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# Adverse Outcome of Continuous Traumatic Stress: A Qualitative Inquiry

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*Fifteen mothers living in Sderot, a small blue-collar town located 1 mile east of the Israel–Gaza border, all diagnosed as suffering from Post-Traumatic Stress Disorder (PTSD), were interviewed about their experiences under the continuous threat of rocket attacks. Respondents described civilian life in a battlefield environment, an experience defined as Continuous Traumatic Stress (CTS). Reported reactions to CTS included (a) changes in arousal and reactivity, (b) negative alterations in cognitions and mood, and (c) radical avoidance. However, unlike PTSD, the reports did not include any intrusive symptoms of flashbacks and nightmares, which was further validated using a methodological triangulation procedure. Suggestions for stress management and clinical intervention in communities affected by CTS are presented.*

**Keywords:** cognitive behavior therapy, Israel (Sderot), PTSD

Existing criteria in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5*; American Psychological Association, 2013) for the identification of triggers of trauma and stress-related disorders exclusively focus on past events (i.e., *The person was exposed to . . .*). However, current diagnostic classifications are remiss in addressing human reactions to ongoing traumatic stress. Indeed, one fundamental question concerns whether individuals exposed to ongoing traumatic stress develop a

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pattern of symptoms identical to or distinct from those presented in posttraumatic stress disorder (PTSD). One source of confusion in this regard relates to the difficulty in differentiating normal and abnormal distress under ongoing exposure to potentially traumatizing conditions. Hence, if we wish to achieve a better understanding of psychological distress under conditions of Continuous Traumatic Stress (CTS), it is important to study the unique perspectives of those exposed to it.

It has been suggested that human reactions to ongoing traumatic stress involve symptoms such as avoidance and hyper-arousal, without triggers from any direct traumatic experience, reactions which appear to be “adaptive responses to abnormal, dangerous conditions” (Diamond, Lipsitz, Fajerman, & Rozenblat, 2010, p. 20). Although the concept of Continuous Traumatic Stress (CTS, Straker & the Sanctuaries Counseling Team, 1987) has recently been the subject of scholarly discussion (e.g., Stevens, Eagle, Kaminer, & Higson-Smith, 2013), we are still far from fully understanding its psychological outcome. Rather than measuring presumed posttraumatic variables among individuals exposed to CTS, we decided to use an inductive exploratory method to achieve a first-hand understanding of how people think, feel, and behave under such unique, adverse conditions. We hope that this qualitative inquiry will shed further light on the nature of CTS-related symptomatology and will help improve our understanding of the psychopathogenic processes and clinical needs of individuals traumatized by CTS.

### **SDEROT AS A CASE STUDY OF CTS**

Sderot, a blue-collar town with a population of around 24,000 residents located about one mile east of the Israel–Gaza border, presents a perfect opportunity to study CTS. Since the year 2000, Palestinian militants from the Gaza Strip have continuously bombarded the town with mortar shells and rockets. At the peak of the violence in 2008, an average of 50 explosive heads had detonated in Sderot every day. In 2004, a computerized antirocket alarm system called Tzeva-Adom (Code Red) was installed in the town, providing civilians with a 10- to 15-second warning before rockets fired from adjacent Gaza would hit the town. Although it generally provides accurate warnings, the system is not full-proof and there have been both occasional misses and false alarms. Adding to the citizens’ sense of ongoing stress is the fact that a considerable number of private residences are not equipped with secure fortified spaces (safe rooms), forcing many inhabitants to take cover in improvised spaces within seconds of the alarm signal being sounded. The data for this study were collected in 2013. However, during the summer of 2014, as the writing of this article neared completion, another round of fierce

hostilities erupted in the area, making the results of this study evermore pertinent for residents of Sderot and Gaza alike.

## AIMS AND GOALS

In this study we strived to collect detailed personal accounts of life in an environment of extreme and persistent danger, to study firsthand data on the characteristics of duress associated with CTS. Because women are more sensitive to traumatic stress than men (Breslau & Anthony, 2007; Sever, Somer, Ruvio, & Soref, 2008), this subgroup serves as a good source of information on the nature of distress and dysfunction associated with CTS. It is hoped that a qualitative inquiry will shed light on CTS symptom development and will help improve early identification of those most at risk. To the best of our knowledge, this is the first study to document life experiences under CTS by means of a qualitative analysis of testimonies provided by traumatized individuals.

## METHOD

### Procedure

Forty female residents of Sderot, all members of One Family, a nonprofit organization that offers support to traumatized victims of terrorism, were invited to take part in the research. Of these, 33 (82.5%) agreed to participate and completed a number of questionnaires to appraise their psychological state. These included the following:

#### *The PTSD Check List–Civilian*

The PTSD Check List–Civilian (PCL-C) is a standardized, self-report rating scale for PTSD consisting of 17 items that correspond to the key symptoms of PTSD (Weathers, Litz, Herman, Huska, & Keane, 1993). Total possible scores range from 17 to 85. The suggested PCL cutoff point score for PTSD appropriate for Veteran Administration clinics or civilian specialty mental health clinics is 45 (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996).

### *The Dissociative Experiences Scale*

The Dissociative Experiences Scale (DES) is a psychological self-assessment questionnaire that measures dissociative symptoms (Carlson et al., 1993). The overall DES score is obtained by adding up the 28 item scores and dividing them by 28. The overall scores range from 0 to 100. A score of 30 is regarded by clinicians as the cutoff point for the pathological range of dissociation.

### *The Generalized Anxiety Disorder 7-item Scale*

The Generalized Anxiety Disorder 7-item Scale (GAD-7) is a screening tool for anxiety. The GAD-7 total score ranges from 0 to 21. Scores of 10 and 15 represent cutoff points for moderate and severe anxiety respectively (Spitzer, Kroenke, Williams, & Löwe, 2006, p. 1092).

### *The Patient Health Questionnaire*

The Patient Health Questionnaire (MDD-PHQ-9) is the nine-item depression scale of the Patient Health Questionnaire. It is based directly on the diagnostic criteria for major depressive disorders in the *Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR*; American Psychiatric Association, 2000). The total PHQ-9 score ranges from 0 to 27. Scores of 10, 15, and 20 represent cutoff points for moderate, moderately severe, and severe depression, respectively (Lamers et al., 2008, p. 679).

Eighteen respondents scoring 45 and above on the PCL (indicating probable PTSD) were contacted. Of these, 15 (83%) agreed to take part in our qualitative study.

## **Participants**

Fifteen women (aged 36–79), all residents of Sderot, all married with children, and all acknowledged by the Israel National Insurance Institute as experiencing PTSD were interviewed. Eight (53%) of the interviewees were gainfully employed. All had been directly exposed to at least one life-threatening rocket attack (e.g., within range of flying shrapnel) and five (33%) had personally experienced more than one potentially lethal attack. Four respondents (27%) had been physically injured during one of the

attacks. All participants obtained elevated scores on the PCL-C that were above the cutoff marker for pathological posttraumatic distress. Eleven (61%) reported anxiety levels that were moderate or higher, 11 (61%) reported depression levels that were moderate or higher, and two (13%) exhibited pathological levels of dissociation (for specific information see the Appendix).

## Interviews

To maximize our respondents' comfort and achieve optimal understanding of the CTS experience and its consequences, we conducted open and flexible interviews (Fontana & Frey, 2000; Shkedi, 2003). The interviews took place in the women's own homes and followed the phenomenological (Creswell, 2007) and narrative (Clandinin & Huber, 2010) traditions of inquiry, seeking to draw out free accounts of the individuals' experiences and perceptions from their own subjective perspectives. Participants were asked to describe their experience of daily life under ongoing traumatic stress, as well as the associated feelings and sensations, and to tell their stories in a detailed and free narrative. Essentially, the chosen research method did not use an interview guide; the interviewer asked only for clarifications, never posing leading questions.

## Data Analysis

The interviews were transcribed verbatim and analyzed according to principles of thematic organization in narrative analysis (e.g., Labov, 2006) and grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1994), reflecting our commitment to remain as close as possible to the data. We set no analysis categories at the outset of our research. Instead, the categories arose from the field of research itself (Charmaz, 1995, 2000). To achieve "trustworthiness," the qualitative research equivalent of reliability and validity (Guba & Lincoln, 1981), the interviewer in this study (Y.A.) undertook prolonged engagement and persistent observation of all respondents, a process that yielded rich reflections and descriptions. To assure credibility and confirmability, the first author (E.S.) reviewed the gathered data and debriefed Y.A. to flesh out any inconsistencies or ambiguities (Lincoln & Guba, 1985). After Y.A. reviewed and checked the challenged data, remaining discrepancies were resolved by consensus, after discussion between the authors.

## RESULTS

Although respondents' free narratives unveiled the expected traumatic fear conditioning responses, the overall phenomenological picture was unique. Five main themes emerged from their accounts: (a) Fear conditioning of the warning alarm; (b) a constant state of hyper-vigilance; (c) ultimate avoidance—when the home is no longer a castle; (d) Avoidance by proxy—maternal anxiety under conditions of CTS; and (e) estrangement and social constriction. Conspicuously missing from the free CTS narratives were descriptions of intrusive symptoms.

### Fear Conditioning of the Warning Alarm

Most of our respondents described the familiar process of aversive learning, whereby the repeated combination of the warning siren and an incoming explosion led to a classical conditioning to fear the warning sound itself. As a result, our respondents appeared unable to regard the alarms adaptively as prompts for instrumental coping behaviors, but rather reacted to them as if they were the unconditioned stimuli—the attacks themselves. Here are some typical illustrations: *I can't even hear the beginning of the warning siren. It goes straight into my veins, it goes into my body, I can't bear it. It's the end of the world* says P1. CTS provided no opportunity for habituation; on the contrary, reported peri-traumatic reactions presented as total coping insufficiency, resulting in a sense of nihilistic doom. Furthermore, coping ineffectiveness seemed to have led to increasing levels of distress in response to every additional alarm:

That fear is stronger than it once was. Before, I would hear the warning siren; I would go downstairs calmly, carefully, aware of what I am doing. Today, you hear the siren . . . and you're out of control. You just start crying. You lose yourself, you're hysterical. It's terrible, that knowledge that the siren will go off and you'll collapse (P2).

The repeated pairings of warning alarms and explosions led to such a powerful conditioning process that our respondents could no longer differentiate between the two stimuli. Indeed, this phenomenon stands at the core of the CTS symptomatology reported by our respondents: the threats they were reacting to were actually the alarm sounds, not the explosions.

The women interviewed described an ever increasing sensitizing process (Dykman, Ackerman, & Newton, 1997), whereby additional antecedents to the alarm/explosion stimulus acquired threatening properties. For example, animals seemed to perceive the faint sounds of outgoing projectiles or their movement through the air even before the computerized alarms went off. The

following examples describe the chain of sensitizing fear conditioning under conditions of CTS: dog barks and bird flights→alarm→explosions.

The dogs must hear something before we do and they start barking . . . so every time a dog barks it makes me hysterical and every bird in the sky (because they feel it even before the dogs) means hysteria . . . it's an impossible cycle that never ends, you start paying attention to the movement of the ants on the floor, maybe they feel something before I do (P3).

Since barking dogs and flying birds are common occurrences in any town, these generalized conditioned stimuli add to the feeling of constant threat under CTS. As the number of "warning signs" increases, the capacity for effective coping decreases. This may explain, at least in part, why many of the women interviewed in this study lost their ability to assess the real level of threat, resulting in an ongoing and exhausting series of panic-inducing false alarms.

For some of these women, the only open escape route from the ever-growing stress seemed to be a dissociative trance: "Every time there's a warning siren it all comes back to me. And then there's the same scenario of freezing up and fainting" (P1). This respondent described being hit repeatedly by a physio-cognitive shutdown in the form of dissociative freezing. She identified this reflexive response pattern as typical, stating that everything tended to "come back to her" as soon as the sirens went off in reference to her automated fear reaction. The CTS environment seems to have become an inescapable trap, resulting in constant hyper-vigilance which is followed by either hyper- or severe hypo-arousal.

### **A Constant State of Hyper-Vigilance**

Most of our respondents described life under conditions of CTS as an unrelenting state of preparedness. Some seemed troubled by apocalyptic scenarios that consumed their cognitive resources:

I'm sitting in the garden and immediately I start thinking that maybe a rocket will land on me now. Maybe something has happened to my son. Maybe something has happened to my grandson. All kinds of worries, I can't relax . . . it's impossible to relax, to sleep, to concentrate. It's impossible to think about anything apart from where or on whom the next rocket will land. I'm preoccupied with this day and night (P3).

This sense of hyper-vigilance is expressed in the need to be ready around the clock. Most women described the physical toll of maintaining a constant state of alert, expressed primarily in sleep disturbance and fatigue: "You don't sleep, all the time you're ready and waiting" (P1).

Following are typical descriptions of our respondents' relationship with their CTS environment: "I'm afraid to walk down the street . . . Where can

you hide? – That thought is in your head all the time . . . what are 15 seconds? It has no meaning for me, it's just an announcement: 'a rocket is going to fall on you . . . you're going to die' . . . that's it" (P10). According to P4, Sderot is a war-zone: "In reality you're going from shelter to shelter, you are always looking ahead and then quickly moving on to a (relatively) safe area. But in reality nowhere is really safe. You walk down the street and you're terrified" (P4). P5 agrees with this assessment: "The street is a warzone, an area of uncertainty, you simply run from one cover to the next. If I don't really have to, then I don't leave the house" (P5).

In sum, for the traumatized women living in Sderot, leaving the relative safety of their homes was an experience akin to stepping into a war-zone. Yet, as we shall see shortly, some of these women could not feel safe even inside their own homes.

### **The Ultimate Avoidance—When the Home Is No Longer a Castle**

In contrast to most agoraphobic individuals, who can find a sense of safety and comfort within the confines of their own homes, our terrified interviewees could not perceive their homes as safe because they were located in a dangerous war-zone environment. Some women were compelled to create a perimeter of avoidance within their very own homes. For example, certain participants prohibited their children from going up to the top floor of their homes and even avoided going there themselves: "I wouldn't let anyone go upstairs—it's dangerous there. They'll die on me. I myself haven't been up there since then" (P6). Y. adds that "the upstairs became a museum, simply a museum" (P7).

For those whose homes were damaged during one of the bombings, restoring a sense of safety within their house was impossible. For some, even the lower floors no longer seemed secure enough, forcing them to conduct their lives in the space offered by their three-square-meter fortified safe rooms.

The implications of feeling unsafe in one's own home are radical. P2's typical account describes how taking a shower became almost impossible due to her unremitting anticipation of a rocket attack, along with her fear of utter vulnerability and total exposure (while wet and naked): "I've stopped showering at home, I go to my mother's house (in a safer area) to shower, or take really, really quick showers with my husband waiting for me outside" (P2).

Living under the threat of unpredictable daily attacks forced the participants in this study to avoid most areas within their homes and the outdoors, confining themselves to the tiny premises of the safe room. Yet, for the few whose homes had been hit, even the safe room provided no comfort: "I



couldn't stay in that house, everything reminded me, it was just too much—the house itself was like the memory of the trauma and to be in it was to experience everything again and again" (P1).

Under the CTS conditions in Sderot, radical avoidance became a normal reaction to the omni-dangerous environment. An occasional outcome of this withdrawal was social isolation; by closing themselves off in their safe rooms some women cut themselves off their partners and social support networks. P6 is a case in point: "For two years my husband slept on a mattress here with me . . . But afterward he said he couldn't do it anymore, enough! He would go upstairs to sleep in our bed. I said to him 'you can go up, do whatever you want, I'm staying.'"

### **Avoidance by Proxy—Maternal Anxiety Under Conditions of CTS**

The women interviewed in this study were all mothers; the uncontrollable need to look after their offspring motivated them to enforce restrictions on their children's movements and confine them to safe-zones:

All the time when they're at home, the children are with me—I don't let them move. They sit with me at home inside the safe room . . . For five years I've been living here in the safe room. For five years I've been on my own, own, own. I and my children, sleeping in here (P6).

P8 added that not only did she feel the need to be constantly ready physically, she was also preoccupied with knowing where her children are at each and every moment of the day: "The general feeling with all the tension is that you must always be ready for anything. I always have to know where my children are" (P8).

P6's remarks are noteworthy; despite being fully aware of the consequences of her actions she simply could not help herself:

I shut my children up in the secure room with me because I'm so afraid. Even now I'm not living and I'm also killing them. They don't enjoy themselves, they're not living, they don't have a mother, only fear. But this is simply my only option, we don't have a chance of getting out of this city (P6).

Radical and sad as it may seem, P6's situation is indicative of the serious problems facing mothers living under CTS. Participants in this study believed that they were failing mothers since in spite of their efforts, they could not guarantee the safety of their offspring. Yet at the same time, as a result of their obsession with the need to protect their young, many became unable to fulfill their children's basic need for a mother who constitutes a stable emotional resource during a period of ongoing turmoil.

## Estrangement and Social Constriction

Some respondents described themselves as emotionally spent, an experience they labeled as death. For example: "I may be young in body, but my spirit has been through a lot. I don't enjoy myself. Not at all. I don't enjoy life whatsoever. My children don't enjoy themselves enough. I'm not a living person, I'm dead" (P6). Indeed, these women avoid the outside world and at the same time have also become increasingly disconnected from their own families, including their supportive but often burned-out partners. P2, for instance, gave the following description: "There were times that he understood, but there were also times when he had had enough already, I understand him — how much can he take?" (P2). Other women noted that they had lost the ability to touch or be touched intimately: "I have no sexual desire, I see only darkness. I don't go near him, I can't touch him, it's like I'm closed off within myself" (P2). P6 feels the same: "For five years we haven't had sex. Nothing" (P6). These women described an emotional constriction akin to dying because being touched is often considered a precondition for feeling alive (Husserl, 1989).

P2 reported feeling like a stranger to her own family: "It's like your daughter suddenly became a stranger. Your family is alien to you" (P2). P6 added that her family "is falling apart" (P6), while P9 felt she could not even talk to her friends: "I'm not in contact with my friends from before anymore . . . I just can't talk to them, only someone who has been damaged can understand me . . . I don't see people, I don't meet with friends. I don't share things with anyone" (P9). Yet, at the same time, P9 is desperate for help and understanding: "I'm not ready to take help from anyone, and I don't want anyone to pity me. And the truth is that in my heart I need support. I feel miserable" (P9).

It seems that as a result of CTS, these women closed themselves off, even to their own families; they became avoidant both physically and emotionally, strangers to their own children. They were crying out for help, yet were not open to receiving any support, expressing an understanding of their partners' exasperation with them.

## DISCUSSION

### The CTS Environment

CTS in Sderot constitutes an example unique in its psychological toxicity. At least two essential factors characterize the trauma of our interviewees:

*The sensitizing effect*

Through classical conditioning, the 15-s warnings provided by the advanced Code Red alert system installed in Sderot developed into a conditioned source of threat rather than a reassuring prompt to seek safety. Thirteen thousand warning alarms followed by immediate explosions tainted the alerts provided by the alarm sounds, turning them into inescapable threat cues. Our respondents reported that the alarms became not only signals of impending instantaneous danger, but also evolved into triggers of conditioned fear responses. Many of the women we interviewed could not react adaptively to the alarms, and some responded by completely freezing and collapsing.

*Battlefield ecology*

There is not a single street in Sderot that has not been bombed, there is not a single person who has not been exposed to CTS or who has not known someone who was injured. With no refuge or respite, Sderot became a scarred town, with every street corner and fellow citizen potentially triggering fear. For the citizens of Sderot, the home was no longer a castle.

**CTS Syndrome**

The data accumulated during this qualitative study demonstrate that the psychological outcomes of severe CTS resemble but do not correspond exactly with the criteria for PTSD listed in *DSM-5* (American Psychological Association, 2013). Straker (2013) has suggested that the term syndrome is more appropriate in describing the distress associated with CTS (CTSS) because “the term disorder gives more weight to individual vulnerability and less weight to context” (p. 211).

Our interviewees spontaneously recounted symptoms that could clearly be classified into only three of the four clusters necessary for the diagnosis of PTSD. The fourth cluster of symptoms was conspicuously absent from their narratives:

*Changes in arousal and reactivity*

Virtually all respondents talked about heightened physiological arousal characterized by intense, magnified, and perpetual hyper-vigilance, insomnia,

and fatigue. As a result, many of the participants constantly monitored their environments for omens and signs of incoming rockets, expressed profound dread of the rocket alarm sounds that had become independent powerful foci of anxiety, and responded to mild omens of an imminent alarm/rocket explosion (e.g., a flock of birds taking off) by frantically seeking cover.

### *Negative alterations in cognitions and mood*

The inescapability and uncontrollability of the deadly attacks left most respondents in a state of fear and horror, compromising their ability to assess their unstable environments accurately. The women were in a perennial emergency state of mind, unable to maintain a normalized routine, particularly for their children. Several of the mothers interviewed limited their children's movements and activities, disregarding the potential psychological costs of this behavior for their children. The women's defensive constriction included their own emotions. Some respondents talked about their inability to share feelings and to tolerate intimacy with close family members, thus depriving themselves of potential social support and rendering them sad and lonely.

### *Radical avoidance*

Our respondents displayed constant narrowing of their safety zones, resulting, in many cases, in self-imposed confinement to their fortified safe rooms, even avoiding those sections of their own homes perceived to be less secure.

A representative interviewee in this study had a previous diagnosis of chronic PTSD, obtained scores in the pathological range on the civilian version of the PTSD Check List (PCL-C), and was likely to experience elevated levels of anxiety and depression. Yet in opposition to common findings among individuals with PTSD, these severely traumatized women were simultaneously both peritraumatic and posttraumatic. Not only did their clinical syndrome represent a failure to metabolize adverse recent experiences, it also reflected their current horror under existing mortal threat. The clinical syndrome that emerged from the analyzed narratives is characterized by immediate nihilistic fears, hyper-vigilance, and behavioral and emotional constriction.

However, unlike individuals with classical PTSD, respondents presenting with CTSS offered no descriptions of intrusive symptoms of flashbacks and nightmares, previously proposed as pathognomonic to PTSD (Brewin et

al., 2009). In other words, what was missing from the spontaneous clinical picture presented by participants in this study was the psychological focus on traumatizing events from the past. They were not controlled by their pasts (in terms of flashbacks, e.g.) but rather totally preoccupied with their immediate survival-related fears. Arguably, we had not conducted clinician-administered assessments of PTSD and avoided active probing for symptoms. Nevertheless, our respondents spontaneously provided rich accounts of a variety of posttraumatic symptoms, but none describing signs of intrusion. To establish the validity of this finding, we applied a methodological triangulation procedure (e.g., Creswell & Miller, 2000) and examined participant response patterns on the PCL-C. We treated all responses rated 4 or 5 (*Quite a bit* and *Extremely*) as clinically significant. When counting the number of respondents endorsing symptoms as clinically significant, we observed an apparent difference across PTSD symptom clusters. For example, items describing arousal/reactivity and sleep problems were endorsed by 15 (100%) and 14 respondents (93%), respectively. Items describing avoidance of traumatically related situations and thoughts were endorsed by 12 (80%) and 10 (67%) respondents, respectively, whereas items describing intrusion of traumatic dreams and physical reactions in response to trauma reminders were endorsed only by 5 (33%) each. This means that intrusion symptoms were considerably less salient to our respondents, who tended not to report them spontaneously when asked to describe their psychological experience. Even when asked directly whether explicitly described PTSD signs had been experienced, intrusion symptoms were the least endorsed.

Moreover, even the avoidance symptoms reported in this study were not associated with a reluctance to experience a physio-emotional reaction to past events, but rather with the drive to avoid imminent harm. In line with previous conceptualizations (Diamond et al., 2010) and quantitative data (Lahad & Leykin, 2010) on CTS in Sderot, our qualitative results substantiate a conclusion that CTS psychopathology is characterized by anxious preoccupation not with memories but rather with safety.

Our findings also suggest that mothers raising children under conditions of continuous traumatic stress may be particularly vulnerable to incapacitating CTS symptoms, supporting the claim that an elevated allostatic stress load may increase the risk of psychological injury to exposed individuals (McEwen, 1998).

### Conceptual Implications

The ability to differentiate traumatic stress responses from posttraumatic psychopathology is an unresolved dilemma. When individuals are constantly

exposed to a chain of multiple of stressors over a prolonged period of time, it is impossible to ascertain which symptoms are peritraumatic and which are posttraumatic. By contrast, a key factor in the diagnosis of traumatic stress disorders is the amount of time that has elapsed since the exposure to trauma. Indeed, according to the *DSM-5* (American Psychiatric Association, 2013), at least three days must have passed since the exposure to a traumatic stressor before stress reactions can be labeled as acute stress disorder (ASD), allowing treatment to begin. Special diagnostic and interventional challenges arise as a result of exposure to CTS for a month or more since the individuals meet temporal diagnostic requirements for acute stress reaction (the untreated “normal” response occurring within the first three days after exposure), acute stress disorder (occurring three days to one month after exposure), and posttraumatic stress disorder (diagnosed when symptoms persist for more than one month after exposure; see American Psychiatric Association, 2013).

In accordance with arguments raised by Eagle and Kaminer (2013), we propose that the main challenge for clinicians working with traumatized individuals under CTS is how to distinguish accurate and adaptive appraisals of expected dangers from pathological exaggerations of future threats. The *DSM-5* (American Psychiatric Association, 2013) refrained from pathologizing stress-related symptoms presented in the first three days following exposure, reflecting a consensus that no diagnosis is warranted and no treatment should be suggested under these circumstances because symptoms are expected to wane once the stressful event is over. Yet for individuals living under ongoing traumatic stress, who also experience trauma-related psychopathology, the stressful event never ends. Rather it is recurring and continuous. CTS-related psychopathology, therefore, reflects distress that is at once peritraumatic, acutely traumatic, and posttraumatic; a combination of Acute Stress Reaction, Acute Stress Disorder, and PTSD. For these individuals, the experience is one of utter vulnerability to a lethal threat combined with a psychological shattering of their basic assumptions regarding a safe, meaningful, and predictable world (Janoff-Bulman, 1992).

## Clinical Implications

### *Remote treatment locale*

Psychological first-aid principles in military psychiatry call for simple professional interventions with an expressed expectancy for normal functioning, delivered as soon as possible after exposure and in proximity to the trauma scene (Solomon, Shklar, & Mikulincer, 2005). We maintain that interventions with individuals experiencing CTS cannot be effectively deliv-

ered in proximity to the trauma scene. Hence, we propose that such individuals should be temporarily removed from their environment (together with their dependent children and immediate support system), rather than be treated on site. It is conceivable that for some individuals with CTS disorder who suffer primarily from hyper-arousal and avoidance but do not exhibit intrusive symptoms, as described in this study, their very removal from the “killing field” will result in immediate amelioration of symptoms. Because the circumstances of CTS are often communal, many of the interventions offered in such a makeshift remote treatment center can be community-oriented or group-based. Coping skills that can be efficiently taught in group formats also have the advantage of preserving the community fabric.

### *Arousal regulation*

To help control proprioceptive overstimulation and hyper-arousal, we recommend the utilization of mindfulness and acceptance-based interventions (e.g., Rogers & Maytan, 2012). Similar techniques were implemented in Sderot during the same period of hostilities (Diamond, Lipsitz, & Hoffman, 2013).

### *Cognitive restructuring*

Setting the rationale and motivation for compliance with the suggested treatment protocol can be achieved by means of psycho-education concerning the etiological processes that cause and maintain CTS distress. Information-processing-based psychotherapy may be relevant in addressing altered cognitions and resultant emotion and avoidance behavior (e.g., Cognitive Processing Therapy; Resick, Monson, & Chard, 2007).

### *Reclamation of lost domains*

Radical avoidance of the environment under CTS can be extremely debilitating. Many individuals suffering from CTS disorder would probably benefit from a gradual exposure program that could start with imagined involvement implemented at the remote treatment site and proceed to gradual prolonged in vivo exposures (Foa, Hembree, & Rothbaum, 2007).

### *Dyadic mother–child interventions*

The motherhood role appeared to exacerbate the accumulated distress among some Sderot women, resulting in compromised parenting and potential aggravation of distress for both mother and child. Not only do our findings offer phenomenological support for comparative data gathered in Sderot during the same period (Pat-Horenczyk et al., 2013), but they also justify dyadic interventions aimed at restoring maternal calming and modeling function and children's emotional equilibrium.

### **Limitations and Future Directions**

We acknowledge two main limitations of this study. First, although our phenomenological data provided rich primary information that goes beyond statistical data in deepening our understanding of CTS, our results should be regarded as unique to the investigated group, and it may not be possible to make general applications to other settings. Second, although this study adopted an accepted qualitative research method, it was still based on spontaneous narratives from a relatively small sample of a distinct population. Interviewing men, youth, and a nonclinical sample in future studies which also employ active probing for PTSD symptoms will widen sampling diversity and enhance the possibilities for the more general application of the results.

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(Appendix follows)

Appendix  
*Characteristics of the Respondents in the Current Study*

ID	Age	PCL	No. of traumatic exposures	Most severe traumatic exposure	Injury (Yes/No)
E	47	53	4	A rocket landed approximately one meter from her. It did not explode (outdoors).	N
C	36	80	1	A rocket landed on her sleeping baby's bedroom while she was out. The baby was not injured.	N
Z	70	59	1	A rocket landed on her bedroom while she was sleeping.	N
B	42	62	2	A rocket landed in the yard where her children were playing at the time.	N
O	55	54	4	A rocket landed on her car during a journey (she had left the car upon hearing the warning siren).	N
D	61	54	6	A rocket landed on her home while she was outside. Her children were at home at the time.	N
R	71	81	1	A rocket landed close to her home.	N
A	43	63	1	A rocket landed on her home, directly over the room where she was sleeping.	Y (minor)
T	41	82	3	Three rockets landed near her on the same day, and during each of these incidents she was outdoors, without any shelter.	N
L	45	68	1	A rocket landed close to her while she was outdoors without any possibility of taking cover.	Y (minor)
H	41	58	1	A rocket landed in her yard, critically wounding another person.	N
Y	52	61	1	She fell down the stairs running to the reinforced room with her children upon hearing the warning siren.	Y (minor)
G	35	72	1	A rocket landed on the room where she and her two children were at the time.	Y (severe)
V	39	64	3	A rocket landed in an open area – 40 meters from her.	N
N	43	57	1	A rocket landed close to her home.	N

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