

Ongoing Exposure versus Intense Periodic Exposure to Military Conflict and Terror Attacks in Israel

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The manifestation of posttraumatic stress disorder (PTSD) symptoms in two clinical samples in Israel (N = 212) was examined. Individuals suffering ongoing exposure to shelling were compared with subjects exposed to intense periodic exposure. Elevated arousal and avoidance symptoms, but not intrusion were reported in the ongoing exposure group. When compared by age, young participants in the ongoing exposure group had significantly lower PTSD scores, whereas no differences were found between participants among the intense periodic exposure age groups. No gender differences in symptoms were found among participants from intense periodic exposure, whereas in the other ongoing group the difference was in avoidance. Results are discussed in light of past research on exposure to terrorism.

Past evidence indicates that exposure, either direct or indirect, to military conflict and terror attacks has a profound psychological impact on civil populations (Brewin et al., 2008; Galea et al., 2002). One of the most substantial long-term psychopathological sequels of such distress is posttraumatic stress disorder (PTSD; Gabriel et al., 2007). The core symptoms of PTSD (intrusive images and thoughts, avoidance, and arousal) severely impair the sufferer's day-to-day functioning and have a significant negative impact on his or her intrapersonal and social life (Kessler, 2006). In many cases, survivors of terrorist attacks were found to have higher rates of PTSD and impairment compared to other trauma survivors (Norris, Friedman, et al., 2002; Shalev & Freedman, 2005).

Since its independence in 1948, Israel has experienced hundreds of attacks, two major prolonged uprisings (Intifadas), nine wars, and dozens of military operations (Abel & Friedman, 2009). The past and current massive exposure to military conflicts and terror attacks "constitutes a fertile ground for examining the relationships between psychosocial, cultural, and clinical aspects of PTSD" (Witztum & Kotler, 2000, p. 103). Israeli citizens have faced a range of hostilities: mass shootings, homicides, suicide bombers, and missile attacks (for a full list of terrorist attacks, see Johnston, 2008). Nevertheless, some populations have experienced

intense exposure resulting from these acts; incidents that lasted days, weeks, or in one case, over a month. For instance, the inhabitants of Upper Galilee experienced massive Hezbollah rocket attacks during "Operation Accountability" in 1993, lasting for 7 days, and during "Operation Grapes of Wrath" in 1996, for more than 2 weeks. Usually, intermissions between periods of attack have lasted from a few months up to a number of years. On the other hand, some populations have experienced acute and constant stress due to ongoing, unceasing exposure to attacks. For instance, the inhabitants of Sderot, a town in the south of Israel, have been exposed to Qassam rockets fired from the neighboring Gaza Strip since 2001. In this current reality, there are almost no intermissions, and ceasefires are usually brutally disrupted. Hence, we suggest three different types of exposure to terrorism, sporadic exposure, intense periodic exposure, and ongoing exposure. Sporadic exposure covers all of the various cases of terrorist attacks in Israel that have lasted for short periods, and it is not the focus of this study for several reasons. First, sporadic exposure includes suicide bombers, car bombings, ambush snipers, hand grenades, Molotov-cocktails, and more. Second, the intensity of attacks differs when referring to one occasion or to a series of attacks, and the sporadic exposure population cannot be compared as it includes the whole nation. We have therefore opted to study intense and ongoing exposure, which are two similar groups, differing in types of exposure intensity, duration of shelling, and whether there are formal ceasefire agreements that are kept for at least some time.

Over the last few years, the impact of intense periodic exposure has been thoroughly researched (Bleich, Gelkopf, & Solomon, 2003; Bleich, Gelkopf, Melamed & Solomon, 2006; Hobfoll et al., 2008; Kimhi, Eshel, Zisberg, & Hantman, 2009; Lahad, Schaham,

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& Schaham, 2009). This research has covered the psychological impact of acts of terrorism, the impact of the second Intifada uprising, and the 2006 war with Lebanon. However, despite the psychological impact, these incidents have had a clear end or a prolonged intermission, even though some of them recurred over several years. Ongoing exposure studies, on the other hand, are a late development in research about the impact of prolonged and ongoing exposure on a civilian population living under constant threat and attack for years (in the case of Sderot it has already been 8 years). These studies were conducted in Sderot and its surroundings (Besser & Neria, 2009; Dekel & Nuttman-Shwartz, 2009).

Most published research on PTSD in Israel has concentrated on nonclinical populations, attempting to estimate prevalence, risk and protective factors, and comparisons of groups by exposure type—direct versus indirect (Besser & Neria, 2009), geographic proximity domains—close versus remote to the border (Dekel & Nuttman-Shwartz, 2009), and ethnicity—Jews versus Arabs (Yahav & Cohen, 2007). However, little research has been dedicated to comparisons of PTSD manifestation in clinical samples derived from populations vulnerable to hostility in Israel. Existing data on PTSD patients in Israel describe differences in suicidality risk between PTSD patients and other patients including control groups (Kotler, Iancu, Efroni, & Amir, 2001), coping styles (Amir et al., 1997), and related comorbid disorders (Kupchik et al., 2006). However, there are no studies that discuss clinical differences in the manifestation of PTSD between patients from different areas in Israel. Therefore, this study seeks to investigate whether people applying for psychological treatment from two developing areas in Israel, exposed to either ongoing or intense periodic exposure, differ or resemble one another in the severity of their PTSD and its symptoms (intrusion, avoidance, and arousal).

In a recent study on chronic and acute traumatic responses of a normal population, Sagy and Braun-Lewensohn (2009) suggest that normal populations that have been chronically exposed to frequent rocket attacks have shown greater psychological distress, compared to a matching sample exposed to acute attacks. Therefore, we assumed that the ongoing exposure group would show elevated posttraumatic symptoms, compared to the intense periodic exposure group. Some PTSD literature with clinical populations in the United States suggests that Criterion C (avoidance) is the most severe manifestation of PTSD (Foa, Cashman, Jaycox, & Perry, 1997). However, numerous studies of Israeli nonclinical individuals report that among the three core clusters of PTSD, arousal symptoms were the most prevalent and severe (Besser & Neria, 2009; Cohen, 2008). Hence, we assume that in the Israeli context, the arousal component will be more dominant than other symptoms. Finally, it has been widely reported that in terms of gender, compared to men, women are at greater risk of developing PTSD and show greater symptom severity (Bleich et al., 2003; Brewin, Andrews, & Valentine, 2000). Hence, it was assumed

that in each group, women would show higher scores of PTSD in comparison to males.

METHOD

Participants

Data were collected from the Sderot Psycho-trauma Clinic in southern Israel and the Mikud Psycho-trauma Clinic in Kiryat Shmona, northern Israel. The people in these two areas are poor, so those needing psychotrauma treatment access public services. There is also very little social mobility: these residents cannot afford to rent a house elsewhere and no one would buy their homes. The participants of this study were self-referred to the public psychotrauma clinics during or after exposure to shelling of or near their residences. Complete data were found for 229 (95%) of the initial sample of 242 individuals. Then, we excluded 17 participants aged 5 or below because their data were reported by a parent or by a caregiver. Finally, an analysis was conducted on 212 (88%) individuals. The participants of the ongoing exposure group ($n = 107$, 67% women) were aged 6–79 ($M = 31.5$, $SD = 20.5$). Each were either born into this emergent situation or had experienced more than 8 years of ongoing exposure to rocket attacks in Sderot, a small town in southern Israel with a total population of approximately 19,400 residents (Israeli Central Bureau of Statistics, 2009). Ninety-three percent of the participants in the ongoing exposure group were rated above the clinical cutoff points for probable PTSD. The participants of the intense periodic exposure group ($n = 105$, 59% women), aged 6–83 ($M = 37.6$, $SD = 22.8$), were living in Kiryat Shmona, a small town in northern Israel with a population of approximately 22,200. The population had been exposed to sporadic or intensive shelling for over 30 years, with 6 years of ceasefire until 2006 when the Second Lebanon War broke out, lasting for 33 days. Among the intense periodic exposure participants, 93% had an above clinical cutoff point. Participants from ongoing and intense periodic exposure groups respectively were later divided into four age groups; 6–9 ($n = 15$, $n = 14$, respectively), 10–18 ($n = 28$, $n = 20$), 19–47 ($n = 33$, $n = 28$), and 48 or higher ($n = 31$, $n = 43$), with mean ages of 8.0 ($SD = 1.0$) and 8.1 ($SD = 1.0$), 13.0 ($SD = 2.6$) and 12.6 ($SD = 2.9$), 35.3 ($SD = 9.0$) and 34.0 ($SD = 8.3$), and 57.2 ($SD = 9.4$) and 61.1 ($SD = 8.8$). The intense periodic exposure group data was based on referrals beginning immediately after the 2006 war with Lebanon and up to 10 months later (August 2006–June 2007). Data for the ongoing exposure was based on referrals made as soon as the psychotrauma center was opened, up to half a year later (September 2008–February 2009), 8 years from the time rocket missiles were first launched toward the south from the neighboring Gaza Strip. Groups differed in terms of age, $t(210) = 1.97$, $p < .05$, with older ages in the intense periodic exposure group, but not in terms of gender, $\chi^2 < 1$.

Measures

The Hebrew translation of the self-report Posttraumatic Diagnostic Scale (PDS; Foa et al., 1997; Foa, Doron & Yadin, 2006) was used to assess the core 17 symptoms of PTSD. Respondents were asked to report on a 4-point scale (0 = *not at all*, 1 = *a little*, 2 = *moderately*, 3 = *quite a bit*) how distressed they had been by symptoms over the previous month. The scale has a total severity score (ranging from 0 to 51) and three subscales, which represent the core symptoms of intrusion, avoidance, and arousal. Indices for symptom severity and the psychometric properties for the PDS are reported elsewhere (Foa et al., 1997; McCarthy, 2008). Current analysis obtained internal consistency reliability coefficients of $\alpha = .76$, $\alpha = .76$, and $\alpha = .78$ for intrusion, avoidance, and arousal, respectively, for both exposed groups. In addition, the internal consistency reliability for the 17 items was found to be $\alpha = .90$. The cutoff score of 14 was used in the current study for reporting probable PTSD. This score was set earlier in previous studies using the precursor version of the PTSD assessment scale (Coffey, Gudmundsdottir, Beck, Palyo, & Miller, 2006), and the scale itself recently was used by Somer et al. (2009) in estimating the severity of posttraumatic symptoms among Israeli civilians under bombardment during the Second Lebanon War.

The Hebrew translation of the Child PTSD Symptom Scale (Foa, Johnson, Feeny, & Treadwell, 2001) was used to assess PTSD severity and diagnosis among children aged 6 to 18 who had experienced a traumatic event. This scale is a children's version of the PDS, described earlier, and has 17 items that represent the 17 PTSD symptoms according to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*; American Psychiatric Association, 1994) in modified developmentally appropriate language. It has acceptable psychometric properties of internal consistency, test-retest reliability, convergent and divergent validity (Foa et al., 2001). The cutoff score of 11 set by Foa et al. (2001) was used to estimate clinical significance of PTSD participants.

Procedure and Data Analysis

All participants from the ongoing exposure group applying for treatment underwent intake procedures by clinicians in the psycho-trauma treatment center. Participants from the intense periodic exposure group underwent intake by two staff members, and were then referred to therapists. During the first therapeutic session, the PDS (for adults) and Child PTSD Symptom Scale (for children and adolescents) were administered by the therapist. Administration took approximately 8–12 minutes. Data were analyzed via STATISTICA v.8 by an independent author who was blind to the intake procedure, as well as to the administration of the screening instruments. Differences in PTSD symptoms between the two exposure groups were examined through *t* tests for independent samples. Evaluation of the effect of exposure type, age, and gender

on the total PTSD severity score and its subscales was conducted via three-way between-subjects analysis of variance (ANOVA). The between-subjects factors were exposure type, with two levels (ongoing and intense periodic exposure), age with four levels (6–9, 10–18, 19–47, and 48+) and gender (male and female). The assumption of equality of variances was not violated in Levene's test for homogeneity of variances, $F < 1$. In addition, age and PTSD severity associations were tested by bivariate Spearman correlation analysis.

RESULTS

Group Differences

Significant main effects were found for exposure type on PTSD severity score, $F(1, 196) = 5.83$, $p < .05$, arousal, $F(1, 196) = 7.64$, $p < .01$, and avoidance, $F(1, 196) = 3.90$, $p < .05$, but not on intrusion, $F(1, 196) < 1$, *ns*. Higher levels of overall PTSD severity scores were reported in the ongoing exposure group ($M = 30.42$, $SD = 11.60$) compared to the intense periodic exposure group ($M = 26.34$, $SD = 10.16$). Though severity of intrusion symptoms was higher in the ongoing exposure group, those differences were not found to be significant. In addition, in both the ongoing and intense periodic exposure groups there was a significant difference between the severity of PTSD components, $F(2, 392) = 3.44$, $p < .05$. Post hoc comparisons using the Tukey HSD test indicated that in the ongoing exposure group, arousal symptoms were significantly higher compared to the other components, whereas in the intense periodic group, arousal and intrusion symptoms did not differ, but were rated higher compared to avoidance (see Figure 1).

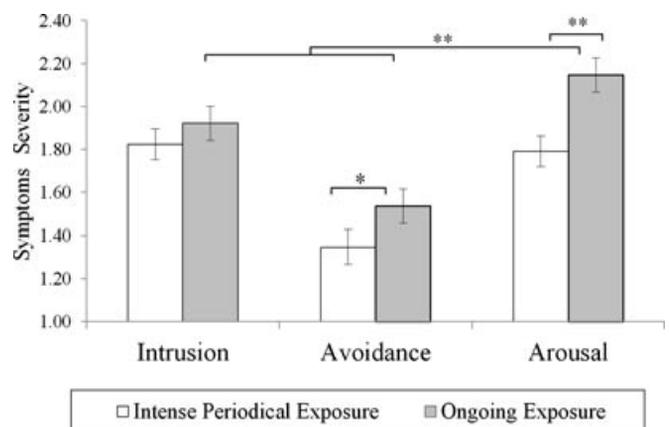


Figure 1. Posttraumatic stress disorder symptoms severity among exposure groups. Vertical bars denote standard errors. PDS = Posttraumatic Diagnostic Scale.

Age Differences

Significant main effects were found for age on PTSD severity score, $F(3, 196) = 2.83, p < .05$, and avoidance, $F(3, 196) = 4.39, p < .01$, but not on intrusion and arousal. Post hoc comparisons using the Tukey HSD test indicated that only the 19–47 age group was significantly higher in total PTSD than the 10–18 age group, but not higher than the 6–9 age group and the 48 and above age group. However, on avoidance symptoms, the 10–18 age group was significantly lower than the two older groups, but not lower than the youngest group. Significant interaction effects were found for age by exposure group on PTSD severity scores, $F(3, 196) = 4.37, p < .01$, avoidance, $F(3, 196) = 4.66, p < .01$, and arousal $F(3, 196) = 4.64, p < .01$, but not intrusion. Means and standard deviations for those effects are described in Table 1 and illustrated in Figure 2. Tukey HSD post hoc comparisons indicated that among participants aged 6–9 and 10–18 no significant differences in PTSD symptoms and overall severity level were reported between the exposure groups (both reporting moderate to severe levels of PTSD), although levels of PTSD were elevated in the intense periodic exposure group. On the other hand, significant differences in PTSD symptoms and overall severity, excluding intrusion, were reported between groups among participants in age groups of 19–47 and 48 and above, both showing moderate to severe levels of PTSD. It should also be noted that severity scores of both the ongoing exposure participants from the older age groups (19–47 and 48+) were not statistically different from the diagnostic 36 cutoff point of severe PTSD level, $t(32) = -1.05, ns$, and $t < 1$, respectively.

Bivariate correlations revealed no relations at all between age and total PTSD score among intense periodic exposure participants; however, in the ongoing exposure group correlations were found significant at low–moderate strength between age and avoidance, arousal and total PTSD severity, $r(108) = .32, p < .001$;

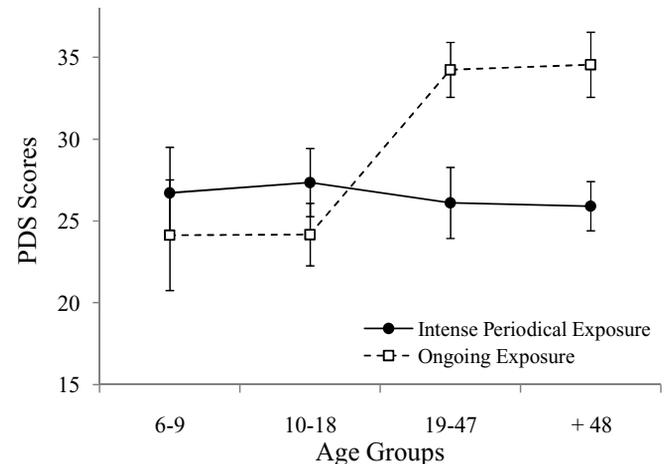


Figure 2. Posttraumatic stress disorder scores among age and exposure groups. PDS = Posttraumatic Diagnostic Scale. Vertical bars denote standard errors.

$r(108) = .34, p < .001$; $r(108) = .31, p < .001$, respectively, but not between age and intrusion, $r(108) = .13, ns$.

Gender Differences

A significant main effect for gender was found on avoidance symptoms, $F(3, 196) = 3.81, p < .05$, but not on the other symptoms or on total severity score. In addition, no significant interaction effects between gender and exposure group were found on any of the PTSD core symptoms, or on total severity score. Means, standard deviations, and F ratios of the interaction effects are described in

Table 1. Means and F Scores for Age Group by Exposure Group Interaction

PTSD Symptoms		Ages 6–9 ^a		Ages 10–18 ^b		Ages 19–47 ^c		Ages 48+ ^d		F
		M	SD	M	SD	M	SD	M	SD	
Intrusion	OGE	1.87	0.87	1.60	0.84	2.02	0.72	2.04	0.74	1.57
	IPEX	2.01	0.91	1.97	0.52	1.85	0.78	1.68	0.74	
Avoidance	OGE	1.14	0.84	1.06	0.60	1.82	0.69	1.83	0.80	4.66*
	IPEX	1.45	0.69	1.27	0.76	1.26	0.72	1.40	0.69	
Arousal	OGE	1.83	1.07	1.77	0.66	2.33	0.65	2.44	0.65	4.46*
	IPEX	1.97	0.80	1.89	0.81	1.65	0.90	1.77	0.68	
Total PDS	OGE	24.13	13.08	24.71	10.06	34.24	9.63	34.55	11.08	4.37*
	IPEX	26.71	10.43	27.35	9.60	26.11	11.51	25.91	9.85	

Note. $df = 3$, Error = 196. OGE = Ongoing exposure; IPEX = intense periodic exposure; PDS = Posttraumatic Diagnostic Scale.

^aOGE, $n = 15$; IPEX, $n = 14$. ^bOGE, $n = 28$; IPEX, $n = 20$. ^cOGE, $n = 33$; IPEX, $n = 28$. ^dOGE, $n = 31$; IPEX, $n = 43$.

* $p < .01$.

Table 2. Means and *F* Scores for Gender and Exposure Groups Interaction

PTSD Symptoms		Ongoing exposure		Intense periodic exposure		<i>F</i> _(1, 196)
		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Intrusion	Women	1.83	0.77	1.81	0.79	2.62
	Men	2.05	0.83	1.85	0.66	
Avoidance	Women	1.44	0.82	1.34	0.71	1.06
	Men	1.73	0.73	1.35	0.70	
Arousal	Women	2.05	0.76	1.79	0.81	1.50
	Men	2.33	0.77	1.79	0.74	
Total PDS	Women	29.11	11.70	26.27	10.69	1.53
	Men	33.00	11.14	26.44	9.46	

Note: PTSD = posttraumatic stress disorder; PDS = Posttraumatic Diagnostic Scale. In ongoing exposure group: women, *n* = 71 and men, *n* = 36; in intense periodic exposure group: women, *n* = 62 and men, *n* = 43.

Table 2. In the ongoing exposure group, men tended to report significantly higher levels of avoidance symptoms, but not significantly higher levels of other PTSD symptoms. In contrast, in the intense periodic exposure group, both men and women showed similar levels of PTSD symptoms.

Finally, no interaction effects of exposure type, age, and gender were found on total PTSD severity score, $F < 1$; intrusion, $F < 1$; avoidance, $F < 1$; and arousal $F(3, 196) = 1.17, ns$.

DISCUSSION

This is the first time in Israel that townspeople exposed to missile attack and seeking help with PTSD symptoms have been compared in an attempt to determine whether intensity or duration of exposure has any impact on symptoms. One group of people came from the town of Kiryat Shmona in the north and its surrounding areas, and the other group lived in Sderot in the south and its environs.

The psychosocial and demographic features of the two populations are similar. Both live in the geographic and social periphery of Israel and are of low socioeconomic status (mostly low-tech industrial workers). They have similar demographic backgrounds: Most of the original generation of settlers came from North Africa or were poor immigrants from the former Soviet Union, who remained in the towns following the large waves of immigration in the 1990s (Israeli Central Bureau of Statistics, 2009). A large percentage of both populations are recipients of social security support.

The main difference between the two groups relates to the security situation. The northern group was subject to periodic shelling from the late 1970s with outbreaks of lengthier and more intensive bombardment up to the 2000 withdrawal of the Israeli army from southern Lebanon, followed by relative peace. The southern region has always been a remote and neglected area of

Israel. In 2001, shelling from Gaza Strip began, followed by almost 8 years of ongoing attacks, particularly on Sderot.

The results indicate that a population living under conditions of overall, ongoing exposure to shelling and constant threat evidence significantly higher levels of overall PTSD severity. It is also evident that symptoms mainly consist of arousal and avoidance rather than intrusion.

These findings suggest that continuous exposure to threat does not enable the limbic aspects of fear to subside and thus, avoidance actually prevents people from leading "normal" lives. Put differently, once the war in the north had ended, the arousal symptoms subsided and the need to use the means of avoidance was lessened (although in comparison to a normal population, it is still higher). However, the high severity of intrusion symptoms in both groups may indicate that the memories of frightening attacks remain with people over a long period. Therefore, even if peace in the north is an illusion (considering the fragile ceasefire with the Hezbollah) the relative calm in the area seems to have reduced the arousal symptoms. However, for the people in the south (ongoing exposure), a constant sense of threat has remained, keeping people permanently on alert and "aroused." Shacham's (2000) study of Kiryat Shmona residents following a 2-week attack found that the first symptoms to diminish over time were the arousal or physiological ones, although initially they were the more intensive ones. Gidron, Kaplan, Velt, and Shalem (2004) proposed that residents of the north, although suffering from periodic shelling, probably assimilated the harsh routine, knowing that eventually the attack would subside and relative peace would prevail. However, residents in Sderot (ongoing exposure) do not have time for respite and are thus constantly governed by their physiological reactions of fight or flight, or employ avoidance in the attempt to control these sensations. Besser and Neria (2009) found similar reactions among a nonclinical populace living in the ongoing exposure area. The arousal element was the most prevalent. In contrast, studies that

examined the psychological effects of intense periodic exposure to terror in Israeli populations indicated that arousal symptoms were usually less prevalent than other PTSD components (Bleich et al., 2003; Hobfoll et al., 2008).

Current findings also suggest that avoidance is still greater in populations exposed to continuous and unpredictable threat. This behavior is driven by the fear that external situations will activate painful internal physiological, cognitive, and affective states (Marshall et al., 2007). Higher severity levels of avoidance symptoms contribute to the group differences and might support previous findings regarding positive correlations between frequency of personal or vicarious exposure history and posttraumatic symptoms severity (Palmieri, Canetti-Nisim, Galea, Johnson, & Hobfoll, 2008). Moreover, in recent studies in both areas with nonclinical populations (Besser & Neria, 2009; Hobfoll et al., 2008; Lahad et al., 2009), avoidance symptoms indicated the lowest severity level, compared to intrusion and arousal. This may imply a similar hierarchy of symptom manifestations among clinical and nonclinical populations in Israel.

Although the majority of the literature suggests that younger age is a risk factor for PTSD (Brewin et al., 2000), being older was linked to war-related subsequent PTSD (Dahl, Mutapcic, & Schei, 1998; Kimhi et al., 2009; Shacham, 2000). In accordance with previous research on clinical and nonclinical populations (Dekel & Nuttman-Shwartz, 2009; Gelkopf, Berger, Bleich & Cohen-Silver, 2009), the current study reveals significant associations between age and posttraumatic stress, and severity scores. However, we found that younger and older adults seem to be more affected than are adolescents. A possible explanation might be that grownups are much more aware of the consequences of the threat and, being responsible not only for themselves but also for their loved ones, they might become much more distressed. Other contributors to the relatively low PTSD severity scores in the younger group—as reported in several studies—include adolescent peer groups, sense of coherence, family sense of coherence, and sense of community. These factors have been found to be moderators of the psychological effects of acute and ongoing exposure to hostilities (Henrich & Shahar, 2008; Kimhi et al., 2009; Sagy & Braun-Lewensohn, 2009).

Unlike former studies that have shown significant gender differences in the experience of distress and PTSD symptoms (Holbrook, Hoyt, Stein, & Sieber, 2002; Norris, Foster, & Weisshaar, 2002; Shacham, 2000), this research found only partial distinctions. In this case, the differences occurred only in avoidance symptoms, but not in arousal or in total severity score. This finding may be attributed to the fact that these were individuals seeking help rather than the general public; still, women as “help seekers” sought help twice as often as men in both samples. Another unusual finding, contrary to findings in previous studies, showed that men in the ongoing exposure group tended to report significantly higher levels of avoidance symptoms. Because this result is unusual in the context of gender differences in PTSD

after terrorist attacks in Israel and abroad (for example, DeLisi et al., 2003; Solomon, Gelkopf & Bleich, 2005), additional research should replicate this research to establish a clearer pattern of post-traumatic symptom severity in males and females who seek help in the context of ongoing exposure to hostilities. Diamond, Lipsitz, Fajerman and Rozenblat (2010) recently suggested a new paradigm for the ongoing exposure situation. They propose a new category to define a subsample living in ongoing exposure areas, expressing PTSD symptoms only in the affected area but not outside it, without a clear incident that has triggered the symptoms but rather the mere ongoing exposure situation producing a traumatizing effect. We suggest further investigation of this group and its characteristics.

There are a few limitations to this study. First, background and psychosocial data including psychosocial/economic status, previous exposure history, length of time since the trauma, and social support were unavailable for analysis. This data includes some factors that previously were found to be influential on risk and on manifestation of PTSD (Hobfoll et al., 2008; Neuner et al., 2004; Palmieri et al., 2008). The role of time elapsed since the trauma is controversial mainly in the context of ongoing exposure because there is not always a clear stressor that motivates the individual to seek help. One explanation could be that they suffer from exhaustion (Selye, 1950) followed by months and years of endurance and resistance. Future research should try to estimate the psychosocial factors that contribute to help-seeking behavior in the context of ongoing exposure to adversity. Another limitation is the absence of matched comparison of clinical data of other exposed areas to terror (i.e., the West Bank); thus, a future study should be the systematic comparison of clinical populations in Israel to establish a clearer “help-seeking” profile of survivors of terrorist attacks and war.

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