“In the Middle, between Anxiety Victims and PTSD, There Are People That Have Some Kind of a Disorder That Has No Name Yet” Insights about the Traumatic Stress Consequences of Exposure to Ongoing Threat

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Abstract: Current diagnostic criteria for post-traumatic stress disorder (PTSD) do not include symptoms resulting from exposure to ongoing traumatic stress. Thus, existing assessment tools do not fully capture stress symptoms associated with exposure to threats that extend over months or years. We aimed to enumerate the symptoms associated with ongoing exposure to stress and to evaluate the need for a new comprehensive tool designed to assess traumatic stress in these situations. Study methods included focus group sessions, interviews, and a content expert’s workshop. Thematic analysis yielded three main themes: 1. PTSD in its current definition does not capture the whole “traumatic picture” observed in ongoing exposure to threat, 2. Some DSM-5 criteria are not applicable in ongoing exposure to threat, 3. The need for a new tool or modifications of commonly used assessment tools. This study supports the notion that PTSD assessment practices are lacking when assessing traumatic stress in ongoing exposure to threat and highlights the need for a new tool specifically designed for these situations.

Keywords: continuous traumatic stress; ongoing exposure to threat; stress assessment

1. Introduction

Ongoing violence and hostility directed at civilian populations are now apparent in many regions around the world, causing a tremendous distraction to life combined with considerable stress and anxiety. There has been a growing recognition in recent years that the traumatic effects of ongoing exposure to threat are complex and go beyond those specified for PTSD in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) [1]. As these criteria were designed for assessing post-traumatic stress in single-event traumas, their diagnostic capabilities in multiple traumatic events or in ongoing exposure to threat are limited. Consequently, as commonly used PTSD assessment tools are based on these criteria, they are not sensitive to the symptomatic effects of ongoing exposure to threat and may not be suitable for use in these situations [2,3].

‘Ongoing Traumatic Stress Response’ [4], ‘Lifetime Cumulative Adversity’ [5] ‘Continuous Traumatic Stress’ [6], and ‘Continuous Traumatic Situations’ [7] are some of the terms used to portray the traumatic picture seen among individuals exposed to ongoing security threat, and to differentiate it from the typical PTSD assessed by DSM-5. Some of the issues raised in these studies concern criteria A (exposure to a traumatic event), criteria
B (intrusion), criteria C (avoidance), criteria E (alterations in arousal and reactivity), and criteria G (functional impairment) required for PTSD diagnosis. One important difference between single exposure to trauma and ongoing exposure to threat concerns the traumatic event itself. PTSD criteria A require the identification of a single traumatic event to serve as the basis for PTSD diagnosis (in the case of multiple traumatic events, symptoms are assessed while relating to the worst event), in ongoing exposure to threat, there may not be a specific event to relate to. In addition, while in single traumatic exposures, stress symptoms relate to a past, no longer dangerous event, in ongoing exposure to threat, stress symptoms may be related both to the past and to potential future events. Indeed, it has been shown that the genuine fear of potential future traumatic events, injury, or death, is in the essence of the anxiety associated with ongoing exposure to security threat [8]. Furthermore, studies show that there is a gradual increase in anxiety symptoms over time as a function of the cumulative exposure to threat [4], and that these effects are not limited to the actual victims but often extend beyond those directly exposed [9,10]. PTSD criteria do not take into account the harmful effect of constant fear of future traumatic events, the cumulative effect of ongoing exposure to threat [4,7,11], or the effect of indirect exposure to threat [9,10].

Ongoing exposure to security threat is associated with additional traumatic stress characteristics, such as ‘sense of danger’, ‘mental exhaustion’, ‘increased morbidity’, and ‘loss of control about the future’, which are not accounted for in the DSM-5 diagnostic criteria for PTSD and are thus, not integrated in currently used mental distress assessment tools [12]. Conversely, typical PTSD symptoms, such as intrusion, avoidance, and alterations in arousal and reactivity, assessed by the DSM criteria for PTSD, may be conceptualized as adaptive reactions in ongoing exposure to threat and may not necessarily reflect a pathology [4,11,13]. Finally, it has been suggested that in ongoing exposure to threat, stress symptoms may be relieved when the source of threat is discontinued (such as when moving away from the area under conflict or during calm times), a phenomenon not commonly seen in typical, chronic PTSD [13].

Despite the availability of effective treatments [14], diagnostic issues may hamper accurate diagnosis and deny effective treatments from individuals exposed to ongoing threat. Further distinguishing the stress reactions associated with ongoing exposure to security threat from those associated with other types of trauma and developing assessment tools specifically designed to capture these stress reactions, is important, as it will allow for an accurate diagnosis and treatment, which may further alleviate symptoms and reduce morbidity and unnecessary suffering.

Owing to the protracted Israeli-Palestinian conflict affecting civilians on both sides, Israel may be regarded as a natural laboratory for studying the effects of ongoing threat. During ‘Operation Protective Edge’ in the summer of 2014, roughly 4600 projectiles were fired from the Gaza Strip (an average of 92 per day), evoking sirens in various areas of the country [15]. Most sirens were in communities closest to Gaza in southern Israel, where residents have only 15 s to secure shelter before rockets land. These communities have been exposed to persistent ‘low intensity’ war-like conditions (e.g., frequent rocket shelling), punctuated by periods of high-intensity conflict since 2001. The latest escalations in the conflict were characterized by terror acts, such as knife stabbing, deliberate running over civilians with motor vehicles, and incendiary balloons. Despite the high frequency of these attacks, the ability to anticipate when and where the next attack will take place is low, creating an atmosphere of fear and insecurity for citizens throughout the country.

In this study, we aimed to assess the traumatic consequences of ongoing exposure to security threat from therapists’ perspectives. More specifically, we aimed to: 1. Identify and differentiate the stress reactions observed in individuals exposed to ongoing security threat from those exposed to a single traumatic event, 2. to document the challenges therapists face when assessing the effect of ongoing exposure to security threat (in terms of the availability of reliable diagnostic criteria and assessment tools), and 3. to evaluate the need for a new comprehensive tool for assessing traumatic stress in individuals exposed to ongoing security threat.
2. Materials and Methods

2.1. Data Collection

In this study, we collected information about the mental health consequences of exposure to trauma in an attempt to identify the traumatic stress characteristics unique to ongoing exposure to war and terror and to hear about the challenges therapists face when assessing the effect of ongoing exposure to security threat. We applied a mixed-methods approach combining both qualitative and quantitative methods, which included a thorough literature review, in-depth one-to-one interviews, focus groups sessions, an academic content expert’s workshop (the qualitative component), and an online survey of therapists assessing the relevance of various stress-related characteristics by trauma type (the quantitative component; [12]). Study participants were all researchers and therapists experienced in treating trauma victims. Along with the literature review, open discussions in the interviews and group sessions provided the ground needed for a comprehensive investigation and understanding of the subject at hand, while allowing for multiple perspectives needed to obtain the full picture. This manuscript describes the qualitative component of the study.

2.2. The First Focus Group

The first focus group session was held in November 2014, in the Community Stress Prevention Center (CSPC) in a city located in Northern Israel that has a history of both intense periodic and ongoing exposure to security threat. The CSPC was established in 1981 with the intention to provide support for residents in northern Israel who were exposed to ongoing periods of missile fire. Following CSPC director’s approval to conduct a focus group discussion at the center, therapists employed by CSPC were invited to participate by a center employee that served as this study liaison with the center. In order to save valuable time during the focus group session, participants’ background information (demographics, professional and work experience, familiarity with available tools used to assess and diagnose PTSD, etc.) and rating of the 32 traumatic stress symptoms was obtained via a web-based online survey (http://www.qualtrics.com, accessed on 4 November 2014) prior to the focus group meeting.

The focus group consisted of 11 therapists (three psychologists, four social workers, one social worker/psychotherapist, one psychotherapist, and two drama therapists) employed at CSPC, all experienced in treating individuals exposed to trauma and all are trained in various PTSD treatment techniques. This focus group also included a research associate employed at CSPC and the first and fourth authors of this manuscript. The discussion was facilitated by the third author, it lasted about 90 min, was audio-recorded, and memos were written by the first author.

2.3. The Interview Guide

The interview guide was initially formulated based on a thorough literature review and with the collaboration of a qualitative research scholar (the second author of this manuscript), aiming to explore the factors that are associated with traumatic stress due to ongoing exposure to security threat. Open-ended questions enquired about the participants’ professional experience in treating individuals exposed to trauma, their views regarding the appropriateness of commonly used questionnaires designed for assessing and diagnosing PTSD, and the need for a new tool specifically designed for assessing the traumatic consequences of ongoing exposure to security threat.

The interview guide further aimed to identify and differentiate the stress reactions most salient to ongoing exposure to security threat from those observed among individuals exposed to other trauma types. In order to ensure that characteristics referred to in the literature were discussed in the interview, a list containing 32 traumatic stress characteristics derived from the literature and from commonly used PTSD assessment tools was prepared to be explored in case they were not spontaneously mentioned by the participants. Participants were asked to rate each of these characteristics on a 1 (irrelevant) to 10 (most relevant) Likert scale with regards to the frequency and severity of the symptom and ac-
cording to trauma type (acute, short duration, ongoing exposure to inter-personal trauma, and ongoing exposure to security threat). Participants were invited to add other traumatic stress symptoms they thought were relevant to ongoing exposure to security threat.

2.4. The Interview

In-depth, semi-structured, one-on-one interviews were conducted with therapists experienced in treating persons exposed to trauma, in an attempt to understand the issues at hand from their point of view and experience. Our selection of potential interviewees aimed to create a maximum variation sampling, inclusive of a broad spectrum of professions (psychologists, psychiatrists, and social workers), experience, and geographical practice regions. We invited potential interviewees to participate in the study via a mail message explaining the study’s motivation and goals. Of the 12 professionals contacted, five did not respond to the invitation, and one was on sabbatical and could not be interviewed.

We conducted six interviews with four psychologists (one from Northern Israel, one from Southern Israel and two from central Israel) and two social workers (both from Southern Israel) between November 2014 and May 2015 at the interviewees’ office or clinic. The inquiry, initially led by the interview guide, was then followed by an open discussion in which the 32 pre-prepared symptoms, as well as others raised by the interviewer, were also addressed. Interviews lasted 60–90 min, all were audio-recorded and transcribed, and memos were written. Interview transcripts were read by the first and second authors of this manuscript, and the interview guide was modified from one interview to the next as needed in order to better clarify issues addressed or to add topics that were not originally included in the interview guide. Participant recruitment continued until theoretical saturation, which was based on knowledge gathered from all study components, was achieved.

2.5. An Academic Content Expert’s Workshop

Thirty-three individuals were approached by mail and invited to join an academic content’s expert workshop aimed at further discussing issues raised up to that point in the study process. Content expert invitees were asked to respond to an online Delphi survey inquiring about the importance of 74 traumatic stress characteristics, with the question ‘How important is this statement for the identification/characterization of traumatic stress associated with ongoing exposure to security threat?’ with regards to each of these items.

The academic content expert’s workshop was held in March 2016 with the participation of ten academic content’s experts, one of which was also interviewed. The project’s aims and progress were presented, followed by a discussion about the scientific process, the relevance of DSM-5 criteria for assessing traumatic stress in ongoing exposure to security threat, and the need for a new tool specifically designed for these situations. The 74 traumatic stress characteristics included in the Delphi survey were then addressed. Participants were asked to specifically attend to the importance of each items’ appearance in an instrument intended for assessing traumatic stress in ongoing exposure to security threat. Item phrasing and categorization were addressed as well, and changes were made as recommended.

2.6. The Second Focus Group

The second focus group discussion was held in April 2016, in the Educational Psychological Service Center in a city located in southern Israel. The population in southern Israel has been continuously exposed to missile attacks from 2001 to this day. The latest major military crisis took place in the summer of 2014. Focus group participants were therapists affiliated with the Israel Trauma Center for Victims of Terror and War. All were experienced in treating trauma victims and individuals exposed to ongoing security threat. The Educational Psychological Service Center director approached focus group participants asking for their approval to participate.

The group consisted of seven therapists (five psychologists, one social worker, and one social worker/psychotherapist), a researcher (the first author), and a research associate. In light of the emergent inappropriateness of the tools currently used for assessing the
traumatic stress consequences of ongoing exposure to security threat (based on knowledge gained from the literature and the study’s previous steps), the second focus group session was carried out to re-evaluate and to facilitate the interpretation of the project’s findings up to that point. The discussion was facilitated by the first author and addressed the traumatic stress characteristics associated with ongoing exposure to security threat, allowing therapists to present their own perspectives. Focus group participants were then asked to rate 48 traumatic stress characteristics for their relevance to ongoing exposure to security threat. The session lasted about 70 min, it was audio-recorded and transcribed, and memos were written by the participating research associate.

2.7. Ethical Considerations

The research protocol was approved by the university’s internal review board (IRB). Participation was voluntary. Interviewees and focus group participants were informed that by accepting to participate in the study, they were providing their verbal informed consent. All participant-identifying information was concealed to preserve anonymity and confidentiality throughout the study.

2.8. Data Analysis

The data were analyzed using thematic analysis [16] and consisted of the following phases: 1. Familiarizing with the data: Transcripts and memos from all interviews and focus group sessions were holistically read and reread by the first author. Transcripts from the first two interviews, as well as memos from the first focus group, were also read by the second author. The texts were reviewed in peer debriefing sessions while attending to the main emerging issues and to the modifications needed in the questionnaire for upcoming interviews. 2. Initial coding: The text was read, and meaning units (words or phrases) were identified and coded. 3. Generating broader themes: Codes were sorted and assembled into themes that were further reviewed and refined. 4. Categorization: Themes were arranged into categories, which were re-validated in later readings while constantly comparing the texts. The emerging categories were backed by quotations for descriptive immediacy. An audit trail ensured quotes were traceable to coded participants while ensuring confidentiality.

3. Results and Discussion

Three main themes emerged from data analysis: 1. PTSD, as defined in DSM-5, does not capture “the whole picture”, 2. Reservations regarding DSM-5 criteria applicability in ongoing exposure to security threat, and 3. A need for a new assessment tool or modification of commonly used tools. These themes with their categories are presented in the next section, supported by quotes.

3.1. PTSD Does Not Capture the Whole Picture

3.1.1. Is It PTSD?

Participants stated that the traumatic stress picture associated with ongoing exposure to security threat is not the typical PTSD but a syndrome that has not been defined yet. As such, it cannot be accurately assessed, diagnosed, or treated.

“And in the middle, between anxiety victims and PTSD, in the middle there are people that have some kind of a disorder that has no name yet. We know that it is ‘ongoing’ but what is it? Quantify it, explain the symptoms, explain exactly what it is” (participant 5).

“Chronic stress is a separate entity. Its psychopathological impact is unique and is not necessarily related to PTSD” (participant 3).

These participants exemplify what was common in the interviews and focus groups, i.e., participants clearly distinguished among different groups of trauma sufferers, while
ongoing exposure to security threat sufferers were perceived as a distinctive group in need of further delineation or definition.

3.1.2. Additional Traumatic Stress Characteristics

The traumatic stress symptoms seen in individuals exposed to ongoing trauma are different then those associated with a single or short traumatic experience. Ongoing exposure to trauma was described as associated with various traumatic stress characteristics, some of which are not integrated into any mental distress assessment tool and may be central to understanding the mental effects of ongoing exposure to security threat. Besides typical PTSD symptoms that may be present due to direct personal or security-related traumatic exposure, ongoing exposure to security threat is characterized by symptoms relating to fear or worries about the future (i.e., worries about the future, worries about the safety of family members and close friends or relatives, and worries about life in general), mental fatigue and physical weariness manifested as ‘sense of danger’, ‘mental exhaustion’, and ‘increased morbidity’, as illustrated below:

“Fatigue and over-vulnerability weaken the systems, all kinds of bodily systems. Various studies have examined these as part of a larger phenomenon relating to the appearance of all kinds of illnesses” (participant 4).

“There is very high arousal which is manifested as hyper-vigilance and is very tiresome. Arousal severely affects concentration . . . ” (participant 5).

“The most dangerous place in the country” (participant 5).

3.1.3. Relief in Symptoms

Traumatic stress symptoms associated with ongoing exposure to security threat may be relieved when the exposure to stress is discontinued (i.e., when moving out from the area under conflict or during calm times). The symptoms become less dominant, and people return to some level of routine and to normal function. This is not typical of (untreated) PTSD in which symptoms persist and are as dominant and distressing even when the source of danger no longer exists.

“As soon as there is peace, things calm down, people forget about it (war) and merge with the water and the desert landscape... It passes. Basic beliefs in someone who experienced a sexual assault or injury to body or soul are more protracted” (participant 2).

“Some of the traumatic stress symptoms become less dominant” (participant 2).

“When things calm down, people do not forget (about the war), but they do return to routine” (participant 6).

3.2. DSM-5 Criteria Applicability in Ongoing Exposure to Security Threat

According to the participants, DSM-5 criteria required for PTSD diagnosis are not entirely applicable to assessing the traumatic stress effects of ongoing exposure to security threat.

3.2.1. Single vs. Multiple Traumatic Events

PTSD criteria in the newly revised DSM-5 relate to single-event traumas and are not designed to capture the traumatic stress picture associated with ongoing exposure to trauma. As such, these criteria are not sensitive to the cumulative effect ongoing exposure to trauma may have on the individual. According to the participants, DSM-5’s diagnostic capabilities in ongoing exposure to a political and military conflict are limited.

“There is a problem in using a PTSD questionnaire in the first place since it refers to a single event... There are no so-called ‘life event questionnaires’. A 14-year-old kid who was born in Sderot... does not remember another situation, to which event will he refer?” (participant 1).
3.2.2. Criterion A

Israeli civilians throughout the country are subject to the threats of terror and are exposed to its consequences either directly (by victimization or acquaintance with victims) or indirectly through constant reminders, such as routine security checks, but mostly through intensive media coverage, which penetrates into the individual’s living room. As is the case with direct exposure, indirect exposure to catastrophic images is anxiety-provoking as it forces upon the individual confrontation with an existential threat. For individuals exposed to ongoing security threat, the effects of constant confrontation with an imminent threat are much more pronounced and may aggravate stress symptoms and traumatic stress symptoms risk.

Criterion A, as defined in the DSM-5 for PTSD diagnosis, may not be applicable in ongoing exposure to security threat as it requires ‘directly experiencing’, ‘witnessing in person’, or ‘learning that the traumatic event occurred to a close family member or close friend’. Under conditions of ongoing security threat, an atmosphere of danger and insecurity is shared by the whole community, not only those directly exposed.

“Objectively, it is there all the time, exposure to trauma is all around . . . ” (participant 1).

One other issue concerning criterion A is reflected in the following quote, which relates to the perception that communities or individuals exposed to a long period of security threat may gradually grow accustomed to it. Most individuals adjust to it, the initial alarmed responses decline, and exposure to trauma becomes the ‘normality’.

“Many people who have been living here [in the south] for eight years under missile fire will say: ‘No, no event occurred’ (i.e., I was not exposed to any security-related traumatic event) (participant 4).

3.2.3. Criterion B, C and E

Individuals exposed to ongoing security threat are mostly preoccupied with the fear and anxiety associated with potential injury or death due to a future traumatic event rather than with the memories and thoughts associated with a past traumatic experience. Thus, intrusion symptoms (criteria B), such as nightmares and flashbacks, are not as frequent among individuals exposed to ongoing security threat (and were not directly exposed to a traumatic event) as they may be among individuals directly exposed to trauma.

“They will not report experiencing a lot of nightmares or flashbacks either” (participant 4).

Participants stated that avoidance and arousal, typical PTSD symptoms, are reality-based precaution measures in ongoing exposure to trauma and may not necessarily be counted as a pathology. In addition, treatment directed at alleviating avoidance and arousal symptoms may be a challenge or not possible altogether in ongoing exposure to trauma.

“It is not thinking that reality is dangerous. Reality may indeed be objectively dangerous” (participant 1).

“It’s not avoidance, it is survival... and if avoidance is required, I cannot count it as pathology” (participant 1).

3.2.4. Criterion G

DSM-5 requires that the individual exposed to trauma experiences significant symptom-related distress or functional impairment (e.g., social, occupational). Participants argued that the effects of ongoing exposure to security threat do not necessarily translate to interference with everyday life or with work routine.

“If they [those who are exposed to ongoing security threat] answer the ‘regular’ PTSD questions, they will not meet criteria since they function, they get up in the morning, they go to work, but it severely effects their quality of life and wellbeing” (participant 5).
“People try to stick to normality, to the routine” (participant 4).

Indeed, individuals strive to ‘normality’ and try to adhere to some routine, as indicated by participant 5, however, ongoing exposure to security threat and traumatic stress symptoms eventually affect their overall quality of life and wellbeing.

3.2.5. A Need for a New or Modified Assessment Tool

Participants indicated that the tools currently used to assess PTSD are inappropriate for accurately assessing the traumatic stress consequences of ongoing exposure to security threat since they rely on DSM-5 diagnostic criteria. Participants expressed the need for new, standard, reliable diagnostic criteria, suggesting the development of a new questionnaire, a modification of existing tools, or simultaneous use of additional questionnaires in order to accurately diagnose and quantify the full range of traumatic stress symptoms associated with ongoing security threat.

“We need to develop a new questionnaire. But the development of new questionnaires should be based on the empirical and theoretical understanding of the phenomenon” (participant 3).

“I’m not sure whether a new questionnaire is needed, I simply don’t know. My inclination is in the direction of expanding the questionnaires used for assessing post trauma to include other elements related to ongoing traumatic stress” (participant 6).

All study participants but one supported the need for a new or modified questionnaire for assessing the traumatic stress symptoms associated with ongoing exposure to security threat.

“There is no need to develop a different diagnostic tool since these are diverse diagnoses anyway” (participant 2).

While acknowledging the difference in the traumatic symptomatology seen among individuals exposed to ongoing stress and those exposed to a single traumatic event, the need for a new or modified questionnaire was not supported by participant 2, who indicated that there is no need for a specific tool for every specific situation or circumstance.

“The questionnaires designed to diagnose PTSD are not different for males and for females even though PTSD is manifested completely differently between males and females. These are different phenomena” (participant 2).

Participant 2 further justified this by saying that currently used questionnaires allow space for the therapist’s experience and abilities to fill the gap in the diagnosis process.

Studies show that continuous or multiple exposure to stressors is associated with various mental and physical health consequences, some of which were brought up in the interviews and focus group sessions as typical consequences of ongoing exposure to security threat. These include: Reduced sense of safety [17–19], impaired personality traits [20–22], mental and physical exhaustion [6,23], distrust [6], feeling lack of control about the future [23], and increased morbidity [5,24–26] among others. According to Bleich et al. [17], over 60% of individuals exposed to ongoing security threat expressed a low sense of safety with respect to themselves or to their relatives. A low sense of safety was, in turn, implicated as a risk factor for post-traumatic symptomatology [27].

Under conditions of constant, unpredictable threat with no perceived ability to control or change the outcomes, mental health symptoms are more pronounced [23,28,29]. In addition, due to the ongoing nature of the exposure, the ability to overcome past stressful experiences may be postponed sometimes for months and even years at a time as stress symptoms associated with past traumatic events blend with a tangible fear of injury or death from future traumatic events. At times, combined with inefficient coping, ongoing exposure to security threat may eventually lead to a cumulative effect of stress and exhaustion [6,23].

Some of the traumatic stress characteristics associated with ongoing exposure to security threat parallel those assessed by the Disorders of Extreme Stress (DESNOS) diagnostic
criteria [30,31]. DESNOS criteria, however, are mostly designed to diagnose the traumatic stress symptoms associated with ongoing exposure of interpersonal nature (complex PTSD) and are, therefore, not suitable for assessing traumatic stress in ongoing exposure to security threat. Other prominent stress characteristics may be understood as manifestations of DSM-5 symptom assessed by PTSD criteria, while others (such as: ‘mental exhaustion’, ‘feeling lack of control about the future’ and ‘feeling of captivity’) are neither assessed by DSM-5 nor by DESNOS criteria.

Another issue raised in this study and supported by our findings is the notion that the traumatic stress symptoms associated with ongoing exposure to security threat subside when the individual is away from the source of danger and become dominant again upon the individuals’ return to the conflicted area [4]. Chronic PTSD symptoms do not fade away unless treated. These notions strengthen the thought conveyed in this study that the symptoms profile associated with ongoing exposure to security threat is not the ‘typical’ PTSD assessed by DSM-5 criteria but rather a different, more complex phenomenon [4,11].

According to Pat-Horenczyk et al. [32], greater exposure to security threat is associated with functional impairment while attempting to maintain routine activities at the same time. In accordance with these findings, participants in our study indicated that individuals exposed to ongoing security threat strive to maintain daily routine. Adherence to daily routine in the face of the stressful atmosphere around may be viewed as a coping mechanism, distracting attention from an unbearable stressful situation. Under conditions of ongoing exposure to security threat, the experience of trauma is a collective experience shared by an entire community. Individuals may be forced to comply with the community’s attempt to put up a face of ‘business as usual’, which may be needed in order to maintain the social frameworks and connections from which individuals derive strengths, support and an inner belief that the world is good [17,33]. In addition, as exposure to security threat is ongoing, sometimes for months and even years, absence from work may result in loss of income, a price individuals cannot afford to pay. The loss of resources (such as income and others) was implied as a risk factor for post-traumatic symptomatology [34–36].

3.3. Similarities and Differences between COVID-19 Pandemic Collective Trauma and Current Study Results

The emergence of COVID-19, with its rapid spread, has exacerbated anxiety in populations globally, leading to mental health disorders, such as depression, anxiety, and PTSD symptomatology [37,38]. Some studies suggested re-emergence of sleep disorders (insomnia and dreaming) in patients whose PTSD was previously in remission [39] or who were previously healthy [40]. In this respect, there are parallels to the current study: Both situations involve chronic stress not necessarily related to PTSD as described in Sections 3.1 and 3.2 above. Similarly, besides typical PTSD symptoms that may be present due to direct personal or family exposure to COVID19, the continuous nature of the pandemic results in ongoing exposure to threat. Symptoms described in the literature [37,38,40,41] may well be related to fear or worries about the future—the health of family members or financial implications of the situation. Our study reported that traumatic stress symptoms that are associated with ongoing exposure to security threat may be relieved when moving out from the area under conflict or during calm times. The parallel for COVID is whether in-between the waves and new variants of COVID there was a relief in anxiety symptoms and stress responses. This remains to be explored.

While initial studies were naturally cross-sectional (descriptive), more recent studies that take a longitudinal view are still inconclusive: A study in the U.S. suggests that the burden of depressive symptoms in the U.S. adult population increased over the course of the COVID-19 pandemic [42], while others [41,43] suggest habituation or return to normalcy after the quarantine was released. As data collection in this study was conducted before COVID-19 took over our lives in 2020, it is definitely intriguing to think of COVID-19 psychological effects as exposure to ongoing threat and we will indeed examine the applicability of the new tool [44] for the COVID-19 era.
3.4. Study Limitations

This study has several limitations. 1. We assessed the traumatic stress consequences of ongoing exposure to security threat from a therapists’ perspective, we have not included the point of view of trauma victims themselves. In addition, while invited to participate, none of the interviewers in this study were psychiatrists. 2. The results cannot be generalized due to the limited sample size, and 3. The proposed tool for PTSD assessment should take into consideration culturally sensitive idioms of distress, individual resilience, and community’s perspective and approach to tackle the stressful situation.

4. Conclusions

Our findings support the notion that initially motivated this study, namely that currently used PTSD assessment practices are lacking when assessing the traumatic stress consequences of ongoing exposure to security threat, emphasizing the need for a new tool specifically designed for these situations [11]. While clinicians involved in treating individuals exposed to ongoing security threat may be more responsive to the effect of such an exposure, this very responsiveness may leave much room for bias and subjectivity on the part of both the patient and the therapist. The use of standardized, reliable definitions for assessing traumatic stress reactions in these situations will allow for a more accurate diagnosis and more effective treatment protocols.

One of the primary therapeutic tasks with trauma patients is the restoration of safety and sense of security. An important component in the treatment of PTSD patients is the confrontation with traumatic memories and avoidance symptoms. As the source of threat is still present under conditions of ongoing exposure to security threat, safety restoration may be unattainable. Stress symptoms, which stem from the anticipation of unpredictable traumatic events, are likely to linger, potentially leading to the development of traumatic stress reactions. Treatment protocols should be modified when treating patients exposed to ongoing stress keeping in mind that the source of trauma is traced in the past but also in the present and in the future [4,6] and should address risk and safety issues.

This study contributes to the overall understanding of the traumatic picture associated with ongoing exposure to security threat by addressing the complex consequences of such exposure from various angles. Our findings further emphasize the importance of investigating the impact of exposure to ongoing security threat beyond PTSD. Comparative studies may be helpful in delineating universal criteria for PTSD due to ongoing exposure to security threat. Further elaborating on these issues has global implications.

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