Comparative study of eating-related attitudes and psychological traits between Israeli-Arab and -Jewish schoolgirls

Yael Latzer\textsuperscript{a,b,*}, Orna Tzischinsky\textsuperscript{c}, Nabil Geraisy\textsuperscript{d}

\textsuperscript{a}Eating Disorders Clinic, Psychiatric Division, Rambam Medical Center, Haifa, Israel
\textsuperscript{b}School of Social Work, Haifa University, Haifa, Israel
\textsuperscript{c}Emek Yezreel Academic College, Emek Yezreel, Israel
\textsuperscript{d}Northern District Office, Ministry of Health, Israel

Abstract

Objective: The aims of the study were to examine weight concerns, dieting and eating behaviours in a group of Israeli-Arab schoolgirls as compared with Israeli-Jewish schoolgirls, as well as to investigate the reliability of the Arabic (Palestinian) version of the eating disorder inventory-2 (EDI-2).

Method: The sample consisted of 2548 Israeli schoolgirls, including 1885 Jewish and 663 Arab adolescents ranging in age from 12 to 18. The study was conducted in 1998–2003 from urban and rural residential settings in the northern part of Israel. The (EDI-2) was the assessment tool used, yielding scores on 11 sub-scales.

Results: The Israeli-Arab schoolgirls scored significantly higher than the Israeli-Jewish schoolgirls in most EDI-2 sub-scales. In addition, the sub-scale inter-item consistency of the translated Arabic (Palestinian version) of the EDI-2 was found to be reliable.

Discussion: The drive to be thin found among Israeli Arab schoolgirls is not reflected in their small number of ED clinic referrals. These discrepancies are discussed in light of the socio-cultural changes...
Introduction

The role of socio-cultural factors in the pathogenesis of eating disorders has been the object of recent interest. Previous studies showed that eating disorders were culture bound (Katzman & Lee, 1997) and were thought to be a problem of socio-cultural elements in wealthier Western countries (Striegel-Moore, Ruth, & Smolak, 2002). However, the view of the 1980s and 1990s that eating disorders are related only to the thin ideal has recently been replaced with an understanding of the interaction between social and biological risks (Hoek & van Hoeken, 2003). Indeed, the phenomenon of eating disorders has been attributed to a combination of socioeconomic development, changing roles of women, a socio-cultural emphasis on thinness, and a shift in eating patterns (Nasser, Katzman, & Gordon, 2001). Moreover, the influence of Western values apparently stretches far beyond the countries that are traditionally considered as Western. Recent survey studies have demonstrated that the problem of eating disorders cuts across geographic and economic lines, and may more appropriately be considered as a cultural byproduct of modernity rather than as a strictly Western phenomenon (Katzman, Hermans, Hoken, & Hoek, 2004).

Israel is a unique multicultural society encompassing various ethnic and religious groups and immigrants from many different countries. Approximately 20% (1.5 million) of the total Israeli population is made up of Israeli Arabs, including Muslims (including Christians, Bedouins) (80%), Druze (9.2%), and Circassians (10.8%) (Central Bureau of Statistics, 2004). Whereas the Israeli majority generally represents a modern, Western-oriented society, Arab culture in Israel still maintains more traditional social norms and customs, as in the rest of the Arab and Muslim world. Significant differences are evident in their basic values and attitudes towards femininity and sex roles, marriage and divorce, family relations, and child rearing (Cnaan, 1987 in Barak & Golan, 2000; Barakat, 2000). Previous studies have found low incidences of ED among Arab populations (Al-Issa, 1966; El-Sarrag, 1968; Nasser, 1986, 1988a, b). Recent studies examining the incidence and prevalence of eating disorders in Arab cultures include two studies that reported cases of BN in Pakistan (Choudry & Mumford, 1992; Mumford, Whitehouse, & Choudry, 1992). In a study of female Arab students in London and Cairo Universities, Nasser (1986) found that 12% of the participants in the London group met Russell’s (1979) criteria for BN, whereas none of the Cairo group reported bulimic symptoms. There were no cases of AN found in either group. Nasser (1994a–c) found prevalence rates of 1.2% for BN and 3.4% for partial syndrome BN among Egyptian secondary schoolgirls.

Twenty years later, a study conducted in Iran (Nobakht & Dezhkam, 2000) found lifetime prevalence rates of 0.9% for AN, 3.2% for BN, and 6.6% for partial syndrome BN. The authors
suggested that the prevalence of eating disorders among female adolescents in Tehran, Iran is comparable to the prevalence rates reported by studies in Western countries and somewhat higher than what has been reported in other non-Western societies. However, due to several research limitations, the authors claimed that one should be cautious in generalizing the results of the study to other Arab countries.

Similarly, in Israel there is a small amount of epidemiological evidence confirming that the Arab population has a lower representation among referrals to ED clinics (Latzer et al., 2004). However, it has become increasingly clear that large numbers of adolescents in non-clinical settings have abnormal eating attitudes and weight concerns that may require attention (Pritchard, King, & Czajka-Narins, 1997). The same phenomenon is apparent in Israeli society (Harel, Ellenbogen-Frankovits, Molcho, Abu-Asbas, & Habib, 2002; Latzer, 2003, Chapter 13).

The Arab version of the EAT-26 (Garner, Olmsted, Bohr, & Garfinkel, 1982) was first validated by Nasser (1986) and more recently by Al-Subaie (1996). To the best of our knowledge, only two studies have been conducted among Arab schoolgirls using the EDI-2, both in Saudi Arabia (Al-Subaie, 2000; Al-Subaie et al., 1996). Al-Subaie et al. (1996) found that 19.6% of an Arab sample from Saudi Arabia scored above 20 on the EAT-26 scale. Nobakht and Dezhkam (2000) found that 24.2% of the Iranian students used in their study (mean age 16.1 ± 2.0) scored above the cutoff point of EAT-26. Body dissatisfaction and the desire to be thin were common in this population.

Various studies using EAT-26 in Western countries reported figures similar to those found in some of the Arab population (18–20% scored >20) (Dancyger & Garfinkel, 1995; Lichener, Arnett, Rallo, Srikameswaran, & Vulcano, 1986; Patton, 1988; Patton, Johnson-Sabine, Wood, Mann, & Wakeling, 1990; Scheinberg, Bleich, & Kolovsky, 1992; Toro, Castro, Gracia, Perez, & Guesta, 1989; Whitaker, Davies, Shaffer, & Johnson, 1989; Wichstrom, 1995). The only study conducted in Israel on the Arab population was carried out by Apter et al. (1994), who used the EAT-26 questionnaire to examine eating attitudes among five Arab subgroups: Muslims, Christians, Druze, Bedouins, and Circassians. They found that the Circassian adolescents had the lowest scores for total eating pathology and most sub-scales of the EAT-26, whereas the Bedouin adolescents had the highest scores (Bedouins, 19.4%; Muslims, 18.6%; Christians, 15.4%; Druze, 14.3%; and Circassians, 8.0%). The authors’ explanation of these results was that the degree of morbid eating behaviour of the diagnosed ED cases depended upon the degree of exposure to Western body ideals and the presence of conflict between modern and traditional values in relation to the female role (Apter et al., 1994).

If we consider the exposure of the Israeli-Arab population to the Western-oriented culture of the Jewish population, then there still remains an open question as to why the influence of the “slenderness culture” is not as strong as in other populations, as reflected in their small number of ED clinic referrals.

Therefore, the aim of the present study was to examine weight concerns, dieting, and eating behaviours among Israeli-Jewish and -Arab adolescent schoolgirls in an attempt to identify psychological eating-related differences between the two populations, as well as to investigate the reliability of the Arabic (Palestinian) version of the EDI-2 within the Israeli-Arab population.
Method

Sample

The sample consisted of 2548 Israeli schoolgirls, including 1885 Jewish and 663 Arab adolescents in the 7–12th grades, ranging in age from 12 to 18 (mean age 14.7 ± 1.5). The study was conducted in 1998–2003 in middle and high schools, for both Israeli-Jewish and Israeli-Arab adolescents, from urban and rural residential settings in the northern part of Israel.

Instrument

The eating disorder inventory-2 (EDI-2) (Garner, 1991) is one of the most widely used self-report questionnaires for assessing psychological characteristics related to eating disorder pathology among Western populations. The EDI-2 is a multidimensional instrument with demonstrated utility for both clinical and non-clinical purposes (Lee, Lee, & Leung, 1997). It is not intended to be used as a diagnostic instrument, but rather provides a profile of certain clusters of symptoms commonly found among individuals with eating disorders.

The EDI-2 contains 91 items, which are rated on a six-point scale and are divided into the following 11 sub-scales: drive for thinness (DT); bulimic tendencies (B); body dissatisfaction (BD); ineffectiveness (I); perfectionism (P); interpersonal distrust (ID); interoceptive awareness (IA); maturity fears (MF); asceticism (A); impulse regulation (IR); and social insecurity (SI). According to the EDI-2 manual (Garner, 1991) a cut-off point of 14 on the drive for thinness sub-scale (EDI-DT) was suggested for screening purposes.

The EDI-2 has been found to be a valid and reliable instrument in a wide range of different settings and has been translated into many different languages, including Chinese, Dutch, French, German, Spanish, Russian, Swedish, Bulgarian, and Hebrew. The EDI-2 was translated into Hebrew and validated with the original English version. Sub-scale inter-item consistency of the translated EDI-2 ranged between 0.67 and 0.93 (Niv, Kaplan, Mitrani, & Shiang, 1998).

To the best of our knowledge, only two studies have used the EDI-2 questionnaire (Garner, Olmsted, & Garfinkel, 1983) and validated it with samples of Arab schoolgirls, both of them in Saudi Arabia (Al-Subaie, 2000; Al-Subaie et al., 1996). There are slight differences between the Arabic language spoken in Saudi Arabia and Israeli Palestinian Arabic. Thus, we adapted the EDI-2 questionnaire to Palestinian Arabic to suit our population. The EDI-2 was translated into Arabic (Palestinian version). The instrument was then back-translated to Hebrew by another translator who had not previously seen the original EDI-2. Most translated items remain similar in meaning to the original items.

Weight and height were self-reported as part of the EDI-2 questionnaire.

Procedure

The questionnaires were approved before the trial by the northern district of the Israel Ministry of Education, as well as by the school principals. Research assistants, school counselors, and social workers distributed the forms in the classroom. Students were told that they were taking
part in a survey about the typical issues related to adolescents’ eating attitudes. Participation was voluntary and anonymous.

**Statistical procedure**

The reliability of the translated Arabic (Palestinian) version of the EDI-2 was assessed by measuring inter-item consistency (Cronbach’s \( \alpha \)) for each scale separately. The body mass index (BMI, which was calculated using weight (kg)/height\(^2\) (m\(^2\)), the EDI-2 total scores, and the scores on the 11 sub-scales for the Israeli-Arab and the Israeli-Jewish population groups were compared by \( t \)-test.

**Results**

There were no significant differences in the average BMI for Israeli-Arab schoolgirls (19.9 ± 3.2) and Israeli-Jewish schoolgirls (19.6 ± 2.9). The Cronbach \( \alpha \) correlation of 0.92 for the EDI-2 was acceptable for the Israeli-Jewish population, and the item-total correlations for the sub-scales were: DT \( \alpha = 0.85 \); BT \( \alpha = 0.62 \); BD \( \alpha = 0.89 \); I \( \alpha = 0.78 \); P \( \alpha = 0.61 \); ID \( \alpha = 0.62 \); IA \( \alpha = 0.68 \); MF \( \alpha = 0.57 \); A \( \alpha = 0.46 \); IR \( \alpha = 0.69 \); and SI \( \alpha = 0.72 \).

The Cronbach \( \alpha \) correlation of 0.90 for the EDI-2 was acceptable for the Israeli-Arab population, and the item-total correlations for the sub-scales were: DT \( \alpha = 0.78 \); BT \( \alpha = 0.60 \); BD \( \alpha = 0.86 \); I \( \alpha = 0.71 \); P \( \alpha = 0.46 \); ID \( \alpha = 0.34 \); IA \( \alpha = 0.70 \); MF \( \alpha = 0.67 \); A \( \alpha = 0.55 \); IR \( \alpha = 0.63 \); and SI \( \alpha = 0.56 \).

Table 1 presents the sub-scale inter-item consistency of the translated Arabic (Palestinian) version of the EDI-2, ranging from 0.34 to 0.90. These findings are nearly comparable to the reliability found for the Israeli-Jewish population, as reported by Niv et al. (1998), and of the original EDI-2 sub-scales (Garner, 1991).

<table>
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<tbody>
<tr>
<td></td>
<td>( N = 663 )</td>
<td>( N = 1885 )</td>
<td>Patients ( (N = 29) )</td>
<td>Control ( (N = 67) )</td>
</tr>
<tr>
<td>Drive for thinness (DT)</td>
<td>0.78</td>
<td>0.85</td>
<td>0.85</td>
<td>0.76</td>
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<tr>
<td>Bulimia (B)</td>
<td>0.60</td>
<td>0.62</td>
<td>0.78</td>
<td>0.44</td>
</tr>
<tr>
<td>Body dissatisfaction (BD)</td>
<td>0.86</td>
<td>0.89</td>
<td>0.94</td>
<td>0.86</td>
</tr>
<tr>
<td>Ineffectiveness (I)</td>
<td>0.71</td>
<td>0.78</td>
<td>0.84</td>
<td>0.83</td>
</tr>
<tr>
<td>Perfectionism (P)</td>
<td>0.46</td>
<td>0.61</td>
<td>0.71</td>
<td>0.60</td>
</tr>
<tr>
<td>Interpersonal distrust (ID)</td>
<td>0.34</td>
<td>0.62</td>
<td>0.83</td>
<td>0.50</td>
</tr>
<tr>
<td>Interceptive awareness (IA)</td>
<td>0.70</td>
<td>0.68</td>
<td>0.77</td>
<td>0.60</td>
</tr>
<tr>
<td>Maturity fears (MF)</td>
<td>0.67</td>
<td>0.57</td>
<td>0.75</td>
<td>0.20</td>
</tr>
<tr>
<td>Asceticism (A)</td>
<td>0.55</td>
<td>0.55</td>
<td>0.76</td>
<td>0.26</td>
</tr>
<tr>
<td>Impulse regulation (IR)</td>
<td>0.63</td>
<td>0.63</td>
<td>0.70</td>
<td>0.59</td>
</tr>
<tr>
<td>Social insecurity (SI)</td>
<td>0.56</td>
<td>0.56</td>
<td>0.68</td>
<td>0.71</td>
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</tbody>
</table>
Table 2 presents the differences between Israeli-Jewish and Israeli-Arab adolescent groups in comparison with the Western group (Shore & Porter, 1990) on all EDI-2 sub-scales. Significant differences were found between the Israeli-Arab and the Israeli-Jewish adolescents in most EDI-2 sub-scales, with the exception of the B and the BD sub-scales (see Table 2). The Israeli-Arab adolescents presented higher means as compared with the Israeli-Jewish adolescents in all EDI-2 sub-scales. The mean (S.D.) EDI scores in this study were similar to those of Shore and Porter (1990) in most subscales.

A total of 135 Israeli-Arab schoolgirls (20.4%) and a total of 160 Israeli-Jewish schoolgirls (9.1%) scored higher than the cut-off point of >14 on the EDI-DT sub-scale ($X^2 = 56.6$, df = 1, $p < .0001$). The mean total EDI-DT score was 8.76 (range 0–21) for the Israeli-Arab schoolgirls and 5.1 ± 5.6 (range 0–21) for the Israeli-Jewish schoolgirls ($t$-test $= -10.6$, df = 1107, $p < .0001$). Significant Pearson correlations between EDI-DT and weight and BMI were found in the Jewish and Arab groups ($r = 0.22$, $p < .0001$ for weight and $r = 0.32$, $p < .0001$ for BMI; $r = 0.23$, $p < .0001$ for weight and $r = 0.31$, $p < .0001$ for BMI, respectively).

**Discussion**

In the last three decades, there has been a growing interest in the relationship between cultural factors and eating disorders. This interest extends to Israel, which is a Western-oriented multicultural country encompassing various ethnic and religious groups. To our knowledge, no previous studies of eating-related attitudes, preoccupations, and psychological traits among Israeli-Arab schoolgirls have been conducted in Israel.

The focus of the current study was twofold: (1) To compare the scores of Israeli-Arab and Israeli-Jewish adolescent schoolgirls on all EDI-2 sub-scales. (2) To examine the application of

<table>
<thead>
<tr>
<th>EDI-2 sub-scales</th>
<th>Arab $N = 663$</th>
<th>Jew $N = 1885$</th>
<th>Significance</th>
<th>Shore &amp; Porter 1990</th>
</tr>
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<tbody>
<tr>
<td>Drive for thinness (DT)</td>
<td>8.0 ± 6.12</td>
<td>5.1 ± 5.61</td>
<td>$P &lt; 0.0001$</td>
<td>7.09 ± 5.94</td>
</tr>
<tr>
<td>Bulimia (B)</td>
<td>2.10 ± 3.06</td>
<td>1.86 ± 2.9</td>
<td>NS</td>
<td>2.17 ± 2.84</td>
</tr>
<tr>
<td>Body dissatisfaction (BD)</td>
<td>7.85 ± 7.21</td>
<td>8.29 ± 7.64</td>
<td>NS</td>
<td>12.14 ± 8.65</td>
</tr>
<tr>
<td>Ineffectiveness (I)</td>
<td>4.88 ± 5.08</td>
<td>3.43 ± 4.33</td>
<td>$P &lt; 0.0001$</td>
<td>4.2 ± 4.89</td>
</tr>
<tr>
<td>Perfectionism (P)</td>
<td>10.98 ± 4.18</td>
<td>5.66 ± 3.93</td>
<td>$P &lt; 0.0001$</td>
<td>4.97 ± 4.1</td>
</tr>
<tr>
<td>Interpersonal distrust (ID)</td>
<td>5.73 ± 3.47</td>
<td>4.03 ± 3.5</td>
<td>$P &lt; 0.0001$</td>
<td>3.36 ± 3.56</td>
</tr>
<tr>
<td>Interceptive awareness (IA)</td>
<td>7.36 ± 5.91</td>
<td>4.05 ± 4.42</td>
<td>$P &lt; 0.0001$</td>
<td>5.46 ± 5.43</td>
</tr>
<tr>
<td>Maturity fears (MF)</td>
<td>8.0 ± 5.4</td>
<td>5.9 ± 4.0</td>
<td>$P &lt; 0.0001$</td>
<td>3.76 ± 3.08</td>
</tr>
<tr>
<td>Asceticism (A)</td>
<td>6.55 ± 4.58</td>
<td>5.40 ± 3.58</td>
<td>$P &lt; 0.0001$</td>
<td>—</td>
</tr>
<tr>
<td>Impulse regulation (IR)</td>
<td>10.47 ± 5.86</td>
<td>4.00 ± 4.66</td>
<td>$P &lt; 0.0001$</td>
<td>—</td>
</tr>
<tr>
<td>Social insecurity (SI)</td>
<td>4.64 ± 3.39</td>
<td>3.11 ± 3.44</td>
<td>$P &lt; 0.0001$</td>
<td>—</td>
</tr>
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</table>

*aShore & Porter (1990).*
the EDI-2 questionnaire (Palestinian version) as an instrument for screening eating-related attitudes, preoccupations, and psychological traits among Israeli-Arab schoolgirls.

The results indicated that the Arabic translation (Palestinian version) of the EDI-2 is indeed reliable. The reliability analysis showed that the meaning of the test items suffered very little from the translation of the Hebrew version (Niv et al., 1998) or that of the original EDI-2 (Garner, 1991). On the whole, the EDI-2 instrument was found to behave in a similar way when used with Israeli-Arab adolescents as with samples from Western cultures, as reflected by the fact that the Arab group’s EDI-2 scores compared favourably with those obtained in recent Western ED studies. The only two sub-scales that were found to yield lower Cronbach $\alpha$ scores, as compared to those of the original Canadian non-patients sample, were ID ($\alpha = 0.34$) and P ($\alpha = 0.46$) (Shore & Porter, 1990).

As far as we know, only two studies have used the EDI-2 questionnaire and validated it with samples of Arab schoolgirls, both of them in Saudi Arabia (Al-Subaie, 2000; Al-Subaie et al., 1996). The mean EDI scores found in Al-Subaie et al.’s (1996) study were similar to those reported by Shore and Porter (1990), with the exception of the P and MF sub-scales, which were higher among the Saudi schoolgirls.

The mean sub-scale scores for both the Israeli Arabs and Jews in these samples fall within the normal range for non-patient groups, as established by the original Canadian sample and as presented in the EDI-2 manual (Garner, 1991). However, the Israeli-Arab schoolgirls scored significantly higher than the Israeli-Jewish schoolgirls in most EDI-2 sub-scales.

These results are in line with those of Al-Subaie et al. (1996, 2000), who used only the first 64 items of eight of the EDI sub-scales and later the EDI-DT sub-scale. The mean and rate of EDI-DT among the Israeli-Arab schoolgirls were found to be much higher than among the Israeli-Jewish schoolgirls and higher than among the Saudi schoolgirls (15.9%; Al-Subaie et al., 2000). Although the current Israeli-Arab results are different from those found by Shore and Porter (1990) among Canadian female students of the same age group (grades 7–12), they do provide support for research on abnormal eating attitudes in three other Islamic countries (Pakistan, Oman, and Turkey), using the EAT-26 questionnaire. The highest rate (39.5%) of abnormal eating attitudes was found among non-Western countries (East Asian and African countries). Despite the fact that the Pakistani sample had the highest rate among the non-Western countries, it is important to note that the sample consisted of female first-year nursing college students, rather than schoolgirls as used in the current study. These results contradict the socio-cultural hypothesis, assuming that adolescents from highly competitive industrialized Western countries should be at a higher risk of eating disorders than those from non-Western countries.

The phenomenon of eating disorders has been attributed to a socio-cultural emphasis on thinness, and a shift in eating patterns in wealthier western countries. Recent survey studies have been documented that eating disorders are a problems across geographic and economic groups and may be considered as a cultural of modernity rather than to a western locality (Katzman & Lee, 1997; Striegel Moore et al., 2002).

Although the current results were partly similar to those of other studies using Arab samples, they were still surprising because of their low representation among referrals to the ED clinics in Israel. A recent socio-cultural profile of patients seeking ED treatment who were referred to the larger eating disorder outpatient clinics in the northern part of Israel showed that the Arab population had the lowest representation (3 out of 1000 patients) who were referred between the
years 1992 and 2002 included 18.2% for Anorexia, 31.8% for Bulimia, 27.3% for EDNOS, and 22.7% for BED (Latzer et al., 2004). As approximately 20% (1.5 million) of the Israeli population is made up of Israeli Arabs, we expected to see almost the same percentage of referrals to the ED clinics. Several researchers have attributed such a low incidence to different attitudes towards beauty in Arab culture, where plumpness is considered to be attractive and a symbol of feminine nurturance (Apter et al., 1994; Dolan, 1991; Nasser, 1997).

The discrepancies between the high rate of problematic eating-related attitudes and psychological traits found among the Israeli-Arab schoolgirls and the low rate of referrals to the ED clinics may be explained by several factors. First and foremost are the help-seeking characteristics of the Israeli-Arab population in relation to treatment in general and psychiatric treatment in particular. Studies have indicated that Israeli Arabs, especially women, seek less help from professional sources as compared with their Jewish counterparts (Haj-Yahia, 1994, 1995, 1997). This explanation is in line with epidemiological data showing that ethnic minorities are less likely to seek eating disorder related treatment than are non-minority groups within Western-oriented countries (Crago, Shisslak, & Estes, 1996; Smolak & Striegel-Moore, 2001).

The second factor is that the actual level of ED pathology may not correspond to the rate of referrals to ED clinics (Ben-Ari & Azaiza, 2003). In addition to the stigma attached to seeking help from sources outside the family support network, Arabs may fear being stigmatized as having mental illness upon application for treatment at an eating disorders clinic. Furthermore, they may have less knowledge about eating disorders and eating disorder treatment facilities.

A related issue is the way in which Arab populations relate to self-report questionnaires in general and questions about eating-related problems in particular. According to the literature, the Arab population presents more pathological attitudes than the Jewish population in other problem areas as well, such as drug and alcohol (Weiss, 1997). This phenomenon may reflect the fact that women in the Arab community are often exposed to more stressors and difficulties than are Western women. This explanation is in accordance with several epidemiological studies (Kessler, Cleary, & Burk, 1985; Kramer & Garralda, 1998; Piccinelli & Simon, 1997), profiling women’s life in Arab society, which is characterized as a patriarchal community where men have more power and authority (Barakat, 2000; Heiberg & Geir, 1994).

Finally, the discrepancies in the referrals to eating disorder clinics may reflect the socio-cultural transformation that the Israeli-Arab population is undergoing due to the influence of Western-oriented life in Israel. Some authors have suggested that the Arabs in Israel are confronted with a fundamental conflict between two very different systems of values and perspectives: Western and traditional (Haj-Yahia, 1997). The current results may reflect such a conflicting value system. The fact that the Arab adolescent females were willing to express their problems may show that they are exercising their independence and sense of individuality achieved in the process of modernization (Ben-Ari & Azaiza, 2003). It might be that the degree of resemblance between the schoolgirls’ eating behaviours and preoccupations and the morbid behaviour diagnosed as eating disorder cases is dependent upon the degree of exposure to Western body ideals and the presence of conflict between modern and traditional values in relation to the female role.

It is important to emphasize that all of the EDI sub-scale scores were within the normal range among both Arab and Jewish schoolgirls and were similar to other Western counterparts (Shore & Porter, 1990). Thus, the fact that the Arab schoolgirls had higher scores than their Jewish counterparts does not necessarily mean that they indeed have a higher incidence of full-blown
eating disorder pathology. Due to the lack of population-based and patient-based research on Anorexia Nervosa and Bulimia Nervosa in non-Western countries, it is difficult to estimate the real prevalence of eating disorders among Arab populations (Makino, Tsuboi, & Dennerstein, 2004).

Several limitations of this study should be noted. First, because the study was conducted only among the population living in the northern part of Israel, one should be cautious in generalizing the results of the study to the entire Israeli population. As such, the study is more descriptive rather than epidemiological. Second, the screening instrument used (EDI-2) was developed for use with Western populations; hence, it cannot be assumed that it will perform the same task and with the same level of efficiency in a different cultural context. Although the reliability of most subscales of the EDI-2 was found to be high among the Israeli-Arab sample, the items on the questionnaire may be interpreted in a different manner than intended and symptoms associated with eating disorders in other cultures may not be identified. Third, it was not feasible to conduct clinical interviews with all participants scoring above the threshold on the EDI-DT.

The study also has important strengths, including the large sample size in both the Israeli-Arab and-Jewish groups. Now that this study has identified the eating-related attitudes, preoccupations, and psychological traits among Israeli-Arab schoolgirls, further epidemiological studies should be conducted, including clinical interviews. In addition, further screening and assessment of the prevalence of eating disorder symptoms among primary health care clinics in the Arab population should be undertaken.

References


