

# Predicting Depression Among Jewish and Arab Israeli Women Who Are Victims of Intimate Partner Violence

Violence Against Women

1–19

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**Drorit Levy<sup>1</sup>, Anat Ben-Porat<sup>1</sup>, Ola Kattoura<sup>1</sup>, Rachel Dekel<sup>1</sup>, and Haya Itzhaky<sup>1</sup>**

## Abstract

This study examined whether there were differences in levels of depression between Arab and Jewish Israeli female victims of intimate partner violence (IPV) and how various personal and environmental variables contributed to depression. A total of 303 women were selected. *T* tests were conducted, and no significant differences were revealed. Hierarchical regressions were also conducted. Background variables (violence in childhood and employment status) and psychiatric treatment contributed significantly to the variance in depression, and a negative contribution was made by personal and environmental variables (sense of mastery and social support). The interaction between ethnic origin and psychiatric treatment was also found to be significant. The discussion highlights the theoretical contribution and implications for practice in the field.

## Keywords

intimate partner violence, depression, sense of mastery, social support

Intimate partner violence (IPV) is a widespread, intersectional epidemic, various aspects of which have been examined among different populations, including minority groups (Lin, Sun, Liu, & Chen, 2018; Martinez-Roman, Vives-Cases & Pérez-Belda, 2017; Rosman & Ariel, 2018).

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<sup>1</sup>Bar-Ilan University, Ramat Gan, Israel

## Corresponding Author:

Drorit Levy, Louis and Gabi Weisfeld School of Social Work, Bar-Ilan University, Ramat Gan 5290002, Israel.

Email: [Drorit.Levy@biu.ac.il](mailto:Drorit.Levy@biu.ac.il)

Data collected in recent years indicate that 10-50% of women worldwide report experiencing physical or sexual assault at the hands of an intimate partner at some point in their lives (World Health Organization, 2013). In Israel, IPV against women is a phenomenon that crosses all cultural boundaries and is most prevalent among immigrants and minorities, including Israeli-Arab women (Shoham, 2012).

The findings of a survey conducted by Eisikovits, Winstok, and Fishman (2004)—the first Israeli national survey on domestic violence—emphasized the serious situation of Arab women in Israeli society. The study found that 32% of Israeli-Arab women had experienced physical violence compared with 11% of women in the overall Israeli population. The same survey also revealed that the lowest level of domestic violence was carried out against Jewish women, and the highest level was carried out against Arab women.

Recently, in a study among women of childbearing age in Israel, conducted by Daoud, Sergienko, and Shoham-Vardi (2017), notable differences were found in the prevalence of IPV among Israeli-born Arab, Israeli-born Jewish, and Israeli-immigrant Jewish women (67%, 27%, and 30%, respectively). Types of IPV (i.e., physical, verbal, and social) and recurrence of IPV were significantly higher among the Arab women than among the women in the other two groups. A review of the research that has been conducted on violence against Arab women indicates that besides the data that underscore the seriousness of the problem, very few attempts have been made—relative to studies on violence against women from other societies—to look at the specific characteristics of the emotional distress these women suffer and the factors that contribute to this distress.

The literature on the characteristics of Arab society in Israel has portrayed it as a conservative, patriarchal, and collectivist society (Al-Krenawi, 1999, 2000; Barakat, 1993). It has also been portrayed as an ethnic minority with a particularly complicated political situation, owing to its minority status in the country and the additional tensions between this population and the Jewish population. The political situation and the discriminatory policies of successive governments have negatively affected the well-being of Arab women (Carmi & Rosenfeld, 1992; Shalhoub-Kevorkian, 2007) in the context of domestic abuse.

One significant difference between Arab women and Jewish women manifests itself in the barriers that Arab women encounter when they utilize services—for example, language barriers, inaccessibility of professional services, and stigmatizing treatment (Erez, Ibarra, & Gur, 2015; Shalhoub-Kevorkian, 2007). These difficulties are exacerbated by social norms that call for Arab women to endure violence, a situation which ultimately leads to their isolation and lack of support (Haj-Yahia, 2002). It is reasonable to assume that all of these factors shape the emotional experience of Israeli-born Arab women who are victims of violence, and the mental distress they experience, in contrast to Israeli-born Jewish women.

In light of the above, the first aim of the study was to determine the prevalence of depression among both Israeli-born Arab women and Israeli-born Jewish women who were victims of IPV and, as a result of the severity of this violence, had been admitted to shelters in Israel. The study's second aim was to identify the factors

contributing to depression among women who were victims of IPV, with a special emphasis on ethnicity. The study was based on the ecological model of trauma (Harvey, 1996). Harvey's model describes how responses to a traumatic event (in this case, the violence experienced by the woman) and the ability to cope with it derive from a combination of the characteristics of the woman, the event, and environmental factors. Therefore, the following variables relating to violence were chosen: the history of violence (the woman's experience of being physically abused in childhood and the IPV she experienced as an adult), the mental state of the attacker, woman's resources (sense of mastery), and environmental resources (social support). In addition, we examined the direct contribution of ethnic origin (Arab/Jewish) to depression, as well as the contribution of ethnic origin as a variable that moderates the relationship between each of the abovementioned variables and the intensity of depression.

## **Depression Among Women Who Are Victims of Violence**

Research has shown that IPV has implications for women's mental health, and one of the most prevalent mental health variables subject to the influence of IPV is depression (Coker et al., 2002; Kulwicksi, Ballout, Kilgore, Hammad, & Dervartanian, 2015; Refaeli, Levy, Ben-Porat, Dekel, & Itzhaky, 2016; Rodriguez et al., 2008; Wong, Tiwari, Fong, & Bullock, 2016). Specifically, exposure to IPV has been found to increase its risk (Bean & Moller, 2002; Cascardi, O'Leary, & Schlee, 1999; Kessler, Molnar, Feurer, & Appelbaum, 2001). Furthermore, a meta-analysis conducted by Golding (1999) presented 18 studies which showed that the severity and duration of IPV were associated with depression, and the average rate of depression in all of these studies was 47%. In Israel, Bargai, Ben-Shakhar, and Shalev (2007) found that out of 101 women who stayed in shelters for victims of IPV, 40% experienced major depression. In many cases, women who suffer from IPV have experienced violence in their family of origin and have been exposed to violence in childhood, both of which significantly affect mental health and can result in the development of significant emotional deficiencies (Klein & Waldman-Levy, 2013).

Although there is extensive literature on depression and on the factors that contribute to depression among women who are victims of IPV (Coker et al., 2002; Rodriguez et al., 2008), relatively little is known about the specific factors that contribute to depression from a sociocultural perspective. Various studies conducted among traditional minority groups have revealed that one of the factors associated with depression is a patriarchal culture which views men as superior and women as inferior (Bargai et al., 2007; Pineless, Minkea, & Zinbarg, 2008). These studies have emphasized the role of culture in terms of its ability to shape manifestations of distress (Hurwitz, Gupta, Liu, Silverman, & Raj, 2006; Tabora & Flaskerud, 1994). Other studies have found an association between a high prevalence of depression and belonging to an ethnic minority (Campbell, Belknap, & Templin, 1997; Lerner, Kanevsky, & Witztum, 2008; Yick, Shibusawa, & Agbayani-Siewert, 2003). To the best of our knowledge, although depression among women entering shelters has been examined, there is a

lack of knowledge concerning the specific prevalence of depression among Arab women in comparison with other populations.

### **Environmental Resources: Social Support and Depression**

In the context of women who are victims of violence, social support refers to their receipt of emotional and instrumental support while they are coping with the abuse—support which can make a substantial contribution to these women, particularly in situations in which they are isolated from their communities (El-Bassel, Gilbert, Rajah, Foleno, & Frye, 2001; Mitchell & Hodson, 1983). Research findings have revealed that high levels of social support are related to low levels of depression among women who are victims of violence (Beeble, Bybee, Sullivan, & Adams, 2009; Coker et al., 2002; Humphreys, Lee, Neylan, & Marmar, 2001; Pickover et al., 2018). Social support is of even greater significance when the woman belongs to a society typified by patriarchal attitudes, where there is partial justification for gender inequality and for maintaining family unity at almost any price (Al-Sadawi, 1985; Haj-Yahia, 2000).

### **Personal Resources: Sense of Mastery and Depression**

IPV is a recurrent scenario in which women feel that they lack control over their situations and in which they often have difficulty predicting what will trigger the next episode of violence (Walker, 2009). Studies conducted among women who have experienced IPV have revealed that there is a relationship between the women's sense of mastery and their symptoms of depression (Bargai et al., 2007; Refaeli et al., 2016; Rodriguez et al., 2008). The findings of these studies further indicate that a high sense of mastery is associated with lower levels of depression and hopelessness (Clements, Sabourian, & Spiby, 2004; Clements & Sawhney, 2000; Kim & Gray, 2008; Meadows, Kaslow, Thompson, & Jurkovic, 2005). In addition, studies conducted among minority groups have revealed an association between lack of mastery and depressive symptoms (Chou, 2009; Lerner, Kertes, & Zilber, 2005; Noh & Avison, 1996). This is perhaps especially true in Arab society, where specific cultural characteristics may create a reality in which women feel that they are dominated by male figures and by cultural codes (Al-Krenawi, 1999, 2000; Barakat, 1993).

### **Sense of Danger and Mental State of the Attacker**

The literature emphasizes that a sense of danger—which is defined as an attempt to assess and predict the likelihood that the attacker will continue harming the victim—constitutes one of the main reasons for the emergence of severe depressive symptoms among women who are victims of IPV (Clements et al., 2004; Gleason, 1993; Tutty, Weaver, & Rothery, 1999). Regarding this aspect, studies conducted in Israel have shown that Arab women reported a greater sense of danger than did Jewish women (Al-Krenawi, 1999; Morrison, 2004; Rabin, Markus, & Voghera, 1999). And, in terms

of the mental health of the attacker, in studies of a population of men who were treated with court-mandated interventions for domestic violence, rates of mental distress among these men were found to be up to 3 times as high as they were in the general population (Askeland & Heir, 2014; Dutton, 1995; Hoyt, Wray, Wiggins, Gerstle, & Maclean, 2012; Rosenbaum & Leisring, 2003; Shorey, Febres, Brasfield, & Stuart, 2012).

Nevertheless, in terms of treatment for such men, research findings indicate that in traditional contexts, such as in Arab society, individuals are wary of Western methods of treatment, and they prefer to rely on traditional treatments instead (Abu-Asbeh, Ryyan-Garra, & Abu-Nasra, 2014). Although seeking psychological treatment has been shown to yield positive results, in these societies it is often accompanied by social labeling (Corrigan, 2004), and therefore may be avoided. This state of affairs is unfortunate, as many accounts have been offered documenting the relationship between violent men's receipt of psychological assistance and lower levels of depression among their partners. In light of the literature reviewed here, specifically, the aims of the study were as follows:

1. To examine the differences in levels of depression among Arab versus Jewish women who were exposed to domestic violence and were staying in domestic abuse shelters.
2. To examine, based on the ecological model of trauma, the contribution of variables relating to violence (i.e., history of violence among women, effects of current violence, and characteristics of the attacker), sense of mastery, and social support as predictors of depression, as well as the contribution of ethnicity to depression.

## Method

### Sample

The current study was part of a larger study conducted by the authors, and the sample of participants for the current study was drawn from the larger sample of 506 women who were staying in 12 shelters for victims of domestic violence in Israel. The larger sample included 149 Israeli-born Jewish women, 154 Israeli-born Arab women, 125 Jewish women born in the Former Soviet Union (FSU), and 78 Jewish women born in Ethiopia. Participants for the larger sample had been chosen out of a total of 1,409 women who applied to shelters between September 2009 and April 2014. After eliminating from the sample those women with cognitive impairments or pathological conditions, as well as those who left the shelter within 7 days after arrival (as the authors felt that the women who left would not be representative of the sample as a whole), data were collected from 526 women, and the response rate was 68.97%. Twenty women were excluded from the research sample due to completion of less than 42% of the questions. Therefore, the final sample for the larger study included 506 participants.

To examine the current study's research questions, the authors selected from the larger research sample only the Israeli-born Arab women (154) and the Israeli-born Jewish women (149), for a total of 303 women, and did not include the women who had immigrated from the FSU or Ethiopia. These 303 participants ranged in age from 19 to 73 ( $M = 32.84$ ,  $SD = 8.99$ ). About 51% of them were married, 26% were single, and the rest were separated or divorced; 80% had children; and about 40% had worked during the past year. The women had been living with domestic violence for periods ranging from less than 1 to 54 years ( $M = 9.34$ ,  $SD = 8.26$ ).

## **Procedure**

The study was conducted at 12 out of 14 shelters in Israel for battered women and their children, by a team of Jewish and Arab researchers. In the first stage of the study, the research team and the shelter directors held meetings with their supervisors at the Ministry of Social Affairs and Social Services. In these meetings, the aims of the study were defined and adapted to expectations about the topics that would be examined. In the second stage of the study, the shelter appointed a coordinator for the project, who was supported by the research team. The coordinator approached each woman who came to the shelter within the first 2 weeks of her arrival and requested her consent to fill out the questionnaire. The coordinator emphasized, with each woman, that the findings would be anonymous and confidential, and that the responses would not be accessible to the shelter staff. Women who consented to participate in the study received a questionnaire in a blank envelope so that the shelter staff would not see their responses and confidentiality would be maintained to the greatest extent possible. To obtain data from the Arabic-speaking women, two female social workers whose native language was Arabic and who specialized in the field of domestic violence reviewed the questionnaires and translated them into Arabic. Each one separately translated the responses, and the two then subsequently met to compare texts, ultimately reaching an agreement on the translations. The study was supervised by the Research Department of the Ministry of Social Affairs and Social Services and by the Ethics Committee of the School of Social Work at Bar-Ilan University.

## **Instruments**

### ***Demographic Questionnaire***

The participants were asked about their personal characteristics: year of birth, ethnic origin, years of education, income level, employment status, and number of children.

### ***Depression***

To measure depression, we used a scale based on the Brief Symptom Inventory (BSI), which examines psychiatric disorders (Derogatis, 1992). The questionnaire consists of a list of six problems (e.g., "no hope for the future"). Participants were asked to indicate the extent to which they had experienced each of the problems on a 5-point scale

ranging from 0 (*not at all*) to 4 (*to a great extent*). The Cronbach's alpha internal reliability of the scale used in a previous study was .80 (Wang et al., 2010). Norms were constructed for the BSI among the general population, and the average norm in Israel for the depression subscale was  $M = 0.70$ ,  $SD = 0.69$  (Gilbar & Ben-Zur, 2002). In a study conducted among immigrants from different countries, the average on the depression scale was 0.94 (Aroian, Patsdaughter, Levin, & Gianan, 1995).

### *Traumatic Life Events in Childhood*

Two traumatic childhood events were presented to the women: "As a child, did your parents hit you?" and "Did you witness violence between your parents?" Participants were asked whether they had experienced either of these two events, and they provided "yes/no" answers.

### *Questionnaire About the Attacker*

The women were asked questions about the characteristics of the attacker, including aspects such as whether the attacker had received or was receiving psychiatric treatment.

### *Frequency of Violence*

This questionnaire was developed by Eisikovits et al. (2004) and measures different types and frequencies of violence: verbal aggression (e.g., cursing, insulting, yelling); psychological/emotional abuse (e.g., threatening, controlling, domineering, stalking, attempting to isolate the woman, limiting her contact with family and friends, preventing her from accessing resources); physical assault (e.g., breaking things, moderate physical violence, severe physical violence); and sexual assault (e.g., forced intercourse). For each of these items, the women were asked to rank the frequency of abuse in their relationship with their partners on a scale ranging from 1 (*one time*) to 4 (*daily*). Factor analysis conducted in this study yielded two main factors that explained 44.83% of the variance in the data: physical assault and threats (seven items, Cronbach's  $\alpha = .82$ ) and psychological abuse (five items, Cronbach's  $\alpha = .69$ ). The overall Cronbach's alpha reliability of the instrument used in this study was .81.

### *Sense of Mastery*

This questionnaire was developed by Pearlin and Schooler (1978) and was translated into Hebrew by Hobfoll and Walfisch (1984). It measures participants' feelings of control over their environment and the future and contains statements such as "I have very little control over the things that happen to me." Participants were asked to measure the extent of their agreement with the statements on a 5-point Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). One score was derived by calculating the mean of the scores on all of the items for each participant: The higher the score, the greater the participant's sense of mastery; the lower the score, the higher

the participant's sense of helplessness. In the current study, the Cronbach's alpha reliability was .74. Hobfoll and Walfisch reported an internal consistency of .88 for the questionnaire. In the present study, the internal consistency was .59.

### *Social Support*

This questionnaire was originally developed by Karlsson, Sjöström, and Sullivan (1995), and it was subsequently adapted by Soskolne and Manor (2010). It contains six statements which measure the participants' perceptions of emotional, financial, and informational support (e.g., "How often is someone available to you during a crisis to offer advice, information, or guidance?"). Responses were based on a 5-point Likert-type scale ranging from 1 (*never*) to 5 (*all the time*). Soskolne and Manor (2010) reported a Cronbach's alpha reliability of .89, and the reliability of the instrument used in the current study was .85.

## **Results**

### *Differences Between Groups in Levels of Depression*

To examine whether there were differences between the Jewish and Arab women in levels of depression, *t* tests were conducted for independent samples. The tests revealed no significant differences between the Arab women and the Jewish women ( $M = 2.55$ ,  $SD = 1.12$  and  $M = 2.48$ ,  $SD = 0.95$ , respectively;  $t = .64$ ,  $df = 297$ ).

### *Predictors of Depression Among Women Who Were Victims of Violence*

In the first stage, we examined the correlations between all of the research variables (see Table 1). In the second stage, we conducted stepwise hierarchical regressions to assess the overall contribution of the research variables. The variables were entered in four steps: In the first step, background variables and ethnic origin were entered; in the second step, variables relating to violence were entered; in the third step, environmental and personal variables (support and sense of mastery) were entered; and in the fourth step, the interaction between ethnic origin and psychiatric treatment of the attacker was entered (see Table 2).

As shown in Table 2, the regression equation explained 23% of the variance in the depression variables. The variables in the first step contributed 6% to predicting depression. In this step, violence in childhood and employment status contributed significantly; specifically, violence in childhood and unemployment predicted higher levels of depression. The variables in the second step contributed approximately 2% to predicting depression, and the contribution of psychiatric treatment of the attacker was significant, over and above the variables entered in the previous step, that is, psychiatric treatment of the attacker contributed to lower levels of depression. The most substantial contribution was made by personal and environmental variables (sense of mastery and social support), which predicted 14% of the variance in depression. The



**Table 1.** Pearson's Correlations Between the Research Variables.

	Depression	Origin	Age	Years of schooling	Violence in childhood	Witnessing violence	Employment	Access to weapons	Psychiatric treatment	Total violence	Sense of danger	Support	Mastery
Depression	—	—	—	—	—	—	—	—	—	—	—	—	—
Origin	-.04	—	—	—	—	—	—	—	—	—	—	—	—
Age	.03	.25***	—	—	—	—	—	—	—	—	—	—	—
Years of schooling	-.09	.41***	.03	—	—	—	—	—	—	—	—	—	—
Violence in childhood	.15*	-.19**	-.01	-.03	—	—	—	—	—	—	—	—	—
Witnessing violence	.01	-.20***	-.05	-.06	.47**	—	—	—	—	—	—	—	—
Employment	-.16**	.19**	.03	.09	.01	.00	—	—	—	—	—	—	—
Psychiatric treatment	-.15*	.09	.05	.05	-.10	-.02	.10	.02	—	—	—	—	—
Total violence	.06	-.11	-.13*	-.10	.06	.00	-.00	.31***	.15**	—	—	—	—
Sense of danger	.08	-.01	.04	.00	.06	.02	-.03	.23***	.05	.50***	—	—	—
Support	-.26***	.08	-.10	.18**	-.90	-.12*	.06	.04	.08	.05	.02	—	—
Sense of mastery	-.36***	.00	-.01	.02	-.07	-.02	.04	-.06	.12*	-.08	-.09	.10	—

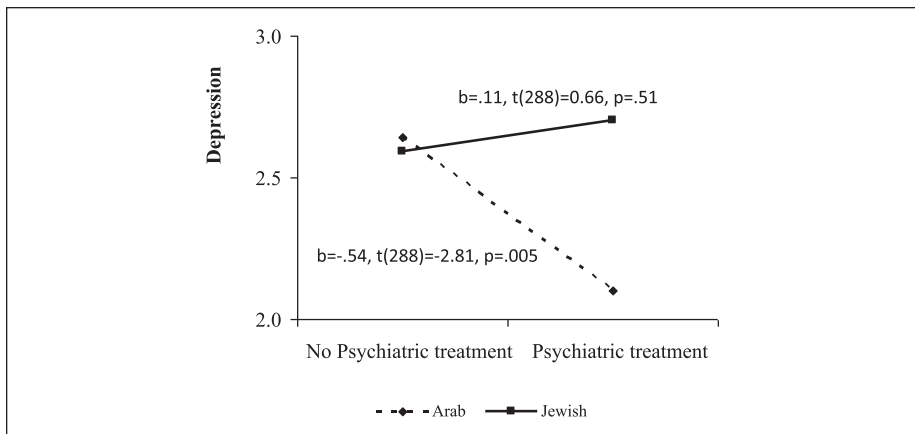
\* $p < .05$ . \*\* $p < .01$ . \*\*\* $p < .001$ .

**Table 2.** Multiple Hierarchical Regressions of Level of Depression on Group and Research Variables (*N* = 303).

Predictors	Steps			
	1	2	3	4
Origin	.05	.09	.07	-.01
Age	.04	.05	.02	.02
Years of schooling	-.09	-.09	-.05	-.05
Violence in childhood	.16**	.14*	.11*	.10
Employment status	-.16**	-.16**	-.14*	-.14**
Psychiatric treatment (attacker)		-.13*	-.08	-.22**
Total violence		.05	.03	.06
Total support			-.20***	-.19***
Sense of mastery			-.31***	-.31***
Origin × Psychiatric Treatment				.21*
<i>R</i> <sup>2</sup>	.06**	.08**	.22***	.24***
$\Delta R^2$	.06**	.02	.14***	.02*

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

association of these variables with depression was negative so that a high sense of mastery and high levels of social support contributed to lower levels of depression, and a low sense of mastery and low levels of social support contributed to higher levels of depression. The variables in the fourth step contributed approximately 2% to explaining the variance in depression, that is, a significant interaction was found between ethnic origin and psychiatric treatment of the attacker. Specifically, among Arab women, psychiatric treatment of the attacker was associated with lower levels of depression (see Figure 1).



**Figure 1.** Interaction between ethnic origin and psychiatric treatment.

## Discussion

The current study aimed to examine predictors of depression among Arab versus Jewish women in Israel who were victims of IPV and who, as a result of the severity of this violence, were currently residing in domestic abuse shelters. The conceptual framework of the study was the ecological model of trauma (Harvey, 1996), which describes how responses to a traumatic event (in this case, violence experienced by women) and the ability to cope with the situation derive from a combination of variables related to the person, the event, and the environment.

First, we compared the two groups of women with regard to their levels of depression. Contrary to expectations, no difference was found between the Arab and Jewish women in levels of depression. Previous studies conducted among minority groups have indicated that a culture characterized by male superiority and female inferiority are among the factors that contribute to depression (Bargai et al., 2007; Pineless et al., 2008). The current finding also contradicts the many studies that have indicated that belonging to an ethnic minority is related to a high prevalence of depression (Campbell et al., 1997; Lerner et al., 2008; Yick et al., 2003). The current finding, thus, seems to support the argument that violence and the resultant emotional consequences are universal problems which transcend populations and sectors (Plichta & Falik, 2001). That said, the fact that the research population in both groups consisted of women staying in battered women's shelters must be taken into consideration. These settings are considered to be at the extreme end of services provided to women who are victims of violence. The women who arrive at these shelters are all victims of severe violence who feel they have no other recourse (Itzhaky & Ben-Porat, 2005), meaning that the factors they have in common may be greater than the factors that divide them.

Of the variables relating to the women's history of violence, violence in childhood was found to contribute to depression. The contribution of violence in childhood to higher levels of depression is consistent with the assumption that women who arrive at domestic abuse shelters often carry wounds from difficult life experiences that are related to family-of-origin violence and to limited emotional resources. These women, in adulthood, seem to return to the same dire reality, and this repetition might lead to higher levels of depression.

In keeping with the theoretical model, the findings of the current study portray an integrative situation, which relates to all of the levels deriving from the model: background variables, variables relating to violence, and personal and environmental variables. Of the background variables assessed (age, years of education, and employment), only employment was found to contribute to depression. This finding corresponds with results that emphasize the major role played by employment and economic status in individuals' overall well-being and mental health. For example, the findings revealed that unemployed women who are victims of violence reported higher rates of depression than women who experienced similar violence but were employed (Carlson, McNutt, Choi, & Rose, 2002).

Additional variables were examined at the individual level (sense of mastery) and at the environmental level (social support). As shown, these variables made the largest contribution to explaining depression. Specifically, high levels of mastery and social

support were found to predict low levels of depression, findings which are consistent with the existing literature on the topic (Bargai et al., 2007; Rodriguez et al., 2008). Mastery is a personal variable that plays an important role in enabling women to evaluate their situations and make the decision to put an end to the violence against them, thereby preventing the development of symptoms of depression (Clements et al., 2004; Clements & Sawhney, 2000; Kim & Gray, 2008; Meadows et al., 2005). Other studies have found that a gendered society that creates inequality and allows for relations in which men retain power and control also contributes to feelings of helplessness among women who endure IPV, and this lack of mastery in turn affects these women's well-being (Davies, Ford-Gilboe, & Hammerton, 2009).

As noted earlier, the negative association between social support and depression is also consistent with previous research (Carlson et al., 2002; Coker et al., 2002; Wong, Tiwari, Fong, Humphreys, & Bullock, 2011). Community and social support are essential for bolstering the mental state of women who are victims of IPV, that is, emotional, financial, and informational assistance serves to empower these women and is particularly crucial for domestically abused Arab women, who generally belong to traditional societies with uniquely paternalistic characteristics (Al-Sadawi, 1985; Haj-Yahia, 2000). Studies have indicated that women who are victims of violence receive minimal social support, and that many of them are socially isolated (El-Bassel et al., 2001; Rodriguez et al., 2008; Theran, Sullivan, Bogat, & Stewart, 2006). This isolation stems largely from the fact that their abusive spouses prevent them from having contact with their family and friends. The importance of social support is also underlined by other research findings that have revealed the critical role that social support plays in a woman's ability to leave an abusive relationship (Estrellado & Loh, 2014; Scheffer, Lindgren, & Renck, 2008).

In the current study, the attacker's psychiatric treatment was found to contribute to the woman's lower levels of depression. Furthermore, even though, as mentioned, no differences in levels of depression were found between the two groups of participants, an interesting finding relating to depression was in fact revealed: A significant interaction was found between ethnic origin and psychiatric treatment of the attacker. That is, among Arab women, when their attackers received psychiatric treatment, the women's levels of depression were significantly lower. This finding gives rise to the following question: Why was this association found only among Arab women? In the literature review, we mentioned that owing to the traditional characteristics of the Arab population and the fear of social labeling, fewer people in the community seek psychiatric treatment, even though such treatment has been found to yield positive results (Abu-Asbeh et al., 2014). Among the Arab population, therefore, psychiatric treatment is usually sought only in severe cases. Thus, one explanation for why the Arab women's depression levels were lower when the attackers received treatment may be as follows: Because the Arab men received treatment only in acute situations where their behavior was extreme, and attested to visible symptoms of illness, the women had likely been in severe distress beforehand so that the husbands' subsequent treatment substantially alleviated the women's situations and reduced their symptoms of depression. Another possible explanation for why the association was found only among the Arab women

is that psychiatric treatment is more prevalent among the Jewish population in general, even in situations that are not acute, and the husbands may even have been receiving treatment at the request of their wives. The Jewish women's lower level of distress prior to their husbands' treatment may therefore reduce the association with depression so that the husbands' receipt of treatment is not as significant for them.

### *Limitations, Summary, and Recommendations*

The study was conducted among women at shelters for victims of IPV throughout Israel. Because the sampling frame focused only on this specific population of women, it may be difficult to generalize the research findings to other populations of women who are victims of IPV, that is, the findings do not fully represent the characteristics of Arab and Jewish women who are victims of IPV, nor do they relate to women who receive assistance from services other than shelters. Another limitation relates to the way that the questionnaires were distributed. Although the questionnaires were sealed in closed envelopes, and although the women were told that the research staff would not be able to see their answers (and that the report was confidential), there may still have been barriers; for instance, the women may have experienced a sense of distrust, especially as they had only recently arrived at the shelter. As a result, in the questionnaires they may have portrayed their situations as more positive than they actually were. Another aspect worth taking into account is that the women were far away from their homes when they filled out the questionnaires. This distance and the stay at the shelter may have created a sense of safety and security for some of the women; for others, however, there might have been adjustment difficulties (Haj-Yahia & Cohen, 2009).

To date, most of the research studies focusing on women who are victims of IPV have examined them as a single entity and have not taken into consideration the situations of victims from specific population groups (Alexander, 2009). Moreover, a review of the literature indicates that there is a lack of empirical research on victims of IPV who are in Israeli shelters in general, and on Arab women in these shelters in particular (Calhoun & Tedeschi, 1998; Itzhaky, Ben-Porat, 2005). Hence, the unique contribution of the present study is twofold: It focuses on the specific population of women staying at shelters, and it compares and contrasts women from the Arab and Jewish sectors.

The findings highlight the importance of various factors that contribute to depression, including the woman's employment status and the attacker's participation in treatment, as well as personal and environmental variables (mastery and social support). In light of these results, we recommend that therapists working with women who are victims of violence, especially with Arab women, focus on developing the women's employment skills, encouraging their partners to receive treatment, strengthening the women's sense of mastery, and reinforcing networks of support. These are important objectives of treatment, both for women staying at shelters and in other settings. For the professionals in the field to make more effective assessments and offer strategies that are more suited to the women's specific situations, it would also be

important to examine additional factors relating to cultural characteristics that predict depression. An additional recommendation for future research therefore relates to the research method. It would be worthwhile to conduct research that combines quantitative and qualitative designs, based on interviews or analyses of open-ended questions relating to cultural and sociopolitical factors in Arab society.

The findings of the current study suggest that Arab women have difficulty expressing emotional distress and may be reluctant to do so (Al-Sadawi, 1985). Therefore, it is important that the therapeutic staff be directed to recognize emotional distress, identify depression among women who are experiencing violence or have experienced violence in the past, and enable these women to receive appropriate treatment.

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## Author Biographies

**Drorit Levy** is the head of the Community and Organization Development Program at the School of Social Work at the Bar-Ilan University in Israel. Her field of specialization is community social work (macro practice). Specifically, she focuses on issues related to macro practice and immigration from three perspectives: research, teaching, and field work.

**Anat Ben-Porat** is a clinical social worker, and her area of expertise is domestic violence. She practiced, supervised, taught, and conducted various research works in this area for the last two decades. Her research projects focus on following female victims of domestic violence in all of the shelters in Israel, the experience of male batterers in treatment, and the implications of treating family violence for the therapist.

**Ola Kattoura** is a clinical social worker and a group therapist. She worked for 15 years as a social worker with minority groups in Israel. She has finished her two degrees in social work at two different universities in Israel: master's degree in clinical social work at Bar-Ilan University and bachelor's degree in social work at Haifa university. She is studying for a PhD at Otago University in New Zealand.

**Rachel Dekel**, is full professor at the Louis and Gabi Weisfeld School of Social Work at Bar-Ilan University and former head of the school. Currently, she serves as the academic head of the International School at Bar-Ilan University. She is the winner of the Israeli Centers of Research Excellence (I-CORE), in the area of mass trauma. She is world-known for her research on caregiver burden and family coping in the context of trauma, posttraumatic stress disorder (PTSD), and domestic violence. She is the founder and the director of the family trauma clinic that advances family-oriented perspectives in helping survivors and provides training and intervention in Cognitive-Behavioral Conjoint Intervention for individuals and caregivers coping with PTSD. She has published more than 120 papers and chapters.

**Haya Itzhaky** is a full professor and former head of the Louis and Gabi Weisfeld School of Social Work, Bar-Ilan University, Israel. Her area of expertise is the field of community work. Her research projects focus on community aspects and trauma, and the human and the social environment.