



Potential Risk and Protective Factors for Eating Disorders in Haredi (ultra-Orthodox) Jewish Women

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Abstract

Little is known scientifically about eating disorders (EDs) in the Haredi (Jewish ultra-Orthodox) community. This paper aims to describe Haredi culture, review available peer-reviewed research on EDs in the Haredi community and discuss possible risk and protective factors for these disorders in a culturally informed way. A literature search for 2009–2019 yielded 180 references of which only nine were studies on ED in the Haredi community. We describe these and use them as a basis for discussion of possible risk and protective factors for ED in Haredi women. Risk factors may include the centrality of food, poverty, rigid dress codes, the importance of thinness for dating and marriage, high demands from women, selflessness and early marriage and high expectations from women. Protective factors may include faith, Jewish laws governing eating and food that encourage gratitude and mindful eating, and body covering as part of modesty laws that discourage objectification. Ways of overcoming the current barriers to research in the Haredi community should be sought to advance ED prevention and treatment in this population.

Keywords Eating disorders · ultra-Orthodox · Haredi · Risk and protective factors · Body image

Introduction

Eating disorders (EDs) are characterized by a persistent disturbance of eating-related behavior that leads to altered consumption of food and the impairment of physical health or psychosocial functioning (APA 2013). Certain risk factors for EDs, such as pressure to be thin, body dissatisfaction, dieting and negative affectivity (Dakanalis et al. 2017; Rohde et al. 2015), seem to be valid across ethnic groups, religions and

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levels of religiosity. However, EDs, like all psychiatric disorders, have value systems derived from specific cultural contexts that contribute to specific sets of symptomatology (Markey 2004). This paper aims to discuss culture-specific risk and protective factors for EDs in Haredi society.

Haredim (or ultra-Orthodox Jews, literally “those who tremble before G-d”) are characterized by a deep respect for religious law and tradition. Beyond this uniting factor, however, the Haredi world is markedly heterogeneous, comprising dozens of subgroups, each with its own distinctive customs, worldviews and theological beliefs (Greenberg 1991; Paradis et al. 1996; Wikler 2001; Witztum and Goodman 1999). The three main Haredi streams are: (1) the Hassidim, adopting a spontaneous, joyous and mystical approach to Judaism, in turn subdivided into groups of differing Eastern European origin, such as Gur, Belz, Chabad, Vizhnitz and Braslaw; (2) the Mitnagdim (“opponents”), who hail from Lithuania, oppose the Hassidic approach and propagate serious, in-depth study of Jewish texts; and (3) the Sephardi (“Spanish”) or Oriental Haredi stream, many of whom left Arab and Muslim countries during the 1950s and 1960s. There is also some tension between those born into the Haredi community and “repentants”, who choose to enter it later in life (Witztum and Goodman 1999).

Beyond these divisions, the Haredim share many values and practices. They observe the Halachah (“way” or system of Jewish Law and Ethics) strictly, according to traditional rabbinic interpretations in the daily life of Jews who define themselves as Haredim. The Haredi population is distinct from the modern Orthodox (“or national religious” in Israel) population in a variety of ways (Don-Yehiya 2005; Friedman 1991). For example, in comparison with modern Orthodox Jews, the Haredim have more stringent standards of religious observance, more rigid and conservative dress codes, a greater focus on Jewish studies in their educational institutions and a less Zionist attitude toward the State of Israel, to the extent that they often object to its existence in the pre-Messianic era. Modern Orthodox Jews also follow Jewish law but are far more open to western culture, medicine, technology, media and research (Don-Yehiya 2005).

Gender roles are highly distinct in Haredi society. Whereas men are encouraged to focus their lives on studying Jewish texts, women are relegated to other functions that facilitate their husbands’ spiritual development, such as earning money, homemaking and child raising. Men’s education therefore does not prepare them for employment in the labor market, and women have low rates of employment because of high birth rates (Regev 2013). As a result, fully 45% of Israeli Haredi families fall under the poverty line (Cahaner et al. 2017). In 2013, 70% had per capita income in the lowest tertile, as opposed to 16% of the non-Haredi Jewish population (The Central Bureau of Statistics 2013).

Haredi communities tend to live in their own neighborhoods with their own school system so as to focus on religious precepts and protect themselves from secular influences (Witztum and Goodman 1999). Television, films, the secular press and Internet use for nonbusiness purposes are strictly forbidden, and smartphones with censored “kosher” Internet use are allowed in some, but not all ultra-Orthodox communities. Without permission from the Rabbis (religious leaders) of these communities, epidemiological and other research on psychopathology in Haredi settings

is virtually impossible to conduct. We therefore know very little about mental health in general and about EDs in particular in strictly Haredi communities.

Whereas the prevalence of EDs in the Haredi community is not known, and it is unclear whether or not it is increasing, there are indications that stigma may be decreasing and that access to therapy for EDs may be increasing. Books about EDs have been written by prominent Rabbis (Goldwasser 2010; Twerski 1997), a film about EDs was produced by the Orthodox Union in the USA (Diamond 2008) and a plethora of articles about EDs in the Orthodox community have been published on the Internet (e.g., Heinlein 2014; Ross 2014). An article by Roni Carin Rabin in the *New York Times* entitled “Rabbis Sound an Alarm over Eating Disorders” (Rabin 2011) describes a growing awareness of the life-threatening nature of EDs.

The biblical commandment “Be fruitful and multiply” (Genesis, 1: 28; 9:1,7) has many consequences in Haredi society, including parent-facilitated dating (“shid-duchim”), early marriage, minimal use of birth control and subsequently very large families (Heilman and Witztum 1997). Proverbs 31 opens with a description of the woman of valor and her many facets of achievement, traditionally sung by a man in praise of his wife on his return from synagogue on Friday evenings. Whereas verse 20, “Charm is deceitful, and beauty is vain, a God-fearing woman is much to be praised”, seemingly discounts physical appearance, Haredi women are expected to dress well, watch their figure, cook well and be hospitable. This profile of demanding expectations and responsibilities has been termed the “superwoman ideal” (Weinberger-Litman et al. 2008). Endorsing but failing to achieve the superwoman ideal leads to feelings of inadequacy, stress and low self-image, and in some cases the development of disordered eating and even EDs (Duin 2010).

We conducted a search of the available research about body image, disordered eating and EDs in the Haredi community and used this literature as a basis to discuss known risk and protective factors for these disturbances within the specific cultural context of ultra-Orthodox Jewry. The jury is still out on whether an ultra-Orthodox lifestyle confers protection from body image and eating pathology or whether it may increase risk. In our discussion, we therefore aim to identify and describe features of Haredi way of life that may influence the development of EDs. We discuss to what extent these may be protective or alternatively broaden the fault lines that threaten the physical and psychological health of individuals in other cultural contexts, heightening the risk of Haredi women for the development of body image and eating pathology.

Methods

We conducted a systematic search in February 25, 2019, using the search engine Google Scholar over multiple databases, limiting the timeframe to 2009–2019, using the search term keywords: {ultra-Orthodox} OR {Haredi} OR {Haredim} OR {Orthodox} OR {Jewish} AND keywords: {eating} OR {eating disorders} OR {disordered eating} OR {body image}. The search yielded 180 items for which the abstracts were screened for relevance. Studies considered relevant were those specifically about Haredi (ultra-Orthodox) individuals that related to body image, EDs

or disordered eating, in peer-reviewed publications (journals and books) as well as Ph.D. dissertations. By order of frequency, references were excluded for: (1) including modern Orthodox but not Haredi participants, (2) focusing on psychopathologies other than eating disorders, (3) dealing with spirituality and/or religiosity but not specifically within a Jewish or Haredi context and (4) not distinguishing Haredi participants from the other participants.

Findings

Nine references were considered relevant according to our criteria and are presented in Table 1. Of the nine studies, six were conducted in Israel, two in the USA and one in South Africa. All but one included comparison groups. A variety of measurement approaches and outcome variables were used, precluding meta-analysis.

Discussion

Whereas the nine studies identified in our search provide the main body of work on which the following discussion rests, we also weave in other literature to our explorations, ponderings and hypotheses about Haredi culture as a backdrop to the development of body image problems, eating disturbances and EDs in this understudied community. Some of the studies identified in our search suggest that Haredi culture confers risk for body image and/or eating pathology, others suggest a protective role and yet others neither. The situation seems unclear because little research has been conducted and risk versus protection may vary between countries and different types of Haredi communities. We will take a look first at possible risk factors and then for possible protective factors for eating and body image pathology across Haredi communities. An attempt has been made to go beyond statistics and think in terms of culture-specific values, lifestyle and mentality, while keeping in mind what is known in general about risk and protective factors for EDs.

Potential Culturally Related Risk Factors

Food

Food is central in Haredi life with multiple daily meals produced for large families. Culinary traditions prescribe specific, often rich foods for the numerous Jewish holidays and for each Sabbath, when many tend to indulge (Nerman 2014). Women bear responsibility for food provision, so the centrality of food imposes ongoing and intense exposure to food, which may be a source of distress for those with eating and weight concerns (Duin 2010). Strict laws governing kosher food preparation and consumption may also exacerbate anxiety and obsessiveness in vulnerable individuals (Huppert and Siev 2010). Feinson and Meir (2012) cite a Haredi woman struggling with overeating: “Every holiday, everything is centered around food... It is

Table 1 Papers found in the systematic search

Reference	Participants	Instruments	Major findings
Goldzak-Kunik and Leshem (2017)	178 Israeli schoolgirls (81 Jewish secular, 37 Christian Arab, 60 Haredi) and 14 girls with restrictive anorexia nervosa, aged 14–16	Body Image Figure Drawings (Collins 1991)	Girls with anorexia nervosa showed more pathological body image than the other groups. Christian, secular Jewish and Haredi schoolgirls showed similar levels of body dissatisfaction
Handelzalts et al. (2017)	65 secular, 95 modern Orthodox, 70 ultra-Orthodox Israeli mothers aged 25–35	Body Image Concern Inventory, Body Appreciation Scale, Body Care subscale of Hebrew Body Investment Scale	A continuum was observed between secular, modern Orthodox, and ultra-Orthodox women on all body image assessments. Ultra-Orthodox women were found to have the most positive and least negative body image and the most positive attitudes toward body care
Feinson and Meir (2012)	261 Haredi, 181 Orthodox, 167 traditional, 181 secular Jewish Israeli women aged 20–65+	Disordered Eating Behaviors—Screening Questionnaire	Number and frequency of disordered eating behaviors did not differ significantly between Haredi, secular, traditional and Orthodox women
Feinson and Hornik-Lurie (2016)	261 Haredi, 181 modern Orthodox, 166 traditional, 180 secular Jewish Israeli women aged 20–65+ (same as Feinson and Meir 2012)	13 survey items assessing body image satisfaction	Traditional women had greater body dissatisfaction than the other women. No significant differences in body dissatisfaction were observed between Haredi and secular participants
Frenkel et al. (2018)	33 ultra-Orthodox and 22 national religious Israeli women, aged 25–45	Eating Attitudes Test-26 (EAT-26), Superwoman Ideal Questionnaire, Self-drawing+ narrative	No significant difference in eating pathology was found between the ultra-Orthodox and national religious women.

Table 1 (continued)

Reference	Participants	Instruments	Major findings
Friedman (2015)	Six young South African Haredi women aged 18–21	In-depth interviews about thoughts and feelings about the body and the influence of their specific religious context	Five themes emerged: attitude toward food; perceptions of bodily self; influence of peers; the secular world outside; and Judaism and body image. In general, the women were dissatisfied with their body size and facial features, echoing the preoccupation with appearance found in secular western culture
Geller et al. (2018)	205 secular, 163 modern Orthodox, 115 ultra-Orthodox Israeli women aged 18–30	Body Image Concern Inventory, Body Appreciation Scale	Ultra-Orthodox women had more positive attitudes toward their bodies and lower body image dissatisfaction than the secular women. Ultra-Orthodox women had more positive and less negative body image than modern Orthodox women, who had more positive body image than secular women, although not all differences reached statistical significance
Lazar-Feigenbaum (2014)	226 ultra-Orthodox and 67 modern Orthodox US schoolgirls aged 13–19	Eating Attitudes Test-26, Social Control scale	Ultra-Orthodox reported more symptoms of EDs and more social control (pressure to date and marry) than modern Orthodox girls. Pressure to date and marry was a significant predictor of symptoms of ED symptoms
Loketch-Fischer (2016).	33 Hassidic, 19 Chabad, 181 Yeshiva Orthodox, 139 modern Orthodox, 19 Conservative, 44 other US Jewish women aged 18–70	Eating Disorder Examination Questionnaire, EAT-26, MODEST scale, Objectified Body Consciousness Scale	There were no between-group differences in ED symptoms, and ED symptoms were not correlated with religious stringency or modesty of dress

murder. I'm very religious and I have 13 children... I get angry that I have to be in the kitchen a lot" (p. 102).

Poverty

Poverty, so common in Haredi communities (Cahaner et al. 2017), may increase risk for EDs (Johnson et al. 2002). Food scarcity is associated with compensatory eating (Olson et al. 2007), and the link consistently observed between food insecurity and high BMI appears to be explained by preemptive calorie intake (Basiotis and Lino 2003). Indeed, when Bratanova and his colleagues led people experimentally to see themselves as poor, they tended to increase their calorie intake (Bratanova et al. 2016). Poverty and food scarcity may therefore present a risk factor for disordered eating and EDs in the Haredi population due to socioeconomic factors.

Modesty Laws ("tsniyut")

Within the Haredi community, contact between males and females is strictly safeguarded in social contexts such as schools, places of prayer, weddings and public events (Sublette and Trappler 2000). Dating is time-limited, with the distinct purpose of marriage when suitability has been parentally established. Men and women do not touch each other casually, shake hands or place themselves alone together in a potentially intimate situation. Rabbinically established standards of modesty ("tsniut") dictate women's behavior and dress, including the covering of lower neck, arms, legs and, for married women, hair. Women do not dance or sing in the presence of men.

Modesty laws are intended to protect from inappropriate out-of-wedlock attraction. However, they are sometimes open to misinterpretation, especially during adolescence, to induce the shame about the body and sexuality that can be central in the development of ED. Sexual urges resulting from pubertal hormonal changes combined with prenuptial limitations on physical contact can make sexuality feel shameful and produce guilt, self-criticism and negative body image in vulnerable individuals. Disturbed eating attitudes and behaviors, including over- and under-regulation of food intake, can be a maladaptive response to conflict about sexuality. The ambivalence, fear and stress experienced by young women feeling emotionally and psychologically unequipped for marriage (Hoffman and Ben Shalom 2011) are not infrequently expressed in the form of an ED, and an ED can postpone a wedding, for example if weight loss leads to the absence of menstruation.

Loketch-Fischer (2016) explored the relationships among level of religious stringency, modesty, body shame and body surveillance, and ED symptoms in a sample of women from Jewish communities. She found that modesty predicted ED symptoms only in the most religiously stringent, ultra-Orthodox participants.

The Thin Ideal

Western beauty standards and female ideal body image have been seeping further and further into Haredi society and the shidduch process during recent years

(Lazar-Feigenbaum 2014; Shapiro 2013). Slimness is an advantage in seeking a desirable groom, and the prospective groom's family sometimes requests the girl's dress size, and even that of her mother, so that the bride's future bodybuilding can be predicted (Duin 2010; Rabin 2011). The consequences are akin to those of the secular media: great pressure on young women to be thin, compliments for weight loss and encouragement to invest perfectionist tendencies in efforts to achieve perfect (i.e., thin) appearance, seen as critically important (Friedman 2015).

Perfectionism

Perfectionism has a prominent role in the stereotypical personality profile associated with EDs (Bachner-Melman et al. 2007a, b) and acquires unique valence when channeled through the lens of Haredi culture. Haredi women have a great deal on their plates. Out of the home, they are expected to be accepted by and succeed academically in seminars and to develop careers and work to supplement income or even be the major breadwinner so their husbands can devote most of their time to religious study (Loewenthal 2006).

At home, they experience the pressures of marriage and family commitments, such as childbearing and running a large household (Loewenthal 2006). Giving birth to many children is a religious obligation ("be fruitful and multiply"), and a Haredi couple must seek Rabbinical permission to practice birth control. Since this "heter" is generally granted only when childbirth poses a risk to the mother's health (Popovsky 2010; Sublette and Trappler 2000), many women feel they lack the resources to parent the large numbers of children with whom they have been blessed (Sublette and Trappler 2000). Frenkel, Latzer, and Lev-Wiesel (2018) observed that in general, the ultra-Orthodox participants tended more than national religious women to strive for perfection when drawing a picture of themselves.

Selflessness

In Haredi society, a sense of giving to others and a spirit of volunteering to help the needy is ingrained in children from a very early age and typically modeled and encouraged in daily life. Haredi families tend to be so large that they themselves constitute small communities, with the expectation that all family members will think of the common good. Ongoing opportunities to give to others are provided in all sorts of ways. Whereas this offers opportunities for positive growth, intimacy, mutuality and self-esteem, it also has potential dangers.

Hilde Bruch, psychoanalyst and pioneer in the treatment of EDs, pointed out the price paid by individuals with EDs for their tendency to give to others at their own expense (Bruch 1978). Selflessness, the tendency to relinquish one's own interests in order to serve the interests and well-being of others, has been found in research to characterize women with EDs (Bachner-Melman et al. 2007b) and to predict abnormal eating attitudes (Bachar et al. 2010) in adolescent girls in Israel. Gillon, McCorkindale and McKie (1993) and Meyers-Levy (1988) argue that women tend to sacrifice their own needs when family members have different preferences from theirs, and Just, Heiman and Zilberman (2007) found this propensity for women to sacrifice

their own preferences to be linked to religious observance in Israeli families. As a result of circumstances, and perhaps also as a result of this tendency to subordinate their own needs to those of their husband and many children, Haredi mothers often become physically and emotionally overburdened. The suppression or denial of negative emotions, coupled with a “superwoman” ideal and sacrificial selflessness, can lead them to neglect their own basic needs and self-care, creating fertile ground for the development of an ED. Similarly, clinical observation shows that it is common for children, especially first-born daughters, to be extremely sensitive to their mothers’ (real or imagined) burden and neediness. Such “parental children” may take on inappropriate responsibility for supporting their mothers, for example taking responsibility for meal preparation, cleaning and housework, and tending to the physical, emotional and scholastic needs of younger siblings. This would be a fitting profile for an adolescent Haredi girl with an ED.

Unclear Sense of Identity

A disturbance in the development of a clear sense of identity is implicated in the development of EDs (Stein and Cortey 2007). Haredi family expectations might suppress individual identity formation. Growing up with many siblings, time and attention are not always plentiful for each child. In the community at large, moreover, a strong sense of cohesiveness and laws and customs governing almost every aspect of daily life emphasize the community at the expense of individuality and leave little leeway to differ. Strict dress codes dictate every aspect of appearance (Handelzalts et al. 2017; Sublette and Trappler 2000). In Haredi society, it is important to belong, to be modest and to conform, and not to be rebellious. If adolescent girls feel frustrated by familial expectations, social norms or other issues, yet unable to legitimately express frustration, they may find themselves channeling their emotions indirectly via the body and food.

Potential Culturally Related Protective Factors

Faith

Strong and internalized religious beliefs have been shown to be associated with lower levels of disordered eating, psychopathology and body image concern (Boisvert and Harrell 2013; Pinhas et al. 2008; Shafran and Wolowelsky 2013). Superficial faith with a doubtful and anxious relationship with God, however, is associated with greater levels of disordered eating and psychopathology, and body image concern (Akrawi et al. 2015). Women who feel loved and accepted by God are buffered from ED risk factors (Richards et al. 2009). Intrinsic religiosity, which implies that faith is central to one’s identity (Allport and Ross 1967), appears to act as a protective factor by decreasing the likelihood of ED symptoms (Forthun et al. 2003). Geller et al. (2018) found that the strength of Jewish religious faith mediated the association between religious denomination (ultra-Orthodox, modern Orthodox, secular) and positive body image.

Attitudes Toward Food and Food Rituals

In Judaism, eating is both a physical and a spiritual act. Controlling and sanctifying consumption of food and drink is a way drawing closer to God (Brumberg-Kraus 2005). By Jewish law, a blessing is required before each individual food or before a meal, as well as a ritual washing of hands before eating bread, and after a meal, a blessing of thanks “the blessing of the food” is mandated. This encourages gratitude for food and mindful eating, which is physically and spiritually satisfying. Despite the role of fasting and abstinence in repentance, constant abstention from essential physical needs or comfort is emphatically condemned (Maimonides 1955). Mindless bingeing and restrictive eating are therefore in fact foreign to Jewish ritual.

Some characteristics of disordered eating, such as restricting food intake, disturbed satiation response, withdrawal from community and decreased spirituality, are diametrically opposed to the ritual requirements for eating a meal. ED symptomatology may therefore be negatively associated not only with levels of religious observance in general, but more specifically with a personal connection with spiritual practices such as ritual hand washing before eating and blessings before and after a meal. This should be examined in future research.

Body Image and Modesty Laws

As a result of the isolated nature of Haredi communities, the “thin ideal” is not accessed via the media (Gluck and Geliebter 2002; Latzer et al. 2007) and therefore cannot lead directly to negative body image that is a risk factor for EDs. Even though we implicated modesty as a risk factor for negative body image, covering the body may also be protective. Tiggeman (2013) proposed that when the female body is covered and not exposed, it is less objectified, which may be protective from EDs. There is some evidence that covering the body has a protective influence for observant Islamic women. In a large survey of women in Teheran, women who practiced the strictest level of veil use expressed significantly lower levels of body dissatisfaction than other women. These women also reported lower levels of depression and higher levels of self-esteem than women who covered themselves less (Rastmanesh, Gluck and Shadman 2009).

Even though Loketch-Fischer (2016) found that modesty predicted ED symptoms in Haredi women, body shame significantly mediated the association between modesty and ED symptoms. Specifically, higher levels of modesty were associated with lower levels of body shame which, in turn, were associated with fewer ED symptoms. This suggests that women who are more modest may be protected from ED symptoms because they experience less body shame. Women whose clothing covers their body may be less concerned than women whose clothing exposes parts of their body with negative thoughts about their body and how others perceive them. In his in-depth interviews with Haredi women in South Africa, Friedman (2015) found that his interviewees experienced modesty as a means of protecting themselves against objectification both by themselves and by others, saying for example that “it keeps you safe” (p. 81) and “You don’t want people looking at you and it makes you feel better about yourself” (p. 82). It should nevertheless be pointed out

that the same interviewees also reported, on the whole, being dissatisfied with their bodies, so that the association between modesty and body image seems to be far from straightforward.

Conclusion

The purpose of this paper was to describe what is known about body image and eating problems and disorders in the Haredi community, and to discuss possible culture-specific risk and protective factors in this population. Without Rabbinical collaboration, epidemiological and other research on EDs in the Haredi community is very difficult to conduct. This may be partly because of fear that results could spotlight psychopathology in the Haredi community, thereby exposing “flaws”. Notably, there seems to have been virtually no publications about Haredi boys and men with body image, disordered eating or EDs, so we lack any knowledge about them. This paper therefore necessarily limited its scope to a descriptive, postulative and reflective approach. Religious observance as is customary in the Haredi community may be protective in some cases but harmful in others. Potential risk factors emerge from this brief description of this unique culture, as well as some protective factors stemming from the isolated nature of the society and its emphasis on women’s traits and behaviors rather than their physical appearance. Ways of overcoming the current barriers to research in the Haredi community should be sought, for example by developing culturally appropriate educational institutions for the training of Haredi researchers, persuading religious leaders that participation in research stands to improve the physical and mental health of people who seek their guidance. The few Haredi individuals with degrees in the field of mental health may serve as trusted key members of their communities. As such, they may be in a position to facilitate culturally sensitive research that researchers outside their communities cannot conduct. Our knowledge of risk and protective factors for EDs in the Haredi community may then begin to stem from evidence instead of speculation, and members of this community could benefit more than they do at present from what is known about the prevention, detection and treatment of EDs.

Compliance with Ethical Standards

Conflict of interest The authors have no conflict of interest.

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