables (weight, self-criticism, psychological distress) after demographics (age, education, marital status). All possible interactions were checked and only significant interactions are included.

3. Results

3.1. Frequency distributions

Table 1 describes the full community sample ($n = 567$) and two cultural origin groups. The community sample (column 1) is broadly representative of Israel's adult female population (age 21+) regarding age, education, and marital status (Central Bureau of Statistics, 2003). The cultural groups differ significantly regarding demographic characteristics, but not on any clinical measure. Concerning DEB, 15.9% of the full sample has serious disordered eating⁶ with significant differences by cultural group; women of Sephardic origin have significantly less serious DEB compared to second generation respondents: 11.4% vs. 19.4% ($p < .05$).

3.2. Bivariate relationships: DEB and independent variables

Bivariate correlations reveal striking cultural group differences (data not shown). Among Sephardic respondents, DEB is strongly associated with weight ($r = .28$, $p < .001$) while for second generation respondents, DEB is most strongly associated with self-criticism ($r = .33$, $p < .001$). Within both groups, self-criticism and weight are

⁶ Among the 1194 women who completed the DEB screening questionnaire, 14.5% have serious DEB compared to 15.9% for the interviewed sample ($n = 567$).

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