Three Years of Isha Be-Shela, A Women's Counseling Center in the Negev – a Mixed Method Analysis

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ABSTRACT

Background: A university-based counseling center for women, Isha Be-Shela, was established at Ben-Gurion University of the Negev in 2008 based on multi-cultural, feminist treatment models. Psychotherapy is provided by mental health professionals in a variety of treatment methods. **Method:** 122 cases from the first three years of operation were analyzed for demographic features, presenting problems, referral, type and length of treatment. Two cases illustrate principles of gender and cultural sensitive therapy. **Results:** This analysis provides a cross-section of the mental health issues that Israeli women face and that propel them to seek mental health treatment. Trauma was reported by 62% and a past or present health problem by 38%. **Limitations:** The use of validated mental health assessment measures might provide a fuller picture of the range of presenting problems and treatment outcomes. **Conclusions:** The presence of an early trauma often accentuates women's mental health distress and physical health and becomes an underlying issue in psychotherapy.

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BACKGROUND

A consistent feature of psychiatric epidemiology and of mental health care utilization is that women report more depression and anxiety disorders than men and seek care for mental health problems more often than men both in Israel (1-3) and abroad (4-9). The burden of biological, reproductive roles and concomittant hormonal changes and the exposure of women to adverse experiences such as poverty, child sexual abuse and blocked opportunities in education and the workforce are postulated as explanations for the higher prevalence of depression and anxiety disorders among women (3, 8). In addition, it is more socially legitimate for women to express distress and seek help for mental health problems, while men sometimes mask their depression and anxiety through substance abuse and anti-social behavior (1, 10, 11). In Israel these differences are particularly salient among marginalized groups, e.g., immigrants from the former Soviet Union and from Ethiopia and Arab groups (1, 12-15). A recent study of mental health service use among women showed that psychosocial risk factors such as unmarried family status, lack of suitable employment, low levels of educational attainment, chronic illness and exposure to domestic or sexual violence explained only part of the excess in service utilization. Even after controlling for these co-variates, female gender still remained a significant predictor of service use (1). Thus, there are unique aspects of women's societal, working, familial and reproductive roles that increase their mental health risk and that require the development of both gender and ethnic sensitive modes of treatment (4, 8, 16-22).

The Negev, the southern region of Israel, is the most sparsely populated region in the country. It includes a high percentage of immigrants, Jews from the former Soviet Union, Ethiopia, East and West Europe, North

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Africa, and North and South America, as well as a large Arabic-speaking Bedouin (formally nomadic) community. Economically, it is an underprivileged region, with a high rate of unemployment. This constellation of socio-demographic profiles makes this region rather unique (23). Thus, many psychosocial risk factors, such as poverty, low educational attainment and a high proportion of immigrants are particularly acute in the Negev. A recent study demonstrated that approximately one-half of those who suffer from psychiatric disorders do not receive mental health services in Israel (24), but this situation is exacerbated in the peripheral areas such as the Negev where this rate is but one-quarter of those with emotional distress (25).

Table 1. *Therapeutic goals in Gender and Cultural Sensitive Therapy (Worell, 2008 [36])*

General goals in therapy:
1. Promote positive self-esteem and intrinsic value
2. Increased comfort in daily functioning and reduction of distress
3. Problem-solving: Use of relevant problem-solving skills
4. Personal control: perceived internal control/self-efficacy
5. Resource Access: Access/use of personal community resources
Gender and culturally specific goals in therapy:
6. Gender/culture awareness: behavior informed by gender/culture power analysis
7. Self-nurturance: ability to meet needs, avoid abuse
8. Flexibility: Selectivity in use of behavior informed by one's gender/culture
9. Assertiveness: Respectful confrontation/refusal skills
10. Social Activism: Activity toward change for social justice

GENDER AND CULTURALLY SENSITIVE THERAPY

An eclectic, yet unique approach to treatment developed out of the social consciousness and critique of traditional gender norms for women that began with the women's U.S.-based movement the 1960s (26-28). Early psychologists focused attention on the way that traditional Freudian psychotherapy was a prism for understanding how society viewed and socially controlled women (29, 30). With accumulating evidence, it became accepted that cultural gender norms, social locations and the distribution of power in society significantly shape women's mental health and their health in general (1, 6, 8, 15, 28, 31-34). Women often seek treatment due to sexual trauma but then are met by "more of the same" in the relationship with their male psychotherapist who exploits the therapeutic relationship unethically (26-28). This gave further impetus for developing more open, democratic, trauma-informed, gender and cultural sensitive practice (26, 32, 35).

This theory and research knowledge was the basis for the development of a local, Negev-based gender and culturally-sensitive practice for women. Our approach emphasizes the expertise and "voice" of each woman as she reflects on her unique needs and experiences, evoking her strengths as resources in treatment rather than focusing on psychopathology (27, 36). Laura Brown posits, "Feminist practice aspires to the creation of an egalitarian relationship between therapists and clients. Clients are construed as possessing expertise and authority about themselves, their lives and their needs. Therapy then becomes a process of empowering clients to identify and own that authority" (27, p. 465). Judith Worell articulated this stance relying on therapeutic goals that constitute the framework for psychotherapeutic work in our service (see Table 1) where five goals are common to all psychotherapy while others emphasize gender and culturally-sensitive practice (36).

ISHA BE-SHELA - DESCRIPTION OF THE SERVICE

Through the aegis of the University's Center for Women's Health Studies and Promotion, Isha Be-Shela ("a woman in a place of her own," freely translated) was established in August, 2008. The service was modelled after the Counselling Center for Women (CCW) which has operated services in Ramat Gan and Jerusalem as a freestanding non-governmental organization (37). Isha Be-Shela is unique in Israel, as the academic setting allows for students to participate in training, research ideas and projects to percolate and access to the cutting edge of feminist theory and practice. We place an emphasis on: understanding gender as an organizer of social and cultural position, establishing collaborative therapeutic relationships with an appreciation that the client is considered the expert on her own life, integrating between mind and body in understanding the development of symptoms and promoting empowerment, self-care and self-nurturance in recovery. In general the therapeutic approach depends more on understanding the reasons for distress instead of concentrating on pathology and psychiatric labels. Thus, for example we understand the insidious nature of trauma experienced by women and disadvantaged groups as contributing to the unique patterns of women's distress (26, 28, 32, 37-39).

Since its inception, more than 130 women (over the age of 18) have received ambulatory mental health services, using a variety of treatment methods (dynamic ego psychology, short-term, long-term, narrative therapy,

psychodrama, art therapy, cognitive behavioral therapy). We have also conducted seven group interventions in areas such as women's sexuality, parental coping, empowerment of women in development towns, and promotion of mental health among middle-aged women.

Isha Be-Shela employs 15 part-time psychotherapists (including one male psychotherapist), all with MA or higher educational attainment in social work or psychology, experienced in psychotherapy with women. Intakes are for the most part conducted by the second author and supervision is provided to the staff by both authors. A unique in-take procedure was developed to reflect both cultural sensitivity and an awareness of the impact of both biological (experience of pregnancy, abortion and childbirth) and trauma experiences (child sexual abuse, domestic violence and other types of violence and/or trauma). This is detailed below.

PROCESS OF REFERRAL AND INTAKE TO ISHA BE-SHELA

Following referral, the administrative coordinator contacts the woman and explains the intake process and the cost of treatment. The prospective client is sent a self-administered background questionnaire based on questionnaires used in CCW and other mental health clinics to complete prior to the intake interview, which averages 90 minutes. The questions include: the presenting problem, reasons for coming to treatment, family and network history and relationships, health events, eating disorders, trauma history, sources of support and positive personal coping strategies and substance use.

During the intake, these issues are expanded and we specifically address reproductive history including pregnancy, abortion, birth and, if suitable, menopausal symptoms are explored. Specific questions are asked about army service, educational frameworks and employment. Following intake, the best match between client and psychotherapist is made with the following factors taken into consideration: main issues identified in the intake, preferred and appropriate method of treatment, cultural and religious background, preferred language for treatment (Hebrew, Russian, English, Spanish and Arabic) and sexual orientation. Hours available to the patient are matched to suitable psychotherapists. Isha Be-Shela has been officially recognized as "gay friendly" by the Israeli Network of Gay and Lesbian Psychotherapists. Despite attempts to maximize the suitability between clients and therapists, if clients feel there is a lack of compatibility, they may request another therapist. This has happened five times in the past three years, suggesting a high rate of matches that seem to meet the clients' needs.

This paper presents qualitative and quantitative data on the development of a university-based counselling program for women in the Negev that developed out of a deep understanding that Israeli women's unique life experiences require the development of gender and cultural specific therapeutic skills. We report here on the first 122 cases of individual psychotherapy from the first three years of operation.

METHOD

Since the service opened until July, 2011 information was collected on all the clients (N=143) who completed an intake interview. Of them 18 (12%) did not continue, while three files had incomplete information. Data on the remaining 122 cases were entered from the in-take self-report questionnaires, the intake summary and the treatment files into SPSS (version 18) for analysis. Descriptive analyses were conducted using frequencies, t-tests and chi-square analyses. All diagnostic and stressful life events are self-report variables (e.g., type of trauma, presenting problem) which then were developed into coding categories based the clinical judgment of the two authors based on prior research (40, 41) and a review of all the responses. The evaluations were made independently by the two authors and when there were cases of discordance, they were discussed until a single concordant code was generated. Two cases typifying the type of unique issues brought to gender and culturally sensitive treatment are presented and discussed.

RESULTS

The population: It is largely young with an average age of clients of 32.8 (SD 11.9). The distribution of demographic features is shown in Table 2. The majority were native Israelis (77%), more than half were single (58%), the majority (68%) were working at either full or part-time jobs. In spite of this, most still reported financial difficulties, and only 13% paid unsubsidized fees. The wide variety of ethnic and cultural groups and the economic difficulties is a reflection of the populations of the Negev, although some populations are still unrepresented, such as Bedouin residing in the Negev. This is despite the presence of an Arab-speaking therapist on staff.

The majority self-identified as heterosexual (93%)

Table 2. *Description of the population*

		Percent %
Age	20-29	60%
	30-39	18%
	40-49	8%
	50-59	7%
	60-69	7%
Birthplace	Israel	77%
	Former Soviet Union	8%
	North America	4%
	North Africa	3%
	Ethiopia	3%
	Europe	2%
	South America	2%
	Asia	1%
Marital Status	Single	58%
	Married	28%
	Divorced	8%
	Widowed	3%
	Separated	3%
Parity	Have Children	39%
	No Children	61%
Work	Working full/part time jobs	68%
	Not working	32%
Financial Status	Financial difficulties	87%
	No financial difficulties	13%
Army or National Service	Served	84%
	Not served	16%
Education	High School	18%
	BA-student	35%
	Completed B.A	24%
	MA-student	11%
	Completed M.A	7%
	PhD-student	2%
	Completed PhD	3%
Religion	Jewish	94%
	Christian	3%
	Muslim	3%
Religiosity	Secular	59%
	Traditional or religious	18%
	No religiosity mentioned	23%

with 7% having other sexual orientations (gay, lesbian or transgender). All except four clients were female. Examination of the demographic features of those who dropped out of treatment after the intake shows that there were no differences on age, marital status, educational level or ethnic origin (all chi square values NS, p<.27). The reasons for not starting treatment included: relocation to another place, economic difficulties, starting treatment in another service and feeling ambivalent about starting treatment.

Treatment Issues: Approximately half (47%) heard about Isha Be-Shela by word of mouth, one-third (34%) were referred by a mental health professional and 19% had heard about it at lectures by the two authors or from seeing a brochure on the service. A little over half (56%) had previously been in psychotherapy, although only 28% had ever been treated in a psychiatric framework. Twenty-two percent reported that a family member had been in psychiatric care. Of the 23% percent of clients that reported receiving psychoactive drugs, 13% were currently still on anti-depressants or anxiolytics. Twenty-nine percent reported ever having suicidal thoughts, of them 10% still reported them, 7% reported a past suicidal attempt. Of the clients, 31% reported some type of substance use or addiction (14% food addiction, 6% recreational drugs, 5% cigarettes, 3% alcohol and 3% some other type).

The self-reported reasons for seeking treatment are shown in Table 3; 29.5% reported more than one reason. The main reasons were, in general, affective distress (45%) including depression, anxiety, trauma, low self-esteem, grief, reproductive events such as pregnancy loss or post-partum depression.

A significant portion of clients reported childhood or recent stressful life events and 11.5% reported more than one event. No traumatic events that would qualify for DSM-IV criteria for PTSD were reported by 37.7% (46/122); however 66.2% had some traumatic event in the past, largely exposure to sexual or physical assault. Of the 122 clients reviewed, only two brought up traumas in treatment that were not referred to in the intake process.

Approximately half of the traumatic events happened during childhood, including sexual assault, incest, bullying, parental separation and loss and personal injury or illness. Clients also reported being distressed over events that happened to significant others in their network, such as illness, death or suicide (19%). A small portion reported significant traumatic health events (6%). However, in a separate question clients were asked directly about health problems; 38% had a health problem at present and 7% had a significant health problem in the past, the most commonly reported problems being endocrine (14.%), 11% neurological and 11%

Table 3. *Presenting problem (n=158, more than one answer possible)*

Type of presenting problem	Frequency	Percent of Problems
Affective distress	**71***	**45.0***
Depression	18	11.4
Anxiety	18	11.4
Grief	13	8.2
Low self-esteem	13	8.2
Traumatic events	5	3.2
Post-partum depression	3	1.9
Pregnancy loss	1	0.6
Interpersonal disputes-conflicts	**51***	**32.4***
Interpersonal difficulties	6	3.8
Difficulties in family relations	9	5.7
Relationship issues partner	16	10.1
Difficulties finding a partner	10	6.4
Separation – divorce	10	6.4
Role transitions and daily function	**23***	**14.6***
Adaptive problems – feeling stuck	10	6.4
Perfectionism – control issues	4	2.5
Occupational difficulties	9	5.7
Disordered eating	4	2.5
Somatization	3	1.9
Chronic illness	2	1.2
Sexual identity	2	1.2
Stress	2	1.2
Total	**158**	**100.0**

* Count and percentage for category group

reported a previous malignancy. Those who reported a past or present health problem were much more likely to also report a past traumatic event compared to those without health problems (72.7% vs. 53.7%, chi square=4.64, p<.05).

The treatment recommendations were eclectic; primarily (56%) some combination of dynamic long-term therapy with CBT (32% for both, 16% for dynamic, psychotherapy and 8% for CBT alone). Other treatment recommendations were short-term dynamic (12%), crisis intervention and supportive therapy (11%), family oriented therapy (5%), grief work (5%), art therapy (7%) and psychodrama (4%). As of this point in time, 50.8% were still in treatment with visits numbering from 1-115 (mean =25.1, SD=28.3).

The average number of treatment visits for clients who completed treatment (20% or 25/122) is 17.2 (SD=13.5) and for those who left for other reasons (n=35), the average is 7.2 visits (SD = 7.0). Of those who left treatment, the reasons were: 42% finished their treatment, 16.6% had a financial reason, 13% felt stuck or dissatisfied with their treatment, 10% had trouble finding time, 8.5% moved away, 5% left for another treatment framework (public sector) and 5% the reason was unknown. Interestingly, the average number of treatments for those who did not report a traumatic event prior to beginning treatment was almost twice the number of those who did identify earlier traumatic events before commencing treatment (23.5 (SD=16.1) vs. 12.3 (SD= 8.9), t=2.23, df(23), p <.05). Those with past health problems had a higher average number of visits, 34.2 (SD= 38.5) compared to those with present health problems 15.3 (SD=.22.5) and no health problems 18.2 (SD=19.2) (t=2.03,df(53), t=2.03,df(73) respectively, p<.05, for both post-hoc comparisons). Among those who completed their treatment (n=25), short-term therapy, CBT, crisis intervention and family therapy averaged 7.4, 8.2, 13.0 and 15.0 sessions, respectively; dynamic and integrated CBT and dynamic averaged, 22.3 and 24.7 respectively. Grief work was the longest average treatment (33.5 meetings). Those clients in art therapy or psychodrama either were still in treatment (27.8 or 29.5, respectively) or left for other reasons (and thus could not be calculated in the "completed treatment" group).

CASE PRESENTATIONS

Two cases were selected to illustrate the principles of gender and culturally sensitive therapy in conjunction with common issues that propel women into psychotherapeutic treatment. Identifying information has been modified to protect the identity of the clients.

CASE 1 - REGINA

Regina, aged 35, married with two children, was born in the USSR and immigrated to Israel in 1991 with her husband and eldest son, now aged 15. Regina is married to an engineer working in high-tech. Their daughter was born a year ago. She has a BA in economics and business administration and works full-time in a bank where she manages a financial group. The oldest of three, Regina grew up with strict parents who had high expectations of their children. She was an excellent student and excelled also in gymnastics. For two years

she was raised by her grandmother and would see her family only on weekends in order to allow her mother to return to work.

Reason for the referral: Regina was referred from another mental health professional. Just prior to the referral, she had a series of conflicts with a fellow worker who substituted for her while she was on maternity leave and who later tried to undermine her status at work by criticizing her as being too "soft" a manager.

Presenting problems: Reported symptoms included recent sleep disturbances, lack of appetite with weight loss, lack of desire to do things, crying, reduced libido, a feeling of tightness in the chest, heart palpitations, diffuse physical pain, muscle aches, headache, and nervousness. She reported also different types of fears: that her husband would leave her, something terrible will happen to her children, she will be fired from work, and will lose respect from her co-workers.

Process of therapy: Short-term therapy (12 meetings), using CBT (e.g., relaxation techniques, disputing irrational thoughts, behavioral assignments from week to week), focused on anxiety symptoms reduction and psycho-education about her symptoms. Unique aspects of the feminist therapy included: focus on her work-related function rather than her choices of what to do as a mother and a non-judgmental approach to her priorities as a career woman and mother. The therapist carefully maintained a non-judgmental stance regarding the differences between her own approach to balancing work and family and her client's. There were repeated discussions about the meaning of a "good manager" – does she need to bully her employees in order to be recognized as such or can she have an alternative style of management? Does the role of manager require "masculine stereotypical behaviors"? The therapy ended when Regina reported her symptoms had subsided almost entirely and she had regained her former sense of control. This case especially emphasizes the goals #6, 7, 8 and 9 shown in Table 1 (gender/cultural awareness, self-nurturance, flexibility, assertiveness) along with general symptom reduction, problem solving, and promotion of personal control (2, 3 & 4).

CASE 2 - HANNAH

Hannah, 26, married for three years without children, a resident of a religious communal settlement (moshav), and working as a kindergarten teacher in her community.

Reason for referral: Hannah came for treatment some nine months after a miscarriage at 32 weeks of pregnancy which necessitated a "still-birth" that was similar to giving birth to a live infant. Medical work-up revealed a problem with clotting factors of which she had previously been unaware. She was referred by a nurse in her clinic.

Presenting problems: Hannah felt overwhelmed by her sorrow, cried a lot and found it hard to concentrate. She reported difficulty sleeping, lack of appetite, frequent crying spells, lack of energy to work with children, and fear of another pregnancy despite her desire for her own child. She fantasized about how the baby would have been and felt anguish seeing other pregnant women or babies. She felt that in the moshav, where her family also lives, there was no room for her grief. She frequently heard the phrases "G-d gives, G-d takes away," "G-d works in mysterious ways" and that since something was wrong with the pregnancy she should be thankful. Her mother felt that she should immediately get pregnant again. She felt that nobody understood her feelings and was afraid to express her anger toward G-d. She was taken to a well-known rabbi who gave her his blessings and some talismans, but she did not feel encouraged by this.

Process of treatment: At the end of the intake, the patient asked to be treated by a psychotherapist from a religious background in order to allow dialogue based on greater sensitivity to her issues and social messages. The treatment focused on expression of grief and loss, giving legitimacy to anger over the situation and with G-d. Unique aspects of the feminist therapy: the treatment focused on incorporating diverse aspects affecting mental health including physical, social and spiritual and gender and discussions of the social norms specific to her macro environment that made her situation even more difficult. The process of the therapy enabled Hannah to differentiate between the social expectations and her own internal feelings and experiences, which sometimes clashed. After discussions with her psychotherapist, Hannah consulted with her local rabbi and conducted a ceremonial memorial for her child at the one year anniversary of her infant's "un-birth." One month later, she reported she was pregnant again and preferred to continue psychotherapy to manage her anxieties until the next birth. During the year after giving birth to a son, therapy continued on a monthly basis to support coping with new motherhood. This case illustrates the judicious use of the first 8 goals in therapy (see Table 1).

DISCUSSION

Given the research indicating that the majority of users of mental health services are women and that there is a significantly lower rate of service use in the periphery (1, 24, 25), together with the documented reluctance of the population to attend psychiatric clinics (42), the establishment of women-focused mental health services in the periphery is particularly important. This paper reviewed the unique treatment approaches and the variety of treatment options offered by Isha Be-Shela, the heterogeneous nature of the populations served, and illustrated some of the ways these methods are expressed in two representative case examples.

Childhood trauma, particularly sexual trauma, is often the precursor of somatic symptoms that develop over the life course (43-46). Recognizing the long-term effects of trauma have made this an important focus in psychotherapy. In our women-centered approach to treatment, women are asked direct questions about trauma both as part of the self-administered questionnaires and during the intake. This shows clients that the subject can be addressed openly and it is valid and important to address these issues in treatment. The negligible number of clients who reported traumas during treatment that were not reported in the intake provides further validation of our methods. The ability to recall traumatic events was found to be related to past and present health problems which were common among women coming for psychotherapy (46, 47).

We found that women with chronic health conditions were not asked about their trauma histories in earlier medical encounters although there is ample evidence that chronic illness is a frequent outcome of repeated trauma and chronic stress (44, 46, 47). The medical system tends to see women who somatize their distress as mentally disturbed and in need of psychiatric treatment, especially medication. We feel that focused psychotherapy can also be beneficial, as our results demonstrate.

The unique aspects of the service described here differs from the Counseling Center for Women in that it generates academic research and publications (2, 3, 47-53), it serves as the training site for mental health professionals and it provides a significant contribution to the mental health services in the underserved Negev periphery. Until now, we have not had the staff and economic resources to engage in community social activism and outreach, although this is one of our long-term goals in keeping with the principle "the personal is the political" (54). While those who sought treatment represent a wide diversity of clients, there are still sectors such as the very religious or Arab-speaking women that use ambulatory services rarely and for whom focused outreach is recommended.

We have been exploring the use of standardized (2) and newly validated assessment procedures for the service (54), based on earlier work on assessing the efficacy of mental health treatment of women (38). This could add empirical data to evaluate the success of treatment but needs to be introduced before and after treatment to be effective. We are currently evaluating the impact this may have on the treatment process.

This evaluation of three years of work in a new mental health service serving women in the periphery shows that there is a demand for services that are offered at reasonable fees. The current policies of the HMOs to subsidize a small number of treatments would not be sufficient to meet the needs of most who seek treatment. There is a need to apply the principles of culture and gender-sensitive treatment and make psychotherapy accessible to a wider audience of those in distress.

References

1. Levinson D, Ifrah A. The robustness of the gender effect on help seeking for mental health needs in three subcultures in Israel. Soc Psychiatry Psychiatr Epidemiol 2010;45:337-344.
2. Cwikel J, Zilber N, Feinson M, Lerner Y. Prevalence and risk factors of threshold and sub-threshold psychiatric disorders in primary care. Soc Psychiatry Psychiatr Epidemiol 2008;43:184-191.
3. Cwikel J, Ifrah A. The epidemiology of women's mental health in Israel: A life-course perspective. In: Levav I, editor. Psychiatric and behavioral disorders in Israel: From epidemiology to mental health action. Jerusalem, New York: Gefen, 2009: pp. 2-26.
4. Vingerhoets AJJM, Van Heck G. Gender, coping and psychosomatic symptoms. Psychol Med 1990;20:125-135.
5. Romans SE, Tyas J, Cohen MM, Silverstone TJ. Gender differences in the symptoms of major depressive disorder. J Nerv Ment Dis 2007;195:905-911.
6. Piccinelli M, Wilkinson G. Gender differences in depression. Critical review. Br J Psychiatry 2000;177:486-492.
7. Garcia-Moreno C, Heise L, Jansen HA, Ellsberg M, Watts C. Public health. Violence against women. Science 2005;310:1282-1283.
8. Doyal L. What makes women sick: Gender and the political economy of health. New Brunswick, New Jersey: Rutgers University, 1995.
9. Blehar MC. Gender differences in risk factors for mood and anxiety disorders: Implications for clinical treatment research. Psychopharmacol Bull 1995;31:687-691.
10. Gove WR. Gender differences in mental and physical illness: The effects of fixed roles and nurturant roles. Soc Sci Med 1984;19:77-91.
11. Weissman MM, Bruce M, Leaf PJ, Floria LD, Holzer C. Affective disorders. In: Robins LW, Regier DA, editors. Psychiatric disorders in America. New York: Free Press, 1991: pp. 53-80.
12. Ritsner M, Ponizovsky A, Nechamkin Y, Modai I. Gender differences in psychosocial risk factors for psychological distress among immigrants.

Compr Psychiatry 2001;42:151-160.

13. Remennick LI. Immigrants from Chernobyl-affected areas in Israel: The link between health and social adjustment. Soc Sci Med 2002;54:309-317.
14. Mirsky J. Mental health implications of migration: A review of mental health community studies on Russian-speaking immigrants in Israel. Soc Psychiatry Psychiatr Epidemiol 2009;44:179-187.
15. Cwikel JG, Segel-Engelchin D. Implications of ethnic group origin for Israeli women's mental health. J Immigrant Health 2005;7:133-143.
16. Teichman Y, Shenhar S, Segal S. Emotional distress in Israeli women before and after abortion. Am J Orthopsychiatry 1993;63:277-288.
17. Shoham E. Gender, traditionalism, and attitudes toward domestic violence within a closed community. Int J Offender Ther Comp Criminol 2005;49:427-449.
18. Shalev A, Tuddor D. The influence of gender upon mental diseases and their treatment. In: Lev-Weisel R, Cwikel J, Barak N, editors. "Shimri Nafshech" - "Guard your soul" - Mental health among women in Israel. Jerusalem: JDC-Brookdale Institute, The Center for Women's Health Studies and Promotion and the Spitzer Dept. of Social Work, Ben-Gurion University of the Negev, 2005: pp. 229-256.
19. Schiff M, Zeira A. Dating violence and sexual risk behaviors in a sample of at-risk Israeli youth. Child Abuse Negl 2005;29:1249-1263.
20. Aviv A, Levine J, Shelef A, Speiser N, Elizur A. Therapist-patient sexual relations: Results of a national survey in Israel. Isr J Psychiatry Relat Sci 2006;43:119-125.
21. Avgar A. Women's health in Israel: A feminist perspective. Soc Work Health Care 1997;25:45-62.
22. Anson O, Sagy S. Marital violence: Comparing women in violent and nonviolent unions. Hum Relat 1995;48:285-305.
23. Gradus Y. Statistical yearbook of the Negev. Beer Sheva: Negev Center for Regional Development at Ben-Gurion University of the Negev (Hebrew), 2007.
24. Levinson D, Lerner Y, Zilber N, Grinshpoon A, Levav I. Twelve-month service utilization rates for mental health reasons: Data from the Israel National Health Survey. Isr J Psychiatry Relat Sci 2007;44:114-125.
25. Levinson D. Use of mental health services in Israel. In: Psychiatric epidemiology in Israel: 2008, Prof. I Levav, conference chair. Tel Aviv, 2008.
26. Brown LS. Feminist paradigms of trauma treatment. Psychotherapy: Theory, Research, Practice, Training 2004;41:464-471.
27. Worell J, Johnson D. Therapy with women: Feminist frameworks. In: Unger RK, editor. Handbook of the psychology of women and gender. Hoboken, N.J.: Wiley, 2001: pp. 317-329.
28. Brown LS. Feminist therapy: Not for women only. Washington, D.C.: American Psychological Association, 2009.
29. Chesler P. Women and madness. New York: Doubleday, 1980.
30. Chesler P. Twenty years since Women and Madness: Toward a feminist institute of mental health and healing. J Mind and Behavior 1990;11:313-322.
31. Hays PA. Addressing cultural complexities in practice: Assessment, diagnosis, and therapy. Washington, D.C.: American Psychological Association, 2008.
32. Brown LS. Cultural competence in trauma therapy: Beyond the flashback. Washington D.C.: American Psychological Association, 2008.
33. Douki S, Nacef F, Belhadj A, Bouasker A, Ghachem R. Violence against women in Arab and Islamic countries. Arch Womens Ment Health 2003;6:165-171.
34. Dreman SB. Sex-role stereotyping in mental health standards in Israel. J Clin Psychol 1978;34:961-966.
35. Somer E, Nachmanil I. Constructions of therapist-client sex: A comparative analysis of retrospective victim reports. Sex Abuse 2005;17:47-62.
36. Worell J. Are feminist interventions still relevant today? In: Third National Conference on the Promotion of Women's Health. Ben-Gurion University of the Negev, Beer Sheva, Israel, 2008.
37. Brenner JR, Savran B, Singer I. The Counseling Center for Women - Our Herstory. In: Brenner JR, Savran B, Singer I, editors. Writings from CCW. Ramat Gan, Israel: The Counseling Center for Women, 2001: pp. 3-4.
38. Johnson DM, Worell J, Chandler RK. Assessing psychological health and empowerment in women: The Personal Progress Scale Revised. Women Health 2005;41:109-129.
39. Enns CZ, Sinacore AL. Teaching and social justice: Integrating multicultural and feminist theories in the classroom. Washington, D.C.: American Psychological Association Press, 2005.
40. Amir M, Sol O. Psychological impact and prevalence of traumatic events in a student sample in Israel: The effect of multiple traumatic events and physical injury. J Trauma Stress 1999;12:139-154.
41. Kessler RC, Sonnega A, Bromet E, Hughes M, Nelson CB. Posttraumatic stress disorder in the National Comorbidity Survey. Arch Gen Psychiatry 1995;52:1048-1060.
42. Struch N, Shereshevsky Y, Baidani-Auerbach A, Lachman M, Sagiv N, Zehavi T, et al. Attitudes, knowledge and preferences of the Israeli public regarding mental health services. Isr J Psychiatry Relat Sci 2008;45:129-140.
43. Sapolsky RM. Why stress is bad for your brain. Science 1996;273:749-750.
44. Anda RF, Felitti VJ, Bremner JD, Walker JD, Whitfield C, Perry BD, et al. The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. Eur Arch Psychiatry Clin Neurosci 2006;256:174-186.
45. Chapman DP, Whitfield CL, Felitti VJ, Dube SR, Edwards VJ, Anda RF. Adverse childhood experiences and the risk of depressive disorders in adulthood. J Affect Disord 2004;82:217-225.
46. Dube SR, Felitti VJ, Dong M, Giles WH, Anda RF. The impact of adverse childhood experiences on health problems: Evidence from four birth cohorts dating back to 1900. Prev Med 2003;37:268-277.
47. Cwikel J, Segal-Engelchin D, Mendlinger S. Mothers' coping styles during times of chronic security stress: Effect on health status. Health Care Women Int 2010;31:131-152.
48. Sarid O, Segal-Engelchin D, Cwikel J. The contribution of negative reproductive experiences and chronic medical conditions to depression and pain among Israeli women. Psychol Health Med 2011; 17:82-94.
49. Sarid O, Segal-Engelchin D, Cwikel J, editors. Mind body mosaic: Women's health in Israel. Beer Sheva: Ben-Gurion University of the Negev Press, 2010.
50. Huss E, Sarid O, Cwikel J. Using art as a self-regulating tool in a war situation: A model for social workers. Health Soc Work 2010;35:201-209.
51. Huss E, Daphna-Tekoa S, Cwikel JG. "Hidden treasures" from Israeli women's writing groups: Exploring an integrative, feminist therapy. Women & Therapy 2009;32:22-39.
52. Czamanski-Cohen J. "Oh ! Now I remember" : The use of a studio approach to art therapy with internally displaced people. Arts in Psychotherapy, the (Formerly : Art Psychotherapy) 2010;37:407-413.
53. Cwikel J, Segal-Engelchin D, Sarid O, Mendlinger S. Women's perceptions of pregnancy and childbirth among mothers in the Negev. In: The Center for Women's Health Studies and Promotion. Beer Sheva, Israel, 2007.
54. Hawkins EJ, Lambert MJ, Vermeersch DA, Slade KL, Tuttle KC. The therapeutic effects of providing patient progress information to therapists and patients. Psychotherapy Res 2004;14:308-327.