The Impact of Israel’s “Models’ Law” on Young Women

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Abstract

Background: The development of eating disorders (EDs) and disordered eating pathology (DEP) is related to a complex interplay of various factors, with the media being a main risk factor. The high comorbidity related to EDs and DEP highlights the importance of preventive interventions and requires additional prevention strategies that create opportunities for policy changes, while targeting media influences. In 2012, Israel initiated the “models’ law”, setting limits on both the employment of underweight models and the use of photo editing. This study examined the impact of the models’ law on body dissatisfaction, DEP, and EDs among young women in Israel.

Methods: The study included two parts: self-report questionnaires and a telephone interview. The sample of 203 women was divided into two age groups, 81 women aged 18-24 and 122 women aged 25-35—that completed both parts of the study.

Results: The models’ law had significantly higher impact on younger as opposed to older participants. Yet younger participants were found to have higher levels of DEP than the older participants. Additionally, participants who were highly supportive of the law had lower levels of DEP.

Conclusion: These results highlight the importance of implementing prevention programs at younger ages and expanding the spectrum of prevention programs to the field of policy change, using legislation.

Keywords: eating disorders, disordered eating pathology, prevention, models’ law, Israel

1. Introduction

An increasing body of research during the last 5 decades indicates a dramatic increase in the prevalence of eating disorders (EDs) and related symptoms and behaviors, mainly among female adolescents in Westernized societies (Latzer, Weinberger-Litman, Spivak-Lavi, & Tzischinsky, 2019; Udo & Grilo, 2018). These symptoms comprise a continuum ranging from mild disordered eating behaviors and attitudes to moderate levels of disordered eating pathology (DEP), to full-blown clinical levels of EDs such as anorexia nervosa, bulimia nervosa, and binge eating disorder (American Psychiatric Association, 2013; Hoek, 2016; Latzer, Spivak-Lavi & Katz, 2015; Latzer et al., 2019; Smink, Van Hoeken & Hoek, 2012; Udo & Grilo, 2018). Eating disorders are mental disorders involving thoughts and behaviors that reflect serious problems related to body image and body perception (Latzer et al., 2019) with high medical, psychiatric, and psychological comorbidity and higher mortality rates than any other psychiatric illness (Fairburn & Harrison, 2003; Le, Barendregt, Hay & Mihalopoulos, 2017; Treasure, Claudino & Zucker, 2010). In 2016, the prevalence rate of EDs in Israel was estimated between 6% and 8% in adolescent girls and young women between the ages of 15 and 24 (Blanck, 2016). However, more recent international studies indicated that EDs affect up to 4% of men and 15% of women at some point in their lives (Deloitte Access Economics, 2020; Galmiche, Déchelotte, Lambert, & Tavolacci, 2019; Huryk, Drury, & Loeb, 2021; Micali et al., 2017; Udo & Grilo, 2018). Alongside these rates, it is important to note that the COVID-19 pandemic had a negative impact on people suffering from EDs (Miniati et al., 2021).

Disordered eating pathology is a nonclinical term that refers to moderate levels of disturbed eating patterns such as preoccupation with weight and shape, body image disturbance, and food intake. Caloric restriction, constant dieting, overexercising, and use of diuretics and laxatives are common examples of behavior associated with DEP (Latzer et al., 2015). People showing signs of DEP are at greater risk of developing full-blown EDs if not properly treated, emphasizing the importance of identifying those who are at risk (Latzer et al., 2019; Weinberger-Litman,
Latzer, Litman, & Ozick, 2018). Disordered eating pathology is also related to significant psychiatric and physical comorbidities (Hudson, Hiripi, Pope, & Kessler, 2007; Latzer et al., 2019; Skemp-Arlt, 2006), with high prevalence of body dissatisfaction among young girls despite being at normal weight (Buchianieri, Arikian, Hanan, Eisenberg & Neumark-Sztainer, 2013).

A similar trend of increased DEP has been observed in Israel. A multicountry study of adolescents by the World Health Organization reported that in the last 5 decades, Israeli youth have been troubled by eating-related disturbances at one of the highest rates of the 34 industrialized nations in the study (Harel, Ellenbogen-Frankovits, Molcho, Abu-Ashas, & Habib, 2002). Approximately, 22% of Israeli adolescent girls displayed symptoms of DEP, with the highest rate found among girls aged 16-18 (Greenberg, Cwikel, & Mirsky, 2007; Latzer et al., 2015; Latzer et al., 2019; Latzer & Tzischinsky, 2003, 2005; Maor, Sayag, Dahan, & Hermoni 2006). These alarming rates and severe complications highlight the need to identify risk and protective factors among the highest risk groups (Latzer et al., 2019) and develop preventive interventions.

The development of both EDs and DEP is related to a complex interplay of genetic, biological, psychological, familial, and sociocultural factors (Hilbert et al., 2014; Latzer et al., 2015; Le et al., 2017; Levine & Smolak, 2009; Stice, Marti, & Durant, 2011). Early adolescence has been identified as a risk period when girls are particularly vulnerable to developing DEP or EDs because of the normative challenges associated with this developmental stage, such as increased desire for peer acceptance, social comparison, and low self-esteem (Latzer et al., 2019; Steinberg, 2002).

Body dissatisfaction and low self-esteem have consistently been shown to be one of the most proximal risk factors for DEP and relate mainly to mass media messages promoting the thin ideal (Mitchison & Mond, 2015; Stice, Marti, & Rohde, 2013). Simply said, the media plays a pivotal role and is one of the main risk factors (Brown & Tiggemann, 2016; Jackson & Chen, 2014). Social media transmits unhealthy messages and Western sociocultural values that link thinness with beauty, popularity, happiness, and success and promote the thin ideal (Latzer et al., 2015; McBride, Costello, Ambwani, Wilhite & Austin, 2019), a social construct that describes the ideal female body as unrealistically thin (Meyers, 2018). Studies have shown that exposure to the thin ideal through the media has negative effects on the public, particularly adolescents and young women (Lewis, Peled, & Tal-Or, 2020; Volonté, 2019), and is associated with greater body dissatisfaction, low self-esteem, and higher risk of developing EDs and DEP (Latzer et al., 2015; Volonté, 2019).

Furthermore, various prevention programs targeting EDs and DEP should address all identified risk factors (Le et al., 2017; Stice et al., 2021; Wade, Wilksch, Paxton, Byrne, & Austin 2017). The modeling profession is also considered a risk factor (Swami & Szmigielska, 2013), because models are required to maintain an extremely thin figure, which can negatively affect their mental and physical health (Bogar & Tury, 2018; Meyers, 2018; Zancu & Enea, 2017).

These alarming risk factors and high-risk groups with psychological and medical complications highlight the need to develop effective preventive interventions (Dakanalis, Clerici, & Stice, 2019; Jackson & Chen, 2014; Latzer et al., 2019; Le et al., 2017; Meyers, 2018; Stice, 2002; Zilberman, 2013). Prevention programs for youth implemented in schools and communities often aim to provide critical media skills and help young people realize that the images portrayed in the media are not realistic, healthy, or feasible for most of the population (Latzer, Adatto, & Neumark-Sztainer, submitted; Stice et al., 2007; Stice & Shaw, 2002). Although these types of preventive interventions are important, the risks and consequences of EDs and DEP for the public require additional prevention strategies that focus on the public’s health and create opportunities for policy changes (Austin, 2016; McBride et al., 2019), particularly social policy enactment that targets media influences (Latzer et al., submitted).

Israel has been the first country to tackle the problem of unrealistic and unhealthy images in the media through legislation by initiating and passing a new, innovative law (Gutreich, 2017; Hildesheimer & Gur-Arie, 2015). In 2012, Israel initiated the Law for Restricting Weight in the Modeling Industry, 5772-2012 (the “models’ law”), becoming the first country to enact such a law. The models’ law focuses on the role and responsibility of the media and the modeling industry in the development of EDs and DEP (Zilberman, 2013) and sets limits on both the employment of underweight models and the use of photo editing. It prohibits the publication of images and advertisements featuring underweight models, whose BMI is below 18.5 (models are required to present medical documentation certifying that they were not underweight), and requires advertisements to include disclaimers noting when images have been graphically manipulated (Gutreich, 2017; Meyers, 2018; Zilberman, 2013).

The models’ law of 2012 was enacted after two previous legislative attempts; the Restricting Weight in the Modeling Industry Bill of 2010 and the Restricting Weight in the Modeling Industry Bill of 2011 (Hildesheimer
& Gur-Arie, 2015), and it has received support but also criticism from various parties (Gladstone, 2016; Gutreich, 2017; Hildesheimer & Gur-Arie, 2015; Lewis et al., 2020; Zilberman, 2013). Along with the criticism, questions arose as to the effectiveness of the law (Steinberg & Jotkowitz, 2016), and some argued that alternative approaches might be more effective in the prevention of EDs in the public in general and among models in particular (Gutreich, 2017).

The models’ law of 2012 was the first formal recognition that EDs are not a private problem but rather a dangerous social phenomenon (Hildesheimer & Gur-Arie, 2015), and it has raised public awareness about EDs, DEP, and the negative effects of the media and the modeling industry. However, the law is limited in its enactment and enforcement abilities, and it is currently not being enforced. Therefore, further steps are necessary to optimize the existing legislation, regulate the enforcement, and impose sanctions on violators of the law (Gutreich, 2017; Zilberman, 2013). To further optimize the existing legislation, it is important to examine the impact of the models’ law on body dissatisfaction, DEP, and EDs among young women in Israel. Therefore, this study focused on the impact of the models’ law on the Israeli public, specifically on young women, and it had several aims:

1) To examine the participants’ familiarity with the models’ law, their perceptions of the law and its impact, and their views on the role of images and messages transmitted to the public through the media.
2) To examine the rates of DEP and the impact of the models’ law on women aged 18-24, as compared with women aged 25-35.
3) To examine the relationships between the level of exposure to the law and its impact and the levels of DEP and disturbed body image among women aged 18-24, as compared with those aged 25-35.
4) To examine which variables are associated with the level of familiarity with the models’ law, level of support for the law, its impact, and its perceived potential.

The importance of this study lies in the attempt to broaden the understanding of the possible methods for preventing EDs in Israel by examining the relationship between the models’ law of 2012 and disordered eating and body image. The results of this study may lead to significant conclusions about the law and its impact and help improve the existing methods of prevention enshrined in the current law.

2. Method

The study included two parts; in the first part, participants were asked to sign an informed consent form and answer four questionnaires using Qualtrics. The second part involved answering an additional questionnaire through a phone call (see more details in the Procedure section).

2.1 Participants

A sample of 210 Hebrew-speaking young Israeli women aged 18-35 (M = 25.19, SD = 3.28) participated in both parts of the study. The participants were divided into two age groups: 122 young women aged 25-35 (60.1%, M = 27.11, SD = 2.53), who were exposed to the law as adolescents or young adults, and 81 young women aged 18-24 (39.9%, M = 22.28, SD = 1.80), who mostly heard of it in retrospect. Mean BMI for the total sample was 23.01 (SD = 4.12). Among participants aged 18-24, mean BMI was 22.57 (SD = 3.74), and among participants aged 25-35, mean BMI was 23.3 (SD = 4.34). Seven women participated in the first part of the study only and declined to participate in the second part (for information regarding both parts of the study, please see the Procedure section).

Most participants were born in Israel (98.77% among ages 18-24 and 87.7% among ages 25-35) and were native Hebrew speakers (77.78% and 86.89%, respectively). In addition, most were healthy (“good” health status: 74.07% among ages 18-24 and 74.59% among ages 25-35), single (96.3% and 74.59%, respectively), nonreligious (77.78% and 81.5%, respectively), and lived in cities (80.25% and 86.07%, respectively). Among the younger participants, most had a high school education (86.42%) and were currently university students (54.32%), whereas half of the older participants had a bachelor’s degree (50%), 47.54% of older participants were university students, and 43.44% were employed. Moreover, most participants aged 25-35 reported being in the middle class (61.47%), compared to 46.91% of the participants aged 18-24. Additional 48.15% of the younger participants reported being in the higher class, compared to the middle class. Frequencies and percentages of demographic variables are presented in Table 1.
Table 1. Frequencies and percentages of demographic variables \((N = 203)\)

| Variable                                      | 18-24 \((n = 81)\) | 25-35 \((n = 122)\) |
|-----------------------------------------------|----------------------|----------------------|
|                                               | \(n\) or \(M (SD)\) | \(n\) or \(M (SD)\) |
| **Health status**                             |                      |                      |
| Very good                                     | 17 (20.99)           | 20 (16.39)           |
| Good                                          | 60 (74.07)           | 91 (74.59)           |
| Bad                                           | 4 (4.94)             | 11 (9.02)            |
| Better than last year                         | 24 (29.63)           | 27 (22.13)           |
| Same as last year                             | 45 (55.56)           | 80 (65.57)           |
| Worse than last year                          | 12 (14.81)           | 15 (12.3)            |
| **Height, m**                                 | 1.64 (0.07)          | 1.63 (0.06)          |
| **Weight, kg**                                | 60.91 (10.58)        | 62.19 (12.55)        |
| **BMI**                                       | 22.57 (3.74)         | 23.30 (4.34)         |
| **Language spoken at home**                   |                      |                      |
| Hebrew                                        | 63 (77.78)           | 106 (86.89)          |
| Hebrew and other                              | 11 (13.58)           | 13 (10.66)           |
| Other (Russian or Arabic)                     | 7 (8.64)             | 3 (2.46)             |
| **Marital status**                            |                      |                      |
| Married or common-law spouse                  | 3 (3.70)             | 30 (24.59)           |
| Single                                        | 78 (96.30)           | 91 (74.59)           |
| Other                                         | 0 (0.0)              | 1 (0.82)             |
| **Country of birth**                          |                      |                      |
| Israel                                        | 80 (98.77)           | 107 (87.70)          |
| Other                                         | 1 (1.23)             | 15 (12.30)           |
| **Level of education**                        |                      |                      |
| High school                                   | 70 (86.42)           | 41 (33.61)           |
| Tertiary education                            | 2 (2.47)             | 9 (7.38)             |
| Bachelor’s degree                             | 8 (9.88)             | 61 (50.00)           |
| Master’s degree or higher                     | 1 (1.23)             | 11 (9.02)            |
| **Primary occupation**                        |                      |                      |
| University student                            | 44 (54.32)           | 58 (47.54)           |
| Unemployed                                    | 9 (11.11)            | 10 (8.20)            |
| Employed                                      | 17 (20.99)           | 53 (43.44)           |
| Other                                         | 11 (13.58)           | 1 (0.82)             |
| **Socioeconomic status**                      |                      |                      |
| Higher than middle class                      | 39 (48.15)           | 35 (28.69)           |
| Middle class                                  | 38 (46.91)           | 75 (61.47)           |
| Lower than middle class                       | 3 (3.70)             | 10 (8.20)            |
| No answer or don’t know                       | 1 (1.23)             | 2 (1.64)             |
| **Place of residence**                        |                      |                      |
| Urban                                         | 65 (80.25)           | 105 (86.07)          |
| Rural                                         | 12 (14.81)           | 12 (9.84)            |
| Kibbutz                                       | 4 (4.94)             | 5 (4.10)             |
| **Religiosity**                               |                      |                      |
| Nonreligious                                  | 63 (77.78)           | 99 (81.15)           |
| Traditional                                   | 12 (14.81)           | 19 (15.57)           |
| Religious                                     | 6 (7.41)             | 4 (3.28)             |
2.2 Procedure

The current study was a quantitative study. The study received the approval of the Ethics Committee of the Faculty of Social Welfare and Health Sciences at the University of Haifa. Convenience sampling was used, using the participants’ phone numbers and Facebook accounts. At the beginning, participants received a general explanation regarding the study’s goal and the process of participating through a phone call and were told that participation was voluntary and anonymous. A total of 210 women aged 18-35 agreed to participate in the study, and 203 of them completed both parts of the study. Seven participants declined to participate in the second part.

Participation in the study consisted of two parts: In the first part, participants received a link to four questionnaires using Qualtrics, via WhatsApp, Facebook, or email. Before answering the questionnaires, participants were asked to sign an informed consent form that presented the study and its goal. Participants were asked to declare that they had read and understood the explanation provided in the form, that they were at least 18 years old, and that they were willing to answer the questions. Also, participants received phone numbers and email addresses of organizations and resources in case of distress. After completing these questionnaires, participants were asked to answer another questionnaire through a phone call (Israel’s Models’ Law Attitudes Questionnaire).

2.3 Measures

2.3.1 Eating Attitudes Test-26 (EAT-26)

The EAT-26 is a self-report questionnaire, developed by Garner & Garfinkel (1979), to examine a wide range of behaviors and attitudes related to EDs. The questionnaire consists of 26 items, each describing a stance or behavior related to EDs, and the participants were asked to grade each item on a 6-level Likert scale ranging from never to always. The EAT-26 contains a general (sum) score and three subscales. For this study, the total score was used. A higher general score indicates more severe ED symptoms, and scores of 20 or more indicate pathological eating behavior. The EAT-26 is widely used in research on EDs, and its reliability, predictive validity, and internal consistency were found to be very high, making it a useful tool for detecting pathological behaviors related to eating and dieting (Garner, Olmsted, Bohr, & Garfinkel, 1982). The EAT-26 has been translated and validated into Hebrew (Ianuca, 1990). The Hebrew translation of the EAT-26 was found to be valid and reliable (Koslowsky et al., 1992). Internal reliability (Cronbach’s α) of the total EAT-26 scale was .81 for men and .88 for women (Garner & Garfinkel, 1979) and .87 in the present study.

2.3.2 Eating Disorder Inventory 2 (EDI-2)

The EDI-2 is a self-report questionnaire, first developed by Garner, Olmsted and Polivy (1983) and updated by Garner (1991), that consists of 91 items rated on a 6-level Likert scale and divided into 11 subscales assessing behavior, symptoms, and personality traits of people who suffer from EDs. Each item is attributed to one subscale only, and each scale’s grade is a sum of all items in the scale. The EDI-2 has been found to be a valid and reliable instrument, and Cronbach’s α for the subscales has been reported as ranging from .65 to .91 (Garner et al., 1983). The Hebrew translation of the EDI-2 was found to be reliable and valid (Niv, Kaplan, Mitrani, & Shiang, 1998). In the current study, Cronbach’s α for the total EDI-2 was .95 and for the subscales as follows: DT- drive for thinness (α = .90), BUL- bulimia (α = .83), BD- body dissatisfaction (α = .90), INE- ineffectiveness (α = .88), PER- perfectionism (α = .72), IN_D- interpersonal distrust (α = .73), IN_A- interceptive awareness (α = .72), MF- maturity fears (α = .78), ASC- asceticism (α = .44), IR- impulse regulation (α = .75), and SI- social insecurity (α = .77).

2.3.3 Body Shape Questionnaire (BSQ)

The BSQ is a self-report questionnaire (Cooper, Taylor, Cooper, & Fairbum, 1987) assessing body shape concerns, self-deprecation due to physical appearance, and the cognitive experience of feeling fat. The BSQ consists of 34 items rated on a 6-level Likert scale from 1 (never) to 6 (always). The score ranges from 34 to 204, with a higher score indicating greater body dissatisfaction and a score above 98 indicating negative body image. The BSQ’s internal consistency and concurrent and discriminant validity were found to be good, and Cronbach’s α was .97 (Cooper et al., 1987). Cronbach’s alpha for the current sample: α = .97.

2.3.4 Stanford-Washington University Eating Disorders Screen (SWED) 3.0

The SWED (Graham et al., 2019) is a screening tool developed to assess ED behaviors, pathology, and impairment and can be used to identify possible DSM-5 ED diagnoses (Fitzsimmons-Craft et al., 2019). According to their responses, participants are categorized into one of seven possible DSM-5 diagnoses or two risk categories: (a) anorexia nervosa; (b) bulimia nervosa; (c) binge eating disorder; (d) subclinical bulimia nervosa; (e) subclinical binge eating disorder; (f) unspecified feeding or eating disorder; (g) avoidant or restrictive food intake disorder; (h) at risk of an ED; or (i) not at risk of an ED. The SWED was used in past ED research (Fitzsimmons-Craft et al.,
2019), and it has been validated as an ED diagnostic screen for college-age women, with sensitivities ranging from .68 (subclinical bulimia nervosa) to .90 (anorexia nervosa) and specificities ranging from .79 (subclinical binge eating disorder) to .99 (anorexia nervosa) compared to a diagnostic interview (Graham et al., 2019).

In the current study, the categories for meeting criteria were divided as following: clinical or subclinical ED, at risk of an ED, and avoidant or restrictive food intake disorder. The SWED was used to categorize the sample of the current study, and it indicated that the sample included a nonclinical population; 13 participants had a clinical or subclinical ED (6.3%), including seven participants (8.6%) at ages 18-24 and six participants (4.9%) at ages 25-35.

2.3.5 Israel’s Models’ Law Attitudes Questionnaire

The Models’ Law Attitudes questionnaire is based on a questionnaire used in a similar study in Quebec (Gauvin & Steiger, 2012), which examined the public’s reactions and opinions regarding the Quebec Charter for a Healthy and Diverse Body Image. The questionnaire was translated into Hebrew and several questions were added to optimize its suitability for the Israeli public. The questionnaire consists of 42 questions divided into three subsections. The first subsection includes open and closed questions about the reach, influence, and potential impact of the law. Several questions were added to the Hebrew translation of the questionnaire regarding the law’s enforcement. The answers to the open questions were categorized and processed quantitatively. The second subsection consists of six questions, in which participants are asked to rate their level of agreement with “if–then” statements regarding the media’s influence on reducing sociocultural pressures toward thinness. The answers range on a 5-point scale (1 = completely agree to 4 = completely disagree; 5 = don’t know). The third subsection consists of 20 questions that refer to sociodemographic and anthropometric characteristics. The authors of the questionnaire reported on good internal consistency (Cronbach’s α = .79 for questions regarding the law’s potential impact and .71 for questions regarding the media’s influence on reducing sociocultural pressures toward thinness (Gauvin & Steiger, 2012).

2.4 Data Analysis

Data were analyzed using SAS 9.4 for Windows, and descriptive and inferential statistics were compiled. Spearman correlation tests were used to examine the connections between the various variables. T-tests were conducted to compare participants by their age and level of support for the law. Stepwise logistic regressions were conducted to examine which variables predicted the law’s impact, support for the law, and the media’s influence.

3. Results

3.1 First Aim: Participants’ Familiarity with Israel’s Models’ Law

In both groups, most participants were familiar with the models’ law (71.6% of the participants aged 18-24 and 79.51% of those aged 25-35) at a medium level of familiarity (48.15% and 50.82%, respectively). In addition, 33.8% of the participants aged 18-24 first heard about the law 1-5 years ago, whereas 32.23% of the participants aged 25-35 first heard about the law more than 5 years ago. In both age groups, more than half of the participants heard about the law through the media or social networks (50.6% among ages 18-24 and 58.2% among ages 25-35).

Regarding the law’s impact on participants, in both groups, most answered that their beliefs about the influence of images and public messages on body image (54.32% among ages 18-24 and 65.57% among ages 25-35) and the thin ideal and its consequences for health (61.73% among ages 18-24, and 76.23% among ages 25-35) hadn’t changed at all since they heard of the law and that the law had no impact on them or their behavior (62.96% among ages 18-24 and 72.13% among ages 25-35).

Moreover, regarding the potential impact of the law, 38.27% of the younger group said the law has moderate potential to influence people to resist extreme thinness and promote healthy body image. In contrast, 31.15% of the older group said the law has high potential. In addition, 44.44% of the younger group and 35.25% of the older group stated that the law has high potential to sensitize and increase people’s awareness of the negative health consequences of extreme thinness. However, 34.57% and 46.72% of participants by respective age group also said the law has no potential to sensitize and increase people’s awareness of the negative health consequences of disordered eating behaviors.

In both groups, more than 90% of the participants were highly supportive of the law (90.12% among ages 18-24 and 92.62% among ages 25-35). Regarding the law’s enforcement, 33.33% of the younger participants said there is a low level of enforcement and 28.4% said the law is not enforced at all. In comparison, 34.43% of the older participants said the law is not enforced. In addition, 93.83% of the younger participants and 89.34% of the older participants, expressed the need for increased enforcement. Moreover, 69.14% (ages 18-24) and 68.03% (ages 25-35) of the participants believed that the law should be fully enforced and expressed the need to enact another
law (51.85% and 54.1%, respectively). Frequencies and percentages of law-related variables are presented in Table 2.

| Variable | 181-24 (n = 81) | 25-35 (n = 122) |
|----------|-----------------|-----------------|
|          | n (%)           | n (%)           |

### Familiarity

**Familiarity with the law**
- Yes: 58 (71.6) 97 (79.51)
- No: 23 (28.4) 25 (20.49)

**Level of familiarity**
- None: 12 (14.81) 18 (14.75)
- Low: 16 (19.75) 17 (13.93)
- Medium: 39 (48.15) 62 (50.82)
- High: 14 (17.28) 25 (20.49)

**When did you first hear about the law?**
- Never or don’t remember: 51 (42.15) 51 (42.15)
- During the past year: 4 (4.94) 7 (5.79)
- 1–5 years ago: 29 (35.80) 24 (19.83)
- More than 5 years ago: 19 (23.46) 39 (32.23)

**How did you hear about the law?**
- Never or don’t remember: 24 (19.8) 24 (19.7)
- Media or social networks: 71 (58.2) 71 (58.2)
- Lectures, at school or academic studies, or in conversations with friends: 24 (29.6) 27 (22.1)

### Perceived impact

**Change in beliefs about the influence of images and public messages on body image**
- Haven’t changed at all: 44 (54.32) 80 (65.57)
- Moderately changed: 30 (37.04) 36 (29.51)
- Changed a lot: 7 (8.64) 6 (4.92)

**Change in beliefs about the thin ideal and its consequences for health**
- Haven’t changed at all: 50 (61.73) 93 (76.23)
- Moderately changed: 21 (25.92) 26 (21.31)
- Changed a lot: 10 (12.35) 3 (2.46)

**Level of impact on participant or her behavior**
- None: 51 (62.96) 88 (72.13)
- Low: 17 (20.99) 24 (19.67)
- Moderate: 6 (7.41) 3 (2.46)
- High: 7 (8.64) 7 (5.74)

### Potential impact

**Potential to influence people to resist extreme thinness and promote healthy body image**
- High: 27 (33.33) 38 (31.15)
- Moderate: 31 (38.27) 32 (26.23)
- Low: 11 (13.58) 27 (22.13)
- None: 11 (13.58) 25 (20.49)
Don’t know 1 (1.23) 0 (0.00)

Potential to sensitize and increase people’s awareness of the negative health consequences of extreme thinness

High 36 (44.44) 43 (35.25)
Moderate 20 (24.69) 20 (16.39)
Low 10 (12.35) 30 (24.59)
None 15 (18.52) 29 (23.77)
Don’t know 0 (0.00) 0 (0.00)

Potential to sensitize and increase people’s awareness of the negative health consequences of disordered eating and dieting behaviors

High 24 (29.63) 16 (13.11)
Moderate 15 (18.52) 23 (18.85)
Low 11 (13.58) 25 (20.49)
None 28 (34.57) 57 (46.72)
Don’t know 3 (3.70) 1 (0.82)

Support

Level of support

High 73 (90.12) 113 (92.62)
Moderate or low 8 (9.88) 9 (7.38)

Enforcement

Level of enforcement

High 1 (1.23) 6 (4.92)
Moderate 21 (25.93) 31 (25.41)
Low 27 (33.33) 30 (24.59)
None 23 (28.40) 42 (34.43)
Don’t know 9 (11.11) 13 (10.66)

Need of increased enforcement

Yes 76 (93.83) 109 (89.34)
No 1 (1.23) 6 (4.92)
No answer or don’t know 4 (4.94) 7 (5.74)

Required level of enforcement

Not necessary to enforce 5 (6.17) 14 (11.48)
Partial enforcement 7 (8.64) 7 (5.74)
Full enforcement 56 (69.14) 83 (68.03)
Stricter enforcement and expansion of the law 13 (16.05) 18 (14.75)

Need to enact another law

Yes 42 (51.85) 66 (54.10)
No 35 (43.21) 49 (40.16)
No answer or don’t know 4 (4.94) 7 (5.74)

3.2 Second Aim: Rates of DEP and Impact of Israel’s Models’ Law

As seen in Table 3, significant differences were observed between the two age groups (18-24 and 25-35) in DEP according to the EDI-2 questionnaire \((t_{145.59} = 2.83, p < .01)\), with younger participants having higher levels of DEP \((M = 43.86, SD = 31.12)\) compared to participants aged 25-35 \((M = 32.14, SD = 25.00)\). Additionally, significant differences between the two age groups were found in the levels of body dissatisfaction and disturbed body image, according to the BSQ questionnaire \((t_{199} = 2.27, p < .05)\), with younger participants reporting higher levels of disturbed body image \((M = 93.87, SD = 36.58)\) compared to older participants \((M = 82.84, SD = 31.86); \text{ see Table 3}\).
Table 3. Comparison between age groups in levels of disordered eating pathology and disturbed body image

|                         | 18-24 (n = 81) | 25-35 (n = 122) | T     | df   |
|-------------------------|----------------|-----------------|-------|------|
| **Total EDI-2**         | 43.86 (31.12)  | 32.14 (25.00)   | 2.83**| 145.59|
| MF                      | 3.54 (3.23)    | 4.16 (4.04)     | -1.14 | 201  |
| BUL                     | 2.43 (3.85)    | 0.95 (2.14)     | 3.15***| 113.08|
| BD                      | 7.67 (7.01)    | 6.34 (6.66)     | 1.36  | 201  |
| INE                     | 2.98 (4.50)    | 1.92 (3.57)     | 1.77  | 144.14|
| PER                     | 7.42 (3.65)    | 5.79 (3.93)     | 2.98**| 201  |
| IN-D                    | 1.85 (2.54)    | 1.33 (2.41)     | 1.48  | 201  |
| IN-A                    | 3.96 (4.62)    | 2.16 (2.57)     | 3.19**| 113.09|
| DT                      | 6.33 (6.20)    | 4.92 (5.39)     | 1.71  | 201  |
| ASC                     | 2.90 (2.78)    | 2.01 (1.78)     | 2.56* | 123.51|
| IR                      | 2.58 (3.80)    | 1.03 (2.18)     | 3.32**| 115  |
| SI                      | 2.21 (2.88)    | 1.53 (2.47)     | 1.79  | 201  |
| BSQ                     | 93.87 (36.58)  | 82.84 (31.86)   | 2.27* | 199  |
| EAT-26                  | 14.84 (11.84)  | 12.42 (8.92)    | 1.57  | 138.61|

* *p < .05. ** *p < .01. *** *p < .001.

Moreover, a significant difference between the two age groups was observed in the degree of change in beliefs about the thin ideal and its consequences for health following the models’ law (t(132.173) = 2.53, p < .05), with participants aged 18-24 reporting a higher degree of change in their beliefs (M = 1.69, SD = 1.05) compared to participants aged 25-35 (M = 1.35, SD = 0.74).

Additionally, a significant difference between the two age groups was observed in the potential of the law to sensitize and increase the awareness of negative health consequences of dieting behaviors (t(149.799) = -2.19, p < .05), with younger participants being more optimistic about the law’s potential (M = 2.64, SD = 1.33) compared to older participants (M = 3.03, SD = 1.11). The degree of potential in this variable is in descending order (from high to low). No significant differences were found regarding the rest of the variables (see Table 4).

Table 4. Comparison between age groups on the impact of Israel’s models’ law (N = 203)

|                         | 18-24 (n = 81) | 25-35 (n = 122) | t     | df   |
|-------------------------|----------------|-----------------|-------|------|
| Level of familiarity with the law | 2.35 (1.46) | 2.52 (1.45) | -0.82 | 201  |
| Change in beliefs about the influence of images and public messages on body image | 1.68 (0.92) | 1.48 (0.78) | 1.69  | 201  |
| Change in beliefs about the thin ideal and its consequences for health | 1.69 (1.05) | 1.35 (0.74) | 2.53* | 132.173|
| Level of impact on the participant or her behavior | 1.62 (0.96) | 1.42 (0.80) | 1.55  | 150.377|
| Potential to influence people to resist extreme thinness and promote healthy body image | 2.11 (1.06) | 2.32 (1.12) | -1.33 | 201  |
| Potential to sensitize and increase people’s awareness to negative health consequences of extreme thinness | 2.05 (1.15) | 2.37 (1.19) | -1.90 | 201  |
| Potential to sensitize and increase people’s awareness to negative health consequences of disordered eating and dieting behaviors | 2.64 (1.33) | 3.03 (1.11) | -2.19* | 149.799|
| Level of support | 1.17 (0.63) | 1.12 (0.55) | 0.60  | 201  |
| Level of enforcement | 3.22 (1.00) | 3.20 (1.09) | 0.11  | 201  |

* *p < .05. ** *p < .01. *** *p < .001.
3.3 Third Aim: Relationships between Level of Exposure to Israel’s Models’ Law and its Impact and the Levels of DEP and Disturbed Body Image

As seen in Table 5, a significant difference was observed between the levels of support for the law based on the participants’ level of DEP according to their score on the EDI-2 questionnaire ($t_{(201)} = -2.35, p < .05$). Participants who were highly supportive of the models’ law had lower levels of DEP ($M = 35.43, SD = 28.11$) compared to participants who expressed lower levels of support for the law ($M = 52.00, SD = 24.10$).

In addition, significant differences were found in subscales of the EDI-2 questionnaire: maturity fears ($t_{(201)} = -2.04, p < .05$), body dissatisfaction ($t_{(201)} = -2.11, p < .05$), ineffectiveness ($t_{(201)} = -2.26, p < .001$), and social insecurity ($t_{(17.402)} = -2.84, p < .05$). Participants who were highly supportive of the law had lower levels of DEP, according to these subscales, compared to participants who expressed lower levels of support for the law (for means and standard deviations, see Table 5).

Table 5. Comparison between levels of support for the law based on levels of DEP and disturbed body image ($N = 203$)

|                     | High support ($n = 186$) | Moderate or low support ($n = 17$) | $t$   | df  |
|---------------------|-------------------------|---------------------------------|-------|-----|
| EDI-2               | $35.43 (28.11)$         | $52.00 (24.10)$                 | -2.35*| 201 |
| MF                  | $3.75 (3.64)$           | $5.69 (4.82)$                   | -2.04*| 201 |
| BUL                 | $1.54 (3.05)$           | $1.59 (2.83)$                   | -0.07 | 201 |
| BD                  | $6.57 (6.88)$           | $10.18 (5.14)$                  | -2.11*| 201 |
| INE                 | $2.15 (3.94)$           | $4.41 (4.08)$                   | -2.26*| 201 |
| PER                 | $6.34 (3.83)$           | $7.47 (4.52)$                   | -1.14 | 201 |
| IN-D                | $1.5 (2.51)$            | $1.94 (2.01)$                   | -0.70 | 201 |
| IN-A                | $2.77 (3.67)$           | $4.06 (2.99)$                   | -1.40 | 201 |
| DT                  | $5.35 (5.79)$           | $6.97 (5.30)$                   | -1.11 | 201 |
| ASC                 | $2.31 (2.24)$           | $3.00 (2.55)$                   | -1.21 | 201 |
| IR                  | $1.56 (2.96)$           | $2.65 (3.64)$                   | -1.42 | 201 |
| SI                  | $1.59 (2.46)$           | $4.12 (3.59)$                   | -2.84*| 17.402 |
| BSQ                 | $86.03 (34.18)$         | $101.8 (31.71)$                 | -1.78 | 199 |
| EAT-26              | $13.16 (9.85)$          | $15.82 (13.86)$                 | -0.77 | 17.508 |

*p < .05. **p < .01. ***p < .001.

3.4 Fourth Aim: Variables Associated with the Level of Familiarity with Israel's Models’ Law, Level of Support for the Law, its Impact, and its Perceived Potential

Stepwise logistic regression was conducted to predict the participants’ support for the models’ law. Results indicate that the participants’ level of social insecurity (one of the characteristics of DEP in the EDI-2 questionnaire) was associated with support for the law ($\chi^2(1) = 11.89, p < .001$); as the participants’ level of social insecurity increased, the probability they would be highly supportive of the law decreased ($OR = 0.77, p < .001$). The area index of the ROC curve was .764; therefore, the diagnostic capacity of the model was moderate.

Additional stepwise logistic regression was conducted to predict the probability that the participants’ beliefs about the thin ideal and its consequences for health haven’t changed at all. The results show that the levels of maturity fears and bulimia (characteristics of DEP in the EDI-2 questionnaire) were associated with the degree of change in the participants’ beliefs about the thin ideal and its consequences for health ($\chi^2(2) = 12.72, p < .01$). As the level of maturity fears increased, the probability that the participants’ beliefs about the thin ideal and its consequences for health hadn’t changed also increased ($OR = 1.15, p < .05$). Moreover, as the participants’ level of bulimia increased, the probability that their perceptions hadn’t changed decreased ($OR = 0.85, p < .01$). The area index of the ROC curve was .654; therefore, the diagnostic capacity of the model was low to moderate.

In addition, stepwise logistic regression also was conducted to predict the participants’ familiarity with the models’ law. Results indicate that the participants’ age, level of DEP (according to scores on the EAT-26 questionnaire), and risk of developing EDs were associated with familiarity with the law ($\chi^2(3) = 15.33, p < .01$). As the participants’ age increased, the probability they hadn’t heard of the law decreased ($OR = 0.87, p < .05$). In
addition, as the participants’ score on the EAT-26 questionnaire increased, the probability they hadn’t heard of the law decreased ($OR = 0.93, p < .05$). Moreover, if participants were at risk of developing EDs, the probability they hadn’t heard of the law increased ($OR = 9.91, p < .01$). The area index of the ROC curve was .674; therefore, the diagnostic capacity of the model was low to moderate.

Results also show that age and level of asceticism (a characteristic of DEP in the EDI-2 questionnaire) were associated with the participants’ level of familiarity with the law ($\chi^2(2) = 11.08, p < .01$). As the participants’ age increased, the probability they would have lower levels of familiarity with the law decreased ($OR = 0.87, p < .01$), and as their level of asceticism increased, the probability they would have lower levels of familiarity with the law also decreased ($OR = 0.86, p < .05$). The area index of the ROC curve was .650; therefore, the diagnostic capacity of the model was low to moderate. However, it is important to note that Cronbach’s alpha for the subscale of asceticism for this sample was low (α = .44).

Furthermore, additional stepwise logistic regression was conducted to predict the probability that the models’ law had no impact on the participants or their behavior. Results showed that age was associated with the law’s impact on participants and their behavior ($\chi^2(1) = 5.97, p < .05$); as the participants’ age increased, the probability that the law would have no impact on them or their behavior increased as well ($OR = 1.13, p < .05$). Therefore, the law had less impact on older women. The area index of the ROC curve was .588; therefore, the diagnostic capacity of the model was low.

Additional stepwise logistic regression was conducted to predict the potential of the models’ law to influence people to resist extreme thinness and promote healthy body image. Results indicated that both the participants’ age and level of drive for thinness (a characteristic of DEP in the EDI-2 questionnaire) were associated with the law’s potential to influence people to resist extreme thinness and promote healthy body image, in the participants’ opinion ($\chi^2(2) = 15.54, p < .001$). As the participants’ age increased, the probability they would think the law has moderate to high potential decreased ($OR = 0.89, p < .05$). In addition, as the participants’ level of drive for thinness increased, the probability they would think the law has moderate to high potential impact also decreased ($OR = 0.91, p < .001$). The area index of the ROC curve was .668; therefore, the diagnostic capacity of the model was low to moderate. All stepwise logistic regression results are presented in Table 6.

### Table 6. Stepwise logistic regression ($N = 203$)

| Predictors                              | $\chi^2$   | df | OR  | ROC  |
|-----------------------------------------|------------|----|-----|------|
| **Support**                             |            |    |     |      |
| Social insecurity                       | 11.89***   | 1  | 0.77*** | 0.764 |
| Degree of change beliefs about the thin ideal and its consequences for health |            |    |     |      |
| Maturity fears                          | 12.72**    | 2  | 1.15*   | 0.654 |
| Bulimia                                 |            |    | 0.85** |      |
| **Familiarity**                         |            |    |     |      |
| Age                                     | 15.33**    | 3  | 0.87*   | 0.674 |
| DEP                                     |            |    | 0.93*   |      |
| ED risk                                 |            |    | 9.91**  |      |
| **Level of familiarity**                |            |    |     |      |
| Age                                     | 11.08**    | 2  | 0.87**  | 0.650 |
| Ascetism                                |            |    | 0.86*   |      |
| **Impact on participant and her behavior** |            |    |     |      |
| Age                                     | 5.97*      | 1  | 1.13*   | 0.588 |
| **Perceived potential to influence people to resist extreme thinness and promote healthy body image** | | | | |
| Age                                     | 15.54***   | 2  | 0.89*   | 0.668 |
| Drive for thinness                      |            |    | 0.91*** |      |

*p < .05. **p < .01. ***p < .001.
4. Discussion

During the last 5 decades, the prevalence of EDs and related symptoms and behaviors has increased dramatically, mainly among female adolescents in Westernized societies (Hoek, 2016; Latzer et al., 2015; Latzer et al., 2019; Smink et al., 2012; Udo & Grilo, 2018). A similar trend has been observed in Israel (Harel et al., 2002).

These alarming rates and severe complications highlight the need to develop preventive interventions. Prevention programs for youth implemented mainly in schools often aim to provide media literacy skills to help them realize that the images portrayed in the media are not realistic, healthy, or feasible for most of the population (Latzer et al., submitted; Stice et al., 2007; Stice & Shaw, 2002; Wade et al., 2017). Although these types of preventive interventions are important and somewhat effective, the risks and consequences of EDs and DEP for adolescents require additional prevention strategies that focus on the public’s health and create opportunities for policy changes (Austin, 2016; McBride et al., 2019).

Israel has been the first country to tackle the problem of unrealistic and unhealthy images in the media through legislation by initiating and passing a new, innovative law (Gutreich, 2017; Hildesheimer & Gur-Arie, 2015). In 2012, Israel initiated the Law for Restricting Weight in the Modeling Industry, 5772-2012 (the models’ law). The models’ law focuses on the role of the media and the modeling industry in the development of EDs and DEP (Zilberman, 2013) and sets limits on both the employment of underweight models and the use of photo manipulation (Gutreich, 2017; Meyers, 2018; Zilberman, 2013).

However, the impact of Israel’s models’ law on body dissatisfaction, DEP, and EDs among young women in Israel had not been examined. Therefore, this study aimed to examine the impact of the models’ law on the Israeli public, specifically on young adult women from two age groups: 18-24 and 25-35.

The current research results show that most participants from both age groups had heard of the models’ law and were highly supportive. These findings are interesting, because the younger participants (aged 18-24) were very young during the legislative process itself and thus, most of them were not exposed to the law but only heard of it in retrospect. It seems that the models’ law has an impact over time—it is still present in the public discourse, regardless of age, and may have social influence, which continues to arouse great interest.

Most participants heard of the models’ law through the media or social networks, but many others heard of it during lectures, at school, during academic studies, or during conversations with friends. For example, one participant said that she heard of the law “as a scout, during the ninth grade, when the photographer Adi Barkan (an Israeli fashion photographer and model agent, who participated in the initiation of the models’ law) was invited to lecture all the scouts, and he told us about the initiative for the law and about his work.” Other participants said that they have heard of the law “at high school, during a lecturer given by a model photographer” or “when I was in middle school or school, the teacher talked to us about eating, eating disorders, and body image and mentioned the law.” Another example is: “Adi Barkan came to the military base where I served to give a lecture.” The fact that different organizations noticed great value in conducting discourse or a lecture on the subject may also indicate the law’s impact and the importance of emphasizing the law to the younger generation.

Results also indicate that even though many participants had heard of and highly supported the models’ law, most of them reported that the law had little or no impact on them, neither cognitively nor emotionally or behaviorally. However, a partial impact of the law and a change in beliefs regarding the influence of images and public messages on body image were more common among the younger participants as compared to the older participants (37.04% vs. 29.51%, respectively). In addition, 25.92% of the younger participants reported a moderate change in their beliefs about the thin ideal and its consequences for health, compared to 21.31% of the older participants.

A possible explanation for these results is that the models’ law had a slightly higher impact and had been more internalized in the younger group. In fact, several participants, especially from the older group, said that “the law cannot affect me directly, because it was enacted when it was already too late for me” or “there is no impact on me, but maybe there is on younger women. The body image is developed among young girls, and I was 24 when the law was enacted, so in my opinion it did not affect me. When you know about the law from a young age, it has a greater effect.” These results are in line with the prevention literature and emphasize that prevention programs should focus on younger populations (Latzer et al., submitted), because adolescence might be a risk factor for EDs and DEP (Latzer et al., 2019; Le et al., 2017).

In addition, most participants in both age groups (71.6% among ages 18-24 and 57.38% among ages 25-35) said that the models’ law has moderate to high potential to influence people to resist extreme thinness and promote healthy body image. Also, many participants (44.44% among ages 18-24 and 35.25% among ages 25-35) said the law has high potential to sensitize and increase people’s awareness of the negative health consequences of extreme
thinness, but it has no potential (34.57% and 46.72%, respectively) to sensitize and increase people’s awareness of the negative health consequences of disordered eating and dieting behaviors. This result may be related to the internalization of the thin ideal and Western values at an early age, which might create higher risk of the development of EDs and DEP (Latzer, 2016); therefore, participants might not think the law can have much influence on the Israeli public.

It is interesting to note that the younger participants said the law has greater potential impact, compared to the older participants. For example, 38.27% of the younger group said the law has moderate potential to influence people to resist extreme thinness and promote healthy body image, compared to 26.23% of the older participants. Additionally, 44.44% of the younger participants said the law has high potential to sensitize and increase people’s awareness of the negative health consequences of extreme thinness, compared to 35.25% of the older participants. Finally, 29.63% of the younger participants believe that the law has high potential to sensitize and increase people’s awareness of the negative health consequences of disordered eating behaviors, compared to 13.11% of the older participants.

Although the differences are not necessarily significant, it seems that the older participants were not only less affected by the law, but also felt it has less potential impact. This may indicate that younger women can be more affected by the law and as a result, believe it has more potential impact. Mantilla & Birgégård (2015) examined the self-perception of patients with eating disorders aged 16-18 and 19-25 and found that the strongest correlation between perceptions and feelings toward the self and symptoms of eating disorders occurred among the younger participants and that the correlation’s strength decreased as age increased. Among the younger participants, feelings of lack of self-acceptance and self-blame seemed to be the strongest. Moreover, research has indicated that at ages 16-18, the influence of physical appearance on self-esteem is the strongest among all stages of adolescence and that self-esteem tends to stabilize as age increases, with the most significant change in self-esteem occurring during the first decade of adulthood (Paxton, Wertheim, Pilawski, Durkin, & Holt, 2002).

It is possible that the participants in this study, aged 18-35, have already internalized the thin ideal and other sociocultural values associated with the development of EDs and therefore, the models’ law had little or no impact on them. However, there was slightly more impact on the younger participants, possibly due to their younger age, which affected their perceptions and may have influenced them more.

Furthermore, most participants had heard of and highly supported the law, even though the law is not enforced. Maybe if the law had been enforced, it would have had a greater impact on the public. Moreover, most participants in both age groups expressed the need for increased enforcement and said that the law should be fully enforced. The participants seemed to be hoping for change and requested that actions be taken at the governmental and national level. Many participants also expressed the need for additional legislation, with some proposing to include issues related to EDs and body image in the school curriculum.

According to t-test results, the younger participants had significantly higher levels of DEP, body dissatisfaction, and disturbed body image. Also, 25.93% of the younger participants were found to be at risk of developing DEP and EDs, according to the cutoff point on the EAT-26 questionnaire, compared to 18.03% of the older participants. These findings are in line with the existing literature, according to which the prevalence of EDs and DEP is higher among adolescents and young adults, placing younger participants at higher risk (Latzer et al., 2019; Le et al., 2017). Perhaps even at the young ages of 18-24, it might already be too late to prevent EDs and DEP.

Moreover, t-test results also indicate that participants who were highly supportive of the models’ law were found to have lower levels of DEP compared to participants who were less supportive of the law, specifically in characteristics such as maturity fears, bulimia, body dissatisfaction, ineffectiveness, and social insecurity. A possible explanation for these results is that the participants with higher levels of DEP already had more symptoms and therefore, they were less supportive of the law and had less faith in its ability to effect change, because it did not help them or prevent them from developing DEP symptoms. When symptoms are more severe, the chances of recovery decrease (Latzer, 2007), which may lead to lower support of various treatment and prevention options, such as this law. Moreover, research has indicated that effective prevention programs focus on risk factors known to predict onset of DEP (Stice, South, & Shaw, 2012), and in this case, the participants already had DEP symptoms, which might also have led to lower support of prevention options. It is also possible that universal prevention, such as the models’ law, is more effective among low-risk populations, whereas selective prevention programs are more effective among high-risk groups (Latzer et al., submitted; Stice et al., 2012).

Additional t-test results show that compared to the younger group, older participants reported a lower degree of change in beliefs about the thin ideal and its consequences for health and that the law has lower potential to sensitize and increase awareness of the negative health consequences of dieting behaviors. Furthermore, logistic
regression showed that the models’ law had less impact on older women and that older age and higher levels of drive for thinness were associated with lower levels of perceived potential of the law to influence people to resist extreme thinness and promote healthy body image. These findings support the results of the descriptive statistics and are in line with the existing literature (Mantilla & Birgegård, 2015; Paxton et al., 2002).

4.1 Strengths, Limitations, and Further Research

Research regarding the models’ law and its impact is scant, and this study revealed important information on the subject. The main strength of this study is that it is the first to examine the impact of the law on the Israeli public, specifically young women.

However, the study also has several limitations, which need to be addressed. First, the study sample represented a relatively homogeneous population; most participants were from a similar socioeconomic status of middle class or higher. Also, many participants reported being university or college students. Thus, it is difficult to generalize these results to the entire Israeli population, which is quite diverse. Participation in the study was also voluntary. However, EDs and DEP usually occur at a higher rate among middle- and high-class populations compared to the lower class, and it is possible that people who are more engaged in the subject of EDs and DEP, due to these socioeconomic statuses, may experience higher motivation to participate in such studies (Treasure et al., 2010).

In addition, although the measures of DEP used in the study are among the most widely used, the data were collected exclusively through self-report questionnaires and therefore, cannot be used for diagnostic purposes.

Further research on prevention of EDs and DEP should be conducted and expanded to the field of legislation, and future studies should continue to examine the impact of the models’ law, including among adolescent girls younger than 18. Also, it is recommended to conduct further research in about a decade to examine the impact of the law on the younger generation.

In addition, it is important to examine the impact of the models’ law on models themselves, addressing the topics of work conditions and requirements, law enforcement, and development of EDs. It is recommended that the samples in these studies include both models who were working in the fashion industry when the law was enacted and those who started working as models after enactment of the law.

Prevention of EDs and DEP through legislation might be controversial; therefore, it is of great importance to conduct further research and examine the efficiency of the models’ law, which may also encourage and promote the enforcement of the law. Also, the law is not being enforced these days, which further increases the importance of future studies on the subject, which may lead to the enforcement of the law.

4.2 Theoretical and Practical Implications

The prevention of EDs and DEP is of great importance, and it is important to design additional prevention programs that focus on the public’s health and create opportunities for policy changes (Austin, 2016; McBride et al., 2019); particularly social policy enactment that targets media influences, which are known to be one of the main risk factors for DEP and EDs (Latzer et al., submitted). The models’ law is not enforced, and it is necessary to optimize the existing legislation, regulate enforcement, and impose sanctions on violators of the law (Gutreich, 2017; Latzer et al., submitted; Zilberman, 2013). The findings of this study add important information to the existing literature and highlight the importance of full enforcement of the models’ law. Enforcement might increase the law’s impact on the public, particularly adolescent girls and young women, and may help prevent or reduce the rates of EDs and DEP.

Furthermore, in preventing EDs and DEP, it is important to address both risk and protective factors (Latzer et al., submitted; Loth et al., 2014; Neumark-Sztainer et al., 2007). Many studies indicated that the most effective interventions and prevention programs are those targeting people at risk of developing EDs and DEP (Levine, 2019; Stice et al., 2012), and because the prevalence of EDs and DEP is higher among female adolescents and young adults, age itself might be a risk factor (Latzer et al., 2019; Le et al., 2017).

This study found that the models’ law had more impact on younger women. This important finding, alongside the participants’ suggestion to include issues related to EDs and body image in the school curriculum, support the existing literature on prevention of EDs and DEP, according to which effective prevention programs broadly implemented during adolescence might reduce the prevalence of EDs (Stice, Onipede, & Marti, 2021), while also highlighting the importance of designing prevention programs for adolescence and even earlier ages.

However, focusing only on age as a risk factor is not enough. Effective prevention programs also focus on risk factors known to predict onset of EDs and DEP, such as body dissatisfaction, negative affect, dieting, higher media exposure, thin-ideal internalization, and reduced self-esteem relating to body shape and weight (Latzer et al.,
submitted; Latzer et al., 2015; Latzer et al., 2019; Loth et al., 2014; McBride et al., 2019; Neumark-Sztainer et al., 2007; Stice, 2002; Stice et al., 2012).

In this study, participants with higher levels of DEP were less supportive of the law. This finding adds an interesting perspective to the existing literature on prevention of EDs and raises an important question regarding the level of risk and severity of symptoms at which universal prevention can be effective. This suggests that universal prevention programs, such as the models’ law, might be more effective among low-risk populations, compared to selective prevention programs that might be more effective among higher-risk groups (Latzer et al., submitted; Stice et al., 2012).

5. Conclusions

In conclusion, despite difficulties regarding the law’s enforcement and even though most participants reported that the law did not affect them directly, most of them saw great value of the law in preventing DEP and disturbed body image and emphasized the importance of implementing and enforcing the law. Moreover, results indicate that the law’s degree of impact is higher among younger women, regarding both its direct and potential impact.

The results of this study highlight the importance of designing prevention programs and interventions for adolescent and preadolescent girls, who are at high risk of developing EDs and DEP, before they internalize the thin ideal and other sociocultural values that cause EDs and DEP, alongside the importance of implementing universal prevention programs that might also help populations with low risk. Moreover, the study deepened our understanding of the importance of expanding the spectrum of prevention options to the field of legislation and ensuring implementation at a young age (Latzer et al., submitted), while also highlighting the need for increased law enforcement.

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References

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.). American Psychiatric Publishing. https://doi.org/10.1176/appi.books.9780890425596

Austin, S. B. (2016). Accelerating Progress in Eating Disorders Prevention: A Call for Policy Translation Research and Training. Eating Disorders, 24(1), 6-19. https://doi.org/10.1080/10640266.2015.1034056

Blanck, A. (2016). Treatment of Eating Disorders in Israel. The Knesset-Research and Information Center.

Bogar, N., & Tury, F. (2018). Abusing the Body: Psychological Abuse? The Bioethical Aspects of the Fashion Model Profession. Journal of Obesity & Eating Disorders, 4(1). https://doi.org/10.21767/2471-8203.100035

Brown, Z., & Tiggemann, M. (2016). Attractive celebrity and peer images on Instagram: Effect on women’s mood and body image. Body Image, 19, 37-43. https://doi.org/10.1016/j.bodyim.2016.08.007

Bucchianeri, M. M., Arikan, A. J., Hannan, P. J., Eisenberg, M. E., & Neumark-Sztainer, D. (2013). Body dissatisfaction from adolescence to young adulthood: Findings from a 10-year longitudinal study. Body Image, 10(1), 1-7. https://doi.org/10.1016/j.bodyim.2012.09.001

Cooper, P. J., Taylor, M. J., Cooper, Z., & Fairburn, C. G. (1987). The development and validation of the body shape questionnaire. International Journal of Eating Disorders, 6(4), 485-494. https://doi.org/10.1002/1098-108X(198707)6:4<485::AID-EAT2260060405>3.0.CO;2-O

Dakanalis, A., Clerici, M., & Stice, E. (2019). Prevention of eating disorders: current evidence-base for dissonance-based programmes and future directions. Eating and Weight Disorders, 24(4), 597-603. https://doi.org/10.1007/s40519-019-00719-3

Deloitte Access Economics (2020). The social and economic cost of eating disorders in the United States of America: A report for the strategic training initiative for the prevention of eating disorders and the academy for eating disorders. Retrieved from https://www.hsph.harvard.edu/striped/report-economic-costs-of-eating-disorders/

Fairburn, C. G., & Harrison, P. J. (2003). Eating disorders. The Lancet, 361(9355), 407-416. https://doi.org/10.1016/S0140-6736(03)12378-1
Fitzsimmons-Craft, E. E., Balantekin, K. N., Graham, A. K., Smolar, L., Park, D., Mysko, C., Funk, B., Taylor, C. B., & Wilfley, D. E. (2019). Results of disseminating an online screen for eating disorders across the U.S.: Reach, respondent characteristics, and unmet treatment need. *International Journal of Eating Disorders, 52*(6), 721-729. https://doi.org/10.1002/eat.23043

Galmiche, M., Déchelotte, P., Lambert, G., & Tavolacci, M. P. (2019). Prevalence of eating disorders over the 2000-2018 period: a systematic literature review. *The American Journal of Clinical Nutrition, 109*(5), 1402-1413. https://doi.org/10.1093/ajcn/nqy342

Garner, D. M., Olmstead, M. P., & Polivy, J. (1983). Development and validation of a multidimensional Eating Disorder Inventory for anorexia and bulimia. *International Journal of Eating Disorders, 2*(2), 15-34. https://doi.org/10.1002/1098-108X(198321)2:2<15::AID-EAT2260020203>3.0.CO;2-6

Garner, D. M., Olmsted, M. P., Bohr, Y., & Garfinkel, P. E. (1982). The Eating Attitudes Test: psychometric features and clinical correlates. *Psychological Medicine, 12*(4), 871-878. https://doi.org/10.1017/S0033291700049163

Garner, D. M. (1991). *The eating disorder inventory manual*. Psychological Assessment Resources.

Garner, D. M., & Garfinkel, P. E. (1979). The Eating Attitudes Test: An index of the symptoms of anorexia nervosa. *Psychological Medicine, 9*(2), 273-279. https://doi.org/10.1017/S0033291700030762

Gauvin, L., & Steiger, H. (2012). Overcoming the Unhealthy Pursuit of Thinness: Reaction to the Québec Charter for a Healthy and Diverse Body Image. *American Journal of Public Health, 102*(8), 1600-1606. https://doi.org/10.2105/AJPH.2011.300479

Gladstone, J. (2016). The Skinny on BMI-Based Hiring: An assessment of the Legality and Effectiveness of Israel's Weight Restriction Law. *Washington University Global Studies Law Review, 15*(3), 495-512.

Graham, A. K., Trockel, M., Weisman, H., Fitzsimmons-Craft, E. E., Balantekin, K. N., Wilfley, D. E., & Taylor, C. B. (2019). A screening tool for detecting eating disorder risk and diagnostic symptoms among college-age women. *Journal of American College Health, 67*(4), 357-366. https://doi.org/10.1080/07448481.2018.1483936

Greenberg, L., Cwikel, J., & Mirsky, J. (2007). Cultural correlates of eating attitudes: A comparison between native-born and immigrant university students in Israel. *International Journal of Eating Disorders, 40*(1), 51-58. https://doi.org/10.1002/eat.20313

Gutreich, R. (2017). *Implementation and Enforcement of the Law for Restricting Weight in the Modeling Industry, 57/2-2012*. The Knesset-Research and Information Center.

Harel, Y., Ellenbogen-Frankovits, S., Molcho, M., Abu-Ashas, K., & Habib, J. (2002). *Youth in Israel*. Brookdale Institute.

Hilbert, A., Pike, K. M., Goldschmidt, A. B., Wilfley, D. E., Fairburn, C. G., Dohm, F.-A., Walsh, B. T., & Striegel Weissman, R. (2014). Risk factors across the eating disorders. *Psychiatry Research, 220*(1-2), 500-506. https://doi.org/10.1016/j.psychres.2014.05.054

Hildesheimer, G., & Gur-Arie, H. (2015). Just modeling? The modeling industry, eating disorders, and the law. *International Journal of Feminist Approaches to Bioethics, 8*(2), 103-138. https://doi.org/10.3138/ijfab.8.2.103

Hoeck, H. W. (2016). Review of the worldwide epidemiology of eating disorders. *Current Opinion in Psychiatry, 29*(6), 336-339. https://doi.org/10.1097/YCO.0000000000000282

Hudson, J. I., Hiripi, E., Pope, H. G., & Kessler, R. C. (2007). The Prevalence and Correlates of Eating Disorders in the National Comorbidity Survey Replication. *Biological Psychiatry, 61*(3), 348-358. https://doi.org/10.1016/j.biopsych.2006.03.040

Huryk, K. M., Drury, C. R., & Loeb, K. L. (2021). Diseases of affluence? A systematic review of the literature on socioeconomic diversity in eating disorders. *Eating Behaviors, 43*, 101548. https://doi.org/10.1016/j.eatbeh.2021.101548

Ianuca, I. (1990). *Validation of the EAT in Israel* (Unpublished Doctoral dissertation). Tel Aviv University, Israel.

Jackson, T., & Chen, H. (2014). Risk Factors for Disordered Eating During Early and Middle Adolescence: A Two Year Longitudinal Study of Mainland Chinese Boys and Girls. *Journal of Abnormal Child Psychology, 42*(5), 791-802. https://doi.org/10.1007/s10802-013-9823-z
Koslowsky, M., Scheinberg, Z., Bleich, A., Mark, M., Apter, A., Danon, Y., & Solomon, Z. (1992). The Factor Structure and Criterion Validity of the Short Form of the Eating Attitudes Test. *Journal of Personality Assessment, 58*(1), 27-35. https://doi.org/10.1207/s15327752jpa5801_3

Latzer, Y. (2007). Eating disorders and eating attitudes in Israel: Research and Treatment Review. *Hevra Verevah, 27*(3), 453-477.

Latzer, Y. (2016). Media and ED. *Dvarim, 9*, 115-132.

Latzer, Y., & Tzischinsky, O. (2003). Weight concern, dieting and eating behaviors. A survey of Israeli high school girls. *International Journal of Adolescent Medicine and Health, 15*(4), 295-305. https://doi.org/10.1515/IJAMH.2003.15.4.295

Latzer, Y., & Tzischinsky, O. (2005). Eating attitudes in a diverse sample of Israeli adolescent females: a comparison study. *Journal of Adolescence, 28*(3), 317-323. https://doi.org/10.1016/j.adolescence.2004.12.004

Latzer, Y., Adatto, R., & Neumark-Sztainer, D. (submitted). Addressing Eating Disorders through Legislation: The Israeli ‘Models’ Law’ - Process, Enactment, and Dilemmas. *Dialogues in Health*.

Latzer, Y., Spivak-Lavi, Z., & Katz, R. (2015). Disordered eating and media exposure among adolescent girls: The role of parental involvement and sense of empowerment. *International Journal of Adolescence and Youth, 20*(3), 375-391. https://doi.org/10.1080/02673843.2015.1014925

Latzer, Y., Weinberger-Litman, S. L., Spivak-Lavi, Z., & Tzischinsky, O. (2019). Disordered Eating Pathology and Body Image Among Adolescent Girls in Israel: The Role of Sense of Coherence. *Community Mental Health Journal, 55*(7), 1246-1252. https://doi.org/10.1007/s10597-019-00446-0

Le, L. K.-D., Barendregt, J. J., Hay, P., & Mihalopoulos, C. (2017). Prevention of eating disorders: A systematic review and meta-analysis. *Clinical Psychology Review, 53*, 46-58. https://doi.org/10.1016/j.cpr.2017.02.001

Levine, M. P. (2019). Prevention of eating disorders: 2018 in review. *Eating Disorders, 27*(1), 18-33. https://doi.org/10.1080/10640266.2019.1568773

Levine, M. P., & Smolak, L. (2009). Recent developments and promising directions in the prevention of negative body image and disordered eating in children and adolescents. *Body Image, Eating Disorders, and Obesity in Youth, 2*, 215-239. https://doi.org/10.1037/11860-011

Lewis, N., Pelled, A., & Tal-Or, N. (2020). The effect of exposure to thin models and digital modification disclaimers on women’s body satisfaction. *International Journal of Psychology, 55*(2), 245-254. https://doi.org/10.1002/ijop.12572

Loth, K. A., MacLehose, R., Buechianeri, M., Crow, S., & Neumark-Sztainer, D. (2014). Predictors of Dieting and Disordered Eating Behaviors From Adolescence to Young Adulthood. *Journal of Adolescent Health, 55*(5), 705-712. https://doi.org/10.1016/j.jadohealth.2014.04.016

Mantilla, E. F., & Birgegård, A. (2015). The enemy within: the association between self-image and eating disorder symptoms in healthy, non help-seeking and clinical young women. *Journal of Eating Disorders, 3*(1), 30. https://doi.org/10.1186/s40337-015-0067-x

Maor, N. R., Sayag, S., Dahan, R., & Hermoni, D. (2006). Eating attitudes among adolescents. *The Israel Medical Association Journal, 8*, 627-629.

McBride, C., Costello, N., Ambwani, S., Wilhite, B., & Austin, S. B. (2019). Digital Manipulation of Images of Models’ Appearance in Advertising: Strategies for Action Through Law and Corporate Social Responsibility Incentives to Protect Public Health. *American Journal of Law & Medicine, 45*(1), 7-31. https://doi.org/10.1177/0098858819849990

Meyers, E. E. (2018). Fashioning Worker Protections to Combat the Thin Ideal’s Cost on Fashion Models and Public Health. *Vanderbilt Journal of Entertainment & Technology Law, 20*(4), 1219-1257. Retrieved from https://twitter.com/STASHLIT/status/410654368107470848

Micali, N., Martini, M. G., Thomas, J. J., Eddy, K. T., Kothari, R., Russell, E., Bulik, C. M., & Treasure, J. (2017). Lifetime and 12-month prevalence of eating disorders amongst women in mid-life: a population-based study of diagnoses and risk factors. *BMC Medicine, 15*(1), 12. https://doi.org/10.1186/s12916-016-0766-4
Miniati, M., Marzetti, F., Palagini, L., Marazziti, D., Orrù, G., Conversano, C., & Gemignani, A. (2021). Eating Disorders Spectrum During the COVID Pandemic: A Systematic Review. *Frontiers in Psychology, 12*, 663376. https://doi.org/10.3389/fpsyg.2021.663376

Mitchison, D., & Mond, J. (2015). Epidemiology of eating disorders, eating disordered behaviour, and body image disturbance in males: a narrative review. *Journal of Eating Disorders, 3*(1), 20. https://doi.org/10.1186/s40337-015-0058-y

Neumark-Sztainer, D. R., Wall, M. M., Haines, J. I., Story, M. T., Sherwood, N. E., & van den Berg, P. A. (2007). Shared Risk and Protective Factors for Overweight and Disordered Eating in Adolescents. *American Journal of Preventive Medicine, 33*(5), 359-369. https://doi.org/10.1016/j.amepre.2007.07.031

Niv, N., Kaplan, Z., Mitrani, E., & Shiang, J. (1998). Validity study of the EDI-2 in Israeli population. *Israel Journal of Psychiatry and Related Sciences, 35*(4).

Paxton, S. J., Wertheim, E. H., Pilawski, A., Durkin, S., & Holt, T. (2002). Evaluations of Dieting Prevention Messages by Adolescent Girls. *Preventive Medicine, 35*(5), 474-491. https://doi.org/10.1006/pmed.2002.1109

Skemp-Arlt, K. M. (2006). Body Image Dissatisfaction and Eating Disturbances Among Children and Adolescents. *Journal of Physical Education, Recreation & Dance, 77*(1), 45-51. https://doi.org/10.1080/07303084.2006.10597813

Smink, F. R. E., Van Hoeken, D., & Hoek, H. W. (2012). Epidemiology of eating disorders: Incidence, prevalence and mortality rates. *Current Psychiatry Reports, 14*(4). https://doi.org/10.1007/s11920-012-0282-y

Steinberg, L. (2002). *Adolescence*. McGraw-Hill.

Steinberg, S., & Jotkowitz, A. (2016). The Ethics of Public Health Laws, and the Special Case of the New “Model Law”. *Perspectives in Biology and Medicine, 59*(2), 206-212. https://doi.org/10.1353/pbm.2017.0005

Stice, E. (2002). Risk and maintenance factors for eating pathology: A meta-analytic review. *Psychological Bulletin, 128*(5), 825-848. American Psychological Association Inc. https://doi.org/10.1037/0033-2909.128.5.825

Stice, E., & Shaw, H. E. (2002). Role of body dissatisfaction in the onset and maintenance of eating pathology. *Journal of Psychosomatic Research, 53*(5), 985-993. https://doi.org/10.1016/S0022-3999(02)00488-9

Stice, E., Marti, C. N., & Durant, S. (2011). Risk factors for onset of eating disorders: Evidence of multiple risk pathways from an 8-year prospective study. *Behaviour Research and Therapy, 49*(10), 622-627. https://doi.org/10.1016/j.brat.2011.06.009

Stice, E., Marti, C. N., & Rohde, P. (2013). Prevalence, incidence, impairment, and course of the proposed DSM-5 eating disorder diagnoses in an 8-year prospective community study of young women. *Journal of Abnormal Psychology, 122*(2), 445-457. https://doi.org/10.1037/a0030679

Stice, E., Onipede, Z. A., & Marti, C. N. (2021). A meta-analytic review of trials that tested whether eating disorder prevention programs prevent eating disorder onset. *Clinical Psychology Review, 87*, 102046. https://doi.org/10.1016/j.cpr.2021.102046

Stice, E., Shaw, H., & Marti, C. N. (2007). A Meta-Analytic Review of Eating Disorder Prevention Programs: Encouraging Findings. *Annual Review of Clinical Psychology, 3*(1), 207-231. https://doi.org/10.1146/annurev.clinpsych.3.022806.091447

Stice, E., South, K., & Shaw, H. (2012). Future Directions in Etiologic, Prevention, and Treatment Research for Eating Disorders. *Journal of Clinical Child & Adolescent Psychology, 41*(6), 845-855. https://doi.org/10.1080/15374416.2012.728156

Swami, V., & Szmigielaska, E. (2013). Body image concerns in professional fashion models: Are they really an at-risk group? *Psychiatry Research, 207*, 113-117. https://doi.org/10.1016/j.psychres.2012.09.009

Treasure, J., Claudino, A. M., & Zucker, N. (2010). Eating disorders. *Lancet, 375*, 583-593. https://doi.org/10.1016/S0140-6736(09)61748-7

Udo, T., & Grilo, C. M. (2018). Prevalence and Correlates of DSM-5–Defined Eating Disorders in a Nationally Representative Sample of U.S. Adults. *Biological Psychiatry, 84*(5), 345-354. https://doi.org/10.1016/j.biopsych.2018.03.014
Volonté, P. (2019). The thin ideal and the practice of fashion. *Journal of Consumer Culture, 19*(2), 252-270. https://doi.org/10.1177/1469540517717775

Wade, T. D., Wilksch, S. M., Paxton, S. J., Byrne, S. M., & Austin, S. B. (2017). Do universal media literacy programs have an effect on weight and shape concern by influencing media internalization? *International Journal of Eating Disorders, 50*(7), 731-738. https://doi.org/10.1002/eat.22689

Weinberger-Litman, S. L., Latzer, Y., Litman, L., & Ozick, R. (2018). Extrinsic Religious Orientation and Disordered Eating Pathology Among Modern Orthodox Israeli Adolescents: The Mediating Role of Adherence to the Superwoman Ideal and Body Dissatisfaction. *Journal of Religion and Health, 57*(1), 209-222. https://doi.org/10.1007/s10943-017-0443-8

Zancu, S. A., & Enea, V. (2017). Eating disorders among fashion models: a systematic review of the literature. Eating and Weight Disorders. *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity, 22*(3), 395-405. https://doi.org/10.1007/s40519-016-0293-5

Zilberman, H. (2013). Fashion Victims. *Hukim, 5*, 237-281.

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