THE DANCE OF SLEEPING AND EATING AMONG ADOLESCENTS: NORMAL AND PATHOLOGICAL PERSPECTIVES

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CONTENTS

Preface **Error! Bookmark not defined.**

Introduction **Error! Bookmark not defined.**
Yael Latzer and Orna Tzicshinsky

Section 1. Healthy Sleeping and Eating in Adolescents

Chapter 1 **Healthy Eating among Adolescents** **Error! Bookmark not defined.**
Geila S. Rozen

Chapter 2 **Sleep in Adolescents** **Error! Bookmark not defined.**
Tamar Shochat

Section 2. Eating and Sleeping Disturbances among Adolescents

Chapter 3 **Relation of Dieting to Eating Pathology** **Error! Bookmark not defined.**
Eric Stice, Katherine Presnell and Heather Shaw

Chapter 4 **Anorexia Nervosa in Adolescents: A review of Clinical and Treatment Issues** **Error! Bookmark not defined.**
Mark Norris, Pier Bryden and Leora Pinhas

Chapter 5 **Bulimia Nervosa in Children and Adolescents** **Error! Bookmark not defined.**
Seena Grewal and Leora Pinhas

Chapter 6 **Binge Eating Disorders and Behaviour among Adolescents** **Error! Bookmark not defined.**
Lien Goossens and Caroline Braet

Chapter 7 **Food Avoidant Emotional Disorder** **Error! Bookmark not defined.**
Rose Geist

Chapter 8 **Disordered Eating and Eating Disorders in Israeli Adolescents** **4**
Yael Latzer, Eliezer Witztum and Daniel Stein

Chapter 9 **Sleep Problems during Adolescence: Links with Daytime Functioning** **Error! Bookmark not defined.**
Liat Tikotzky and Avi Sadeh

Section 3. The Impact of Eating Disorders on Sleep Behaviour in Adolescents **Error! Bookmark not defined.**

Chapter 10 **Obesity and Sleep in Adolescents** **Error! Bookmark not defined.**
Riva Tauman

Chapter 11 **Sleep Patterns in Adolescents with Anorexia Nervosa** **Error! Bookmark not defined.**
Tzischinsky Orna and Latzer Yael

Chapter 12 **Sleep Wake Cycle in Adolescents Girls with Bulimia Nervosa** **Error! Bookmark not defined.**
Yael Latzer and Orna Tzischinsky

Chapter 13 **Sleep Pattern in Overweight Adolescents with and without Binge Eating Episodes** **Error! Bookmark not defined.**
Yael Latzer and Orna Tzischinsky

Chapter 14 **Night Eating Syndrome in Adolescents** **Error! Bookmark not defined.**
Cristin D. Runfola and Rebecka Peebles

Chapter 15 **Klein-Levin Syndrome: Periodic Sleepiness, Binge Eating and Sexual Disinhibition** **Error! Bookmark not defined.**
Giora Pillar and Sarit Ravid

Section 4. Guidelines for Parents and Healthcare Professionals on Healthy Sleeping and Eating

Chapter 16 **Screening of Sleep Problems among Adolescents: Guidelines for Healthcare Professionals** **Error! Bookmark not defined.**
Marsha Luginbuehl

Chapter 17 **Assessment of Sleep Problems in Adolescents** **Error! Bookmark not defined.**
Sricharan Moturi and Anna Ivanenko

Chapter 18 **Impact of Sleep Loss on Adolescents: Guidelines for Adolescents and Parents** **Error! Bookmark not defined.**
Valerie McLaughlin Crabtree and Lisa Ann Witcher

Chapter 19 **Medical Evaluation of Adolescents with Eating Disorder** **Error! Bookmark not defined.**
Diane Wilkins Mickley

Chapter 20 **Impact of Dieting Behavior on Adolescents - Guidelines for Adolescents and Parents** **Error! Bookmark not defined.**
C. Alix Timko

Section 5. Acknowledgements

About the Editors **Error! Bookmark not defined.**

About the Faculty of Social Welfare and Health Sciences, University of Haifa, Israel **Error! Bookmark not defined.**

About Emek Yezreel College, Emek Yezreel, Israel **Error! Bookmark not defined.**

About the “Health and Human Development” Book Series Error! Bookmark not defined.

Index Error! Bookmark not defined.

Chapter 8

DISORDERED EATING AND EATING DISORDERS IN ISRAELI ADOLESCENTS

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Abstract

In the present chapter, we aimed to analyze the current state of affairs concerning disordered eating and eating disorders among adolescents in Israel. In comparing different Jewish sub-populations, kibbutz women have been found until recently to show higher rates of disordered eating than other Israeli samples. However, recent studies show no such difference between kibbutz members and the general Israeli population. No clear-cut findings emerge with respect to the influence of immigration on the frequency of disordered eating. However despite the massive immigration that Israel has experienced since the late 1980s, the number of immigrants seeking treatment for EDs has been relatively quite low.

In contrast the frequency of disordered eating is less prevalent among Jewish religious observance and among Israeli Arabs, reflecting the traditional non-Westernized characteristics of their society. Accordingly, diverse Israeli-Arab sub-populations show different rates of disordered eating, depending upon their degree of exposure to Westernized influences and the presence of conflict between modern and traditional values. One important finding highlighted in our review is the high rate of disturbed eating behaviors among Israeli male and female adolescents in comparison to many other Western industrialized countries. This finding raises critical questions about the emotional well-being of Israeli adolescents.

Introduction

As a multicultural nation, Israel provides an exceptional opportunity to study the role of ethnic and socio-cultural parameters in the development and maintenance of various psychological disturbances, including disordered eating syndromes. Anchored in ancient traditions, yet poised at the apex of cutting-edge technology, it is a country of contrasts. Israeli society is comprised of many ethnic and religious groups, with immigrants from a multitude of countries. Moreover, there

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is a varying level of exposure of different Israeli socio-cultural subgroups to Westernized ideals, including the drive to be thin.

Disordered eating is a broad construct which includes subclinical eating disorders [eating disorders not otherwise specified (EDNOS) [1]], as well as aberrant preoccupations, attitudes, and behaviors related to shape, weight, body image, and food that do not reach the level of EDNOS. Unlike full-blown eating disorders (EDs), disordered eating is not a psychiatric diagnosis obtained with accepted diagnostic criteria (e.g.,[2]. Rather, it represents a broad spectrum of subsyndromal features of EDs, a term that is often used in the description of maladaptive ED-related features (e.g., [3-6].

The aim of the present chapter is to analyze the current state of affairs concerning eating disorders and disordered eating behaviors among adolescents in Israel. As there are no valid Israeli studies with respect to the epidemiology of Anorexia Nervosa (AN) and Bulimia Nervosa (BN), we have focused primarily on findings related to disordered eating, which is a less defined entity. The first part of the present review focuses on EDs and disordered eating behaviors and attitudes within the larger Israeli society. We then turn to the association between socio-cultural issues and disordered eating in diverse Israeli sub-populations. Special emphasis is given to reviewing disordered eating among new immigrants, the kibbutz population, and the Israeli-Arab population, as well as to the influence of religious affiliation on EDs and disordered eating. In the last part of the article, we discuss the disordered eating phenomenon among adolescents in Israel as a reflection of Israeli society being a culture in transition with constant exposure to traumatic events. In addition, there is a varying level of exposure of different Israeli socio-cultural subgroups to Westernized ideals, including the drive to be thin.

Eating Disorders among Adolescents in Israel

Only a few community-based studies have been performed to assess the prevalence of EDs in Israel. Scheinberg et al. [7] surveyed 1112 Israeli female soldiers between the ages 18-20 and found 2.4% with a subsyndromal ED, 0.2% with AN, and 0.5% with BN. However, the results of this study cannot be generalized, as it includes only specific age groups and specific populations (not all Israeli female adolescents are recruited to the army). Mitrany et al. [8] surveyed all Israeli ED treatment facilities, including 24 inpatient and ambulatory centers, over a five-year period (1989-1993). Of the 632 new cases identified, almost all of whom were females and most were adolescents, 60% were diagnosed with AN, 17% with BN, 4% with AN and BN, and 20% with EDNOS. From these results, the authors extrapolated that the mean annual incidence for all EDs among Jewish Israeli female adolescents was 48.8 per 100,000, for AN 29.0/100,000, and for BN 8.6/100,000. As the authors themselves acknowledged, the results of this study, which were markedly different from most epidemiological data (e.g., [9], were confounded by serious methodological problems, casting doubt on their validity and most likely leading to an underestimation of the actual incidence.

Stein et al. [10-12] evaluated the rate of subsyndromal restrictive and binging/purging type EDs in a series of female 10-12th graders and army recruits according to the combination of a pathological EAT score (>22 points) and the presence of some of the DSM-IV criteria for AN or BN. Between 12-21% of the subjects were identified as having a subsyndromal restrictive type ED, and 8-19% as having a subsyndromal binging/purging type ED. Individuals with subsyndromal EDs had greater rates of core ED-related traits (e.g., obsessionality or impulsivity) than non-ED participants, supporting the validity of this distinction. Unlike most studies that report rates of these subsyndromal EDs in the range of 5-15% (e.g., [13] , the authors attribute the relatively high rates of subsyndromal EDs in their studies to the use of broad ED definitions (e.g., patients who binged or purged only sporadically were included) and self-report questionnaires, rather than structured clinical interviews (e.g., [14].

Another analysis was carried out by Latzer and Gilat [15,16] on all calls [19,776] received by the only Israeli crisis hotline (ERAN) from individuals suffering from EDs over a period of four years. The results revealed a steady increase in the rate of EDs among female adolescent callers, rising from 1.7% in 1994 to 3.1% in 1997, with EDs being the second most frequently identified problem among this group of callers. About one-third of the total ED-related callers could be identified as AN, another third as BN, about a quarter as binge eating disorder (BED), and the rest as EDNOS. The authors attribute the overrepresentation of AN among the hotline callers to the inclination of AN patients to refrain from treatment, making it more likely that they will turn to a crisis hotline when distressed [17].

Disorded Eating Psychopathology and Attitudes in Israeli Adolescents

Between 60-80% of Israeli female adolescents are dissatisfied with their weight and shape, although the vast majority of these youngsters are of normal or even low weight [10,18-20]. A study conducted by Neumark-Sztainer et al. [20] to assess eating attitudes and behaviors among Israeli adolescent females showed that whereas only 17% were overweight, 47% reported dieting at the time and 74% reported dieting in the past.

An international study of health behaviour among schoolchildren (World Health Organization, Health Behaviour in School-Aged Children – WHO-HBSC] was conducted in 28 Westernized countries in 1994 [18], and in 44 Westernized countries in 1998 (most countries in Western and Central Europe and North America participated in one of the two studies or both). In both studies, the frequency of dieting behaviour at the time of evaluation was the highest among Israeli Jewish adolescents as compared with all other participating countries, for both girls (34.5% and 28%, respectively) and boys (8.9% and 11%, respectively) [18,19]. In a more recent study undertaken in 2001-2002, Israel ranked the second among 33 Westernized countries, surpassed only by Denmark, with 26% of Israeli girls engaged in dieting behaviour at the time of the assessment [21]. It is important to note that only 6% of the respondents reported that they were dieting under professional supervision, meaning that approximately 13% of Israeli adolescents diet without appropriate supervision. Moreover, almost 50% of all students reported that they engaged in physical activities to lose weight, 3% reported purging behaviors (vomiting and laxative use), and another 2% reported the use of diet pills [19].

Another two studies conducted by Latzer and Tzischinsky with 12-18 year-old Jewish Israeli girls assessed maladaptive eating-related behaviors with the EAT-26 (1270 participants) [17] and eating-related preoccupations with the Eating Disorders Inventory-2 (EDI-2, 1316 participants) [22]. Results showed that almost 20% of the participants had pathological EAT-26 scores, with the 16-18 year old girls having the highest EAT-26 and EDI-2 scores as compared to the other age groups. More recent studies using the EAT-26 in Israeli adolescents have also demonstrated that about 20% of the females (and 5% of the males) interviewed had pathological EAT-26 scores [23,24]. Maor et al [24]analyzed the findings on the EAT-26 in all students between the ages of 12-16 who were studying in the only school of a suburban upper class community during 2001. Twenty percent (145) of all 730 female students were found to have a pathological EAT-26 score, as compared to 6.8% [53] of all 775 male students. A constant rate of pathological EAT-26 scores was found in the male students regardless of their age (6-10%), whereas among the females, a significant increase was noted in the 16-year-old participants (29%) as compared to the younger populations (18-21%). Compared to participants with normal EAT-26 scores, both male and female students with pathological EAT-26 results scored higher on all EDI-2 scales, as well as on other scales evaluating core ED features, such as perfectionism and selflessness [24][25]. Interestingly, male students with pathological EAT-26 results scored higher than females with pathological EAT-26 scores on all EDI-2subscales.

A recent study assessed eating behaviors by a modified SCOFF questionnaire, covering lifestyle, dietary and health habits, disordered eating behavior, clinical and socio-demographic data) in a national representative cross-sectional study of 2978 Israeli schoolgirls aged 14-18 (mean age 14.7). Results indicated that 30% of the participants met the criteria for disordered eating. A few factors were identified as increasing the risk for disordered eating behavior, including dieting, early onset of menarche, being overweight or obese, and suffering from constipation. School, socioeconomic status, physical activities, and smoking status were not contributory factors. The authors concluded that these results may help to identify possible interventions to prevent the development of disordered eating behavior [26].

Eating Attitudes from Diverse Socio-Cultural Backgrounds

Israel encompasses several types of socio-cultural residential settings, such as urban, communal village, and kibbutz frameworks. In addition, Israeli Jews differ in their level of religiosity, and there are several types of Arab sub-populations (Muslim, Christian, Druze, Bedouin, and Circassian). Unfortunately, the literature concerning possible differences in eating-related attitudes and behaviors among these sub-populations is scarce. Apter et al. [27] assessed eating attitudes, using the EAT-26, among healthy Jewish girls in five Israeli high schools. The highest mean EAT-26 scores were shown by the kibbutz students (14.1±1.7) and the lowest by the students of two boarding schools (10.2±1.5), with 27.3% of the kibbutz students and 16.2% of the two boarding school students exhibiting maladaptive eating-related behaviors (EAT-26 >20).

In contrast to Apter et al.'s [27] findings, different results were obtained in another two studies conducted about a decade later, which administered the EAT-26 [17][22] and the EDI-2 [22] to 12-18 year-old Jewish girls in several educational settings in northern Israel: urban-secular, kibbutz, and two boarding schools, one secular and the other a religious boarding school. Results from these two studies showed that the kibbutz students had the lowest EAT-26 and EDI-2 scores, whereas the secular boarding school students had the most pathological EAT-26 and EDI-2 scores. These findings suggest that eating-related pathology may increase in the face of adverse conditions in the home, as most of the students in the two boarding schools were from problem families of particularly low socioeconomic backgrounds. In this case, however, it appears that religiosity in itself may have, a protective influence.

Immigration to Israel and Eating Disorders

From 1948 to 2006, Israel experienced a few large immigration waves. The first one took place in the 1950s, bringing to Israel about one million immigrants. In the late 1980's and early 1990's, another massive wave of immigrants came from the Former Soviet Union (FSU) (about a million immigrants) and Ethiopia (close to 100,000). New immigrants currently comprise approximately 15% of the Israeli population. Similar to other countries that absorb large numbers of immigrants, economic, social, and cultural difficulties may emerge in these populations as a result of the cultural gap between Israel and the countries of origin.

Many studies have shown that youngsters who have immigrated to a new country are at greater risk of developing disordered eating, or any psychiatric disturbance for that matter, than their native-born counterparts as a result of the heightened distress associated with immigration [28,29]. Young females may be at an additional risk of developing disturbed eating if emigrating from a non-Western country, such as the FSU or Ethiopia, to Israel because of their inclination to adopt the norms of the absorbing society – in this case, Western norms that reinforce the thin body ideal [30,31]. In this regard, Greenberg, Cwikel, and Mirsky [23] found that 7.9% of young

Russian female immigrants living in Israel for three years or less had pathological levels of disturbed eating attitudes and behaviors, as assessed with the EAT-26, in comparison to both native Israeli females (19.6%) and Russian female immigrants living in Israel for a longer period of time (18.8%). The authors attribute these findings to the new immigrants' desire to fit in with young Israeli-born women. To our knowledge, the issue of disordered eating in new immigrants from Ethiopia to Israel has not yet been studied, probably because this group is highly secluded and inaccessible to research.

We hypothesized that the problems associated with immigration from the former FSU and Ethiopia to Israel would be reflected in increased rates of EDs among the new immigrants as compared to Israeli-born natives. Surprisingly, this has not proved to be the case. Despite the massive immigration that Israel has experienced since the late 1980s, the number of immigrants seeking treatment for EDs has thus far been relatively quite low. This finding, albeit speculative because of the lack of valid epidemiological studies, is based on a review of visits to the largest outpatient ED clinic in Israel, located in Rambam Medical Center in Haifa. This clinic has been operating since 1991 and receives about 150 new patients each year. However, since its establishment, only four women from the former USSR and one Ethiopian woman have been treated at the clinic for an ED. Similarly, only one case study of an ED in a new immigrant from the FSU has been published to date in Israel [32]. Indeed, an extensive literature search yielded only one published study of AN in the FSU [33].

Disrodered Eating among Religious Adolescents in Israel

To the best of our knowledge, only one study [34] has examined attitudes towards eating and disordered eating among religious Jewish adolescent girls in Israel. These girls were studying in an Ulpana, a religious educational institution for girls. A significant difference in the extent of disordered eating was found between girls with high and low levels of religiosity, namely, the more religious the girl, the less disturbed was her eating. Additionally, older girls were found to show greater religiosity, more positive self-esteem, and lower rates of unhealthy eating as compared with younger girls.

These findings are attributed by the authors to the lower likelihood of religious girls to be influenced by mainstream Westernized mass media or to place a strong emphasis on physical attractiveness, success and achievement outside the home. Israeli religious adolescents may generally be reluctant to seek assistance for eating disorders because of their lack of knowledge about available ED treatment facilities, as well as the stigma attached to requesting help from sources outside the family support network [35].

Disordered Eating and Eating Disorders in the Kibbutz

The term "kibbutz" refers to a lifestyle in a relatively small, rural, basically communal settlement that is conceptually based on extensive cooperation and a maximally egalitarian society, offering equal opportunities to all its members, regardless of age, gender, or socioeconomic status. Nowadays, there are approximately 200 kibbutzim in Israel. Kibbutzim might serve as a microcosmic socio-cultural laboratory more than any other social group in Israel because of the dramatic changes occurring in these relatively homogenous communities within a relatively brief period of time. (Editor's Note: Moved from page 24.) The kibbutz traditionally represented a unique framework, different from the mainstream Israeli way of life, and children were typically raised together with their age group by special personnel rather than at home with their parents. Following their collective ideology, occupational choice was generally mediated by

the needs of the collective and kibbutz members did not receive a personal income, with the kibbutz receiving all revenues and covering all personal as well as public needs.

Although these principles are still commonly held, many kibbutzim are currently undergoing a social change in line with more accepted Israeli social norms. In the last decade, the kibbutz has undergone major socioeconomic changes, moving from an equal communal lifestyle to privatization and to the relocation of children back to their parents' residence. In line with these changes, the lifestyle of kibbutz women now more closely resembles that of Israeli women in general. Likewise, these changes are reflected in the incidence of maladaptive eating-related attitudes and behaviors among kibbutz women.

Initially, when the kibbutz members were highly involved and devoted to the unique kibbutz ideology, there was an impressively low rate of reported EDs. Later, particularly from the mid-1960s to the late 1980s, a dramatic increase was observed in the rate of both full-blown EDs and disturbed eating syndromes [36]. This may be attributed to the conflict experienced between the traditional kibbutz norms and the mainstream Israeli lifestyle as the kibbutz became more open to the norms and values of the Israeli society at large. Still, more recently, the rate of disordered eating among kibbutz adolescent girls dropped again to ranges similar to those of the general Israeli population, paralleling the socio-cultural process of assimilation of the kibbutz into the general Israeli way of life. Apter et al. [27] , who assessed Israeli schoolgirls in different residential settings in the late 1980s, found that more than 25% of kibbutz girls had pathological EAT-26 scores (i.e., EAT-26 >20), a significantly higher rate than that found in the other groups of Israeli schoolgirls. However, several recent studies assessing kibbutz schoolgirls in the late 1990s and early 2000s indicated a change in this trend. In a preliminary study conducted by Latzer and Shatz in 1997, 19% of kibbutz adolescent girls had pathological EAT-26 scores, a rate similar to that found in an urban Israeli population [37]. Interestingly, just a few years later, the attitudes towards eating among kibbutz adolescent girls, as assessed by the EAT-26 and the EDI-2, were significantly less disturbed than those of adolescents in urban or rural residential settings [17,22].

Eating Attitudes among Israeli Arabs

Approximately 20% (1.2 million) of the Israeli population consists of Israeli Arabs, including Muslims (82%), Christians (9%), and Circassian, Bedouins, and Druze (9%) [38]. Israeli Muslim Arabs, most of them belonging to the Sunni sect, are very conscious of their culture and religion and do not socialize much with the Jewish population. The Christian Arab population in Israel is closer to the Jewish majority, though sharp distinctions still remain between the two cultures. The Druze, who pay homage to Jethro (Moses' father-in-law), live in separate villages, mostly in the Galilee. They take an active part in national political life, including mandatory service in the Israeli army. Most of the Druze are agriculturists who preserve their traditional way of life. The Bedouins, once highly secluded in their nomad tradition, are nowadays more assimilated in the overall Israeli way of life, having the option to serve in the Israeli army. The Circassians are a specific Muslim group that, more than any other Arab minority, tends to live a secluded life in rural settings.

Israeli Arabs not only face political and economic problems related to their status as a minority in a Jewish state, but they experience great cultural conflicts as well. Whereas the Israeli Jewish population, on the whole, lives according to the social codes and norms of modern Western society, the Arab minority, regardless of belonging to any specific subgroup, maintains more traditional norms and social customs [39-41]. Nevertheless, many are exposed to mainstream media and may be influenced to some extent by the predominantly Western way of life in Israel [42].

Not surprisingly, the incidence rates of EDs in Middle Eastern Muslim countries (e.g., Saudi Arabia, Pakistan, Egypt, Sudan, Iraq and Iran), as well as among Arab minorities in Western

countries (e.g., the UK) are generally significantly lower than those of modern Western countries [31,43-46]. In Israel, although there are as of yet no valid epidemiological studies, there is some evidence to suggest that the Arab population has a lower representation among referrals to ED clinics. For example, of more than 1700 new referrals received by the largest ED ambulatory service in the northern part of Israel, only 2 AN and 8 BN patients were found to be Israeli Arabs [4]. This low incidence may reflect different attitudes towards beauty in the Arab culture, where plumpness is considered attractive and a symbol of feminine nurturance [47,48] . Alternatively, it may be associated with the inclination of Israeli Arabs to refrain from seeking psychiatric assistance because of the stigma attached to requesting help from sources outside the family support network, especially sources belonging to the Israeli state [35,41].

A few studies have attempted to assess whether different Israeli-Arab populations have different rates of maladaptive eating-related preoccupations and behaviors. Apter et al. [27] administered the EAT-26 to schoolgirls belonging to five different Israeli-Arab subgroups: Muslims, Christians, Druze, Bedouins, and Circassians. Results showed that the Circassian female adolescents had the lowest percentage (8.0%) of pathological EAT-26 scores (EAT-26 >20), the Bedouins had the highest percentage (19.4%), and the Muslims (18.6%), Christians (15.4%), and Druze (14.3%) scored somewhere in between. The authors conclude that the degree of eating-related pathology depends upon the degree of exposure to Western body ideals and upon the presence of conflicts between modern and traditional perspectives in relation to the female gender role [27]. Given that Circassian adolescents live in small, relatively self-contained, endogenous communities [42] as compared to the other Arab groups, mass media has relatively little impact on their norms and values. Thus, Circassians tend to maintain the traditional female nurturing role, rendering them less concerned with thinness and dieting [27].

Latzer, Tzischinsky, and Azaiza [4,49] examined the prevalence of disordered eating attitudes and behaviors among different subgroups of Israeli-Arab schoolgirls. Their sample included 922 (81.5%) Muslim, 125 (11.1%) Christian, and 84 (7.4%) Druze female students in 7^{th} to 12^{th} grades from both urban and rural residential settings throughout Israel. Compared with the Druze and Muslim subgroups, which had similar scores, the Christian subgroup had lower scores on all of the "personality" EDI-2 sub-scales, but not on the "core ED" Drive for Thinness, Bulimia, Body Dissatisfaction, and Asceticism subscales. These findings suggest that the between-group differences in EDI-2 might actually reflect the existence of conflicts within the Muslim and Druze subgroups that are not specific to disordered eating.

Discussion

Traditionally, the development of eating disorders (EDs), including anorexia nervosa (AN) [50] and bulimia nervosa (BN) [51], has been related to a host of socio-cultural parameters. Both disorders have been conceptualized until recently as representing culture-dependent syndromes, namely as syndromes that cannot be understood separately from their cultural context [50] and that are limited to certain cultures by virtue of psychosocial factors [51,52]. Recent studies, however, cast doubt on the notion of EDs as culturally dependent [9].

Israel provides an exceptional opportunity to study the role of ethnic and socio-cultural parameters in the development and maintenance of various psychological disturbances, including disordered eating syndromes, because of its unique socio-cultural background. As there are no valid Israeli studies with respect to the epidemiology of AN and BN, we have focused primarily on findings related to disordered eating, which is a less defined entity. One important finding highlighted in our review is the high rate of disturbed eating among Israeli male and female adolescents in comparison to many other Western industrialized countries. This finding raises critical questions about the emotional well-being of Israeli adolescents.

Several processes might be contributing to this increased risk. First, exposure to terrorist threats, as has been the case in Israel throughout most of its existence, may increase risk-taking behaviors in general and those related to eating in particular [53]. The high rates of disturbed eating found not only in Israeli female adolescents, but also in males as compared with other Western countries [18,19], lend further support to the notion that disturbed eating represents, at least in part, a reaction to stress which is not necessarily limited to one gender. Second, Israeli teens nowadays often do not identify with traditional religious, national, and socio-cultural values [19] and thus might be highly inclined to adopt Western norms, including those related to the thin body ideal [20]. Third, more perhaps than many other nations, Israel is a society in transition [19,54], with continuous changes in the structure of its population due to the massive waves of immigration and with constant alternation between war and peace conditions. Various psychological and psycho-physiological disturbances, including disordered eating, may emerge as a means of coping with high levels of distress in cultures in transition [55].

Indeed, it is the contribution of social instability that appears to be most critical in determining the disposition towards disordered eating. Namely, it is the rapid societal change, rather than the characteristics of the specific society, that seem to increase the risk of developing disordered eating, and perhaps even clinical forms of EDs. These processes cut through the entire Israeli society, affecting new immigrants, kibbutz members, and Israeli Arabs alike – all of whom are caught in the conflict between modern Western ideals and traditional norms.

Thus, the results of our study, together with previous research [29], support the notion that living in a culture in transition may increase the risk for disordered eating. A similar process was described by DiNicola [56], namely that what is detrimental is not so much a "culture-dependent syndrome," that is, the maladaptive influence of a specific culture in predisposing to an ED, but rather, a "culture-reactive syndrome." According to this process, rapid changes occurring within a culture may interfere with the cultural conditions for the development of a stable identity, likely increasing the risk for psychopathology. In this case, the changes that embrace a Westernized culture which reinforces the thin body ideal also serve to increase the risk of developing disordered eating.

The main limitation of the analysis of EDs in Israel is the lack of epidemiological studies on these disorders, precluding any definite conclusions as to the role of socio-cultural factors specific to Israeli society in the predisposition to an ED.

Furthermore, in most of the reviewed studies, disordered eating is defined with self-report questionnaires rather than with structured clinical interviews, usually considered the more valid procedure in the study of EDs [13]. Nevertheless, current research usually regards disturbed eating as clinically relevant because individuals with disturbed eating may share many characteristics common with patients with full-blown EDs [10,57] and because between 15-45% of these individuals may progress to full-blown syndromes within several years [13].

The lack of valid epidemiological data also makes it difficult to determine whether the low rates of disordered eating in the Israeli -Arab adolescent and the orthodox religious Jews adolescents, reflect genuine findings or are the result of inconsistencies in the reporting of these behaviors, in sampling methods, and/or in treatment-seeking behaviors.

In Conclusion, the picture that emerges from the current data on weight loss and eating behaviors of Israeli youth is highly disturbing, especially considering that these problems have continued to deteriorate in recent years [21]. Although our review does not generate solutions to this serious situation, it contributes to doing so by emphasizing that living in a culture which is both in transition and in constant socio-political stress is associated with the development of at-risk behaviors, in our case disordered eating. This situation calls for urgent intervention to assist young Israelis in coping with the maladaptive conditions in which they are living. As a result of this problem the Israeli Parlament have recently proposed a new law to limit the appearance of models to BMI 18.5 not to allow fashion models to perform if they are below BMI 18.5 (ref of the law).

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