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Continuous Traumatic Situations in the Face of Ongoing Political Violence: The Relationship Between CTS and PTSD

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Abstract

This article presents a literature review of the concept of continuous traumatic situations (CTS), which relates to residents living in ongoing situations of political violence and national security threats. The first aim of this review is to narrow the gap regarding knowledge about the concept of CTS by presenting findings from studies that have assessed the effects of CTS on civilian populations. The second aim is to describe CTS in a way that highlights the differences and similarities between posttraumatic stress disorder and responses to CTS. This distinction is a necessary precondition for examining CTS, as is a careful clinical analysis of the development and course of symptoms. This literature review also highlights the importance of adopting a supplementary perspective for understanding the psychological impact of ongoing exposure to real threats, which can be used as a basis for developing intervention strategies that are appropriate for coping with life in the context of persistent violence. CTS can be manifested as emotions, behaviors, and perceptions among individuals, families, communities, and societies. The nature of the proposed model of CTS is a circular one, combining past and future perceptions and emotional reactions that have resulted from continuous and repeated traumatic experiences over an extended period of time. This wider understanding reflects the complexity of the CTS phenomenon. Various micro and macro interventions relating to CTS as the result of political violence situations and national security threats are presented, and recommendations for practice, policy, and future research are offered.

Keywords

continuous threat, ongoing traumatic stress response (OTSR), prolonged chronic stress situations, posttraumatic stress, terror, war

Introduction

Studies have indicated that both direct and indirect exposure to political violence such as war and terror attacks have a profound psychological impact on civilian populations (Brewin et al., 2008; Galea et al., 2002). Some civilian populations experience intense exposure to these events, lasting days, weeks, and months. For example, after the bombing of the Alfred P. Murrah Federal Building in Oklahoma City in 1995, residents of the area were at higher risk for developing posttraumatic symptoms (Tucker, Pfefferbaum, Nixon, & Dickson, 2000). Similar findings were revealed in studies conducted among residents of New York City after the September 11 attacks (Galea et al., 2002, 2003; Silver, Holman, McIntosh, Poulin, & Gil-Rivas, 2002) and among residents in many parts of Israel after ongoing, massive rocket attacks in all parts of the country (Lahad & Leykin, 2010).

Usually, the length of time between attacks lasts from a few months to several years. However, some populations experience acute and constant stress due to their exposure to ongoing perpetual attacks. These situations can lead to a variety of adverse responses, including emotional distress and psychiatric disorders such as depression and posttraumatic stress disorder (PTSD), which is considered the most prevailing long-term psychopathological consequence of such distress (Bleich, Gelkopf, & Solomon, 2003).

However, with regard to chronic stress due to ongoing, perpetual exposure to war and terror attacks, it has been recognized that existing conceptualizations of traumatic stress, such as PTSD and complex PTSD, may have limited utility in a reality of ongoing threat and danger (Stevens, Eagle, Kaminer, & Higson-Smith, 2013). This limitation is due to the notion that trauma exposure is temporally located in the past. As such, it fails to adequately capture the daily experiences of trauma or the realistic expectations of ongoing threat and danger, which

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are often combined with an absence of safe spaces in which to find protection and experience recovery (Hobfoll et al., 2009; Kimhi, Eshel, Zysberg, & Hantman, 2010; Stevens et al., 2013). Thus, supplementary frameworks are needed to understand the psychological impact of living with ongoing exposure to danger, as well as appropriate intervention strategies for coping with life in a reality of persistent violence.

As in every case of exposure to a traumatic event, pathological or salutogenic responses depend on the individual's personal and environmental resources, as well as on coping mechanisms. Although attention has been paid to the impact of repeated terrorist attacks and continuous threat on these responses (Gelkopf, Solomon, & Bleich, 2013), few studies have examined the concept of continuous traumatic situations (henceforth CTS).

Consequently, the first aim of this article is to define CTS and to distinguish it from other traumatic experiences. An additional aim is to enhance the understanding of the differences and similarities between PTSD and other responses to CTS. This distinction is a necessary precondition for examining responses to CTS, as is a careful clinical analysis of the development and course of these responses. The distinction between posttraumatic reactions versus responses to CTS may also be evident in clinical settings. The third aim is to review the existing literature on the impact of CTS and to narrow the gap in knowledge by presenting findings from studies that have assessed the effects of CTS on civilian populations.

Continuous Traumatic Situations: Key Concepts

The term CTS was coined in the context of political violence and social conflict, and refers both to social and individual conditions (Straker, 2013). CTS is likely to be observed in conflict-affected zones such as areas of low-intensity warfare (e.g., Kosovo and Sudan) in which there are frequent terrorist attacks, including attacks on civilian targets or attacks by repressive state forces that operate with impunity. Various terms and definitions have been offered for CTS. The following are some of the key concepts which, when combined, can help build a useful model for understanding the concept of CTS.

As can be seen in Table 1, the CTS key concepts focus mainly on the existing conceptualization of PTSD. Their notion of ongoing exposure is that traumatic events are temporally located in the past. Diamond, Lipsitz, Fajerman, and Rozenblat (2010), on the other hand, suggest that these pathological responses can in fact be understood as natural, protective, and adaptive mechanisms. In light of the contradiction mentioned previously and the ongoing nature of the threat, it is important to combine past and future perceptions and emotional reactions in order to understand the complexity of the CTS phenomenon. As such we argue that the current knowledge on the subject of PTSD fails to adequately capture the daily experiences of trauma or the realistic expectations of ongoing threat and danger. Individuals' responses are not constrained to either the past or the future, but rather seem to be part of a circular process resulting from repeated traumatic experiences over an extended period of time. It is therefore important to build a useful model for understanding the concept of CTS, which will be further elaborated upon later in the current article.

Research Findings on CTS

Recent research has focused on examining the psychological status of populations exposed to CTS as a result of situations of war and terrorism (for a review, see Galea, Nandi, & Vlahov, 2005; Gelkopf et al., 2013; Neria, Nandi, & Galea, 2008; Norris, Stevens, Pfefferbaum, Wyche, & Pfefferbaum, 2008). Most studies have examined pathological responses (mainly PTSD) and have been conducted among nonclinical populations in an attempt to estimate the prevalence of exposure to trauma as well as risk factors and protective factors for pathological responses to traumatic situations. Those studies have focused on comparing groups by type of exposure (direct vs. Indirect; Besser & Neria, 2009), geographic proximity (close to a hostile border vs. far away; Dekel & Nuttman-Shwartz, 2009), geographic location as a proxy for exposure based on the varying *levels* of violence experienced in some areas (Bleich et al., 2003; Galea et al., 2002), and ethnicity (Jews vs. Arabs; Yahav & Cohen, 2007).

In light of the need to deal with continuous trauma exposure, several attempts have been made to identify and define the distinctions between responses to situations of acute exposure to political trauma versus responses to situations of chronic exposure. One major distinction has been made between one-time exposure and ongoing exposure (Bleich et al., 2003; Shalev, Tuval-Mashiach, & Hadar, 2004; Shalev, Tuval, Frenkiel-Fishman, Hadar, & Eth, 2006). In a similar vein, Lahad and Leykin (2010) refer to sporadic exposure and intense periodic exposure to CTS as "ongoing exposure." Several researchers have claimed that persistent exposure to terror is expected to differ from one-time occurrences in several ways. First and foremost, one-time and ongoing exposure fundamentally differ from one another in terms of their cumulative effect. In addition, long-term exposure to possible or potential terror may also affect individuals' perceptions of risk or feelings of insecurity, which have been defined as subjective exposure. CTS differs not only from a single traumatic event but also from multiple traumatic events (related or unrelated) that occurred in the past and are not ongoing (Braun-Lewensohn, Celestin-Westreich, Celestin, Verté, & Ponjaert-Kristoffersen, 2009; Rosenberg, Heimberg, Solomon, & Levin, 2008). The ongoingness of the violent situations to which individuals are exposed is essentially the primary factor distinguishing CTS from PTSD.

Lahad and Leykin (2010, p. 695) suggest that the "constant sense of threat keeps people permanently on alert and aroused" and note that such populations "do not have time for respite and are thus constantly governed by their physiological reactions of fright or flight, or employ avoidance in the attempt to control these sensations" (p. 695). In the same vein, current research findings on adult populations living under a continuous threat show that the contribution of fear reactions to posttraumatic stress responses (e.g., emotional distress and impaired functioning) is

Table 1. Terms and Definitions for Continuous Traumatic Situations.

Term Used	Source	Definition Given
Chronic war-related trauma	Gelkopf, Berger, Bleich, and Silver (2011)	Residents who were under constant rocket fire (mortar shelling and Qassam missile attacks), who experienced significant damage to their homes and property as well as disruption of their daily lives
Constant threat of terror	Cohen and Eid (2007)	Terror attacks are carried out in public places, throughout the country. As a result of this terror, people almost everywhere in the country live in a constant high-risk situation, ever conscious that they or their family members could be involved in a terror attack
Continuous terror/ war threat	Bleich, Gelkopf, Melamed, and Solomon (2006); Dekel and Nuttman-Shwartz (2009); Farchi and Gidron (2010); Shalev, Tuval, Frenkiel-Fishman, Hadar, and Eth (2006)	Scattered and repeated attacks that claim a large number of casualties. This situation disrupts people's daily lives and creates an atmosphere of fear and insecurity, which in turn creates a secondary stressor of "unknown effects"
Ongoing terrorist attacks/conflict/ war/trauma	Besser, Neria, and Haynes (2009); Chipman, Palmieri, Canetti, Johnson, and Hobfoll (2011); Hobfoll et al. (2008); Hobfoll et al. (2009); Hoffman, Diamond, and Lipsitz (2011); Litvak-Hirsch and Lazar (2012)	Attacks that occur with unprecedented frequency and intensity throughout the country. These attacks strike randomly, indiscriminately, and without prior warning
Ongoing exposure	Pat-Horenczyk, Schiff, and Doppelt (2005); Besser, Neria, and Haynes (2009); Braun-Lewenshon, Celestin-Westreich, Celestin, Verté, and Ponjaert-Kristoffersen (2009); Lahad and Leykin (2010)	Populations that have endured several years of exposure to rocket and mortar fire in their area of residence. Such exposure entails a threat to personal and family safety, including damage to property
Ongoing traumatic stress response (OTSR)	Diamond, Lipsitz, Fajerman, and Rozenblat (2010)	Residents may display clinically significant anxiety symptoms, which can best be conceptualized as adaptive yet distressing reactions to an ongoing dangerous situation. These residents do not have symptoms of PTSD. Rather, their symptoms include a range of nonpathological responses that reflect an incipient or subthreshold syndrome in the PTSD spectrum, or incipient or subthreshold PTSD symptoms. These responses can significantly impair everyday functioning and quality of life
Long-term chronic states or prolonged chronic stress situations	Braun-Lewensohn, & Sagy (2010); Sagy and Braun-Lewensohn (2009); Baum (2012); Nuttman-Shwartz, Dekel, and Tuval-Mashiach (2011); and Steel et al. (2009)	Stress situations created by the Israeli political reality, in which children and adolescents are exposed to violence and face danger in their daily lives—exposed to frequent rocket attacks, usually one or two strikes at a time, and 1,000 missile strikes a year
Recurring terrorism/ violence	Pat-Horenczyk et al. (2007) and Rosenberg, Heimberg, Solomon, and Levin (2008)	Long-term impact of war and ongoing and multiple exposure to terrorism

Note. PTSD = posttraumatic stress disorder.

more significant than actual exposure (Nuttman-Shwartz, 2013). Moreover, the implications of long-term exposure to terror have been examined. In their latest study on continuous terrorism, Gelkopf, Solomon, and Bleich (2013) found that the prevalence of probable PTSD, the mean number of symptoms, and the rate of severe posttraumatic symptomatology increased over time. Thus, it was found that prolonged exposure to terror or political violence may increase the level of symptomatology more than it triggers new PTSD cases.

Against this background, a distinction has been made between posttraumatic reactions and reactions to CTS. Although there is reason to expect that PTSD is also prevalent in CTS, the challenge is to evaluate PTSD in this context and to distinguish PTSD from distress and behavioral changes that arise as a result of CTS (Hoffman, Diamond, & Lipsitz, 2011). All symptoms of ongoing distress can have adverse effects on the quality of life and functioning of individuals, even if they do not meet the criteria for psychiatric disorders and are adaptive in the context of pathological circumstances. Diamond et al. (2010) put forth what Lahad and Leykin (2010) refer to as a new paradigm for ongoing exposure situations. 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" (Lahad & Leykin, 2010, p. 696). Clinical and empirical evidence has shown that anxiety is a result of cumulative stress. It is often more about potential future danger or some combination of past and present threat than it is about the horror associated with past events (Diamond, Lipsitz, Fajerman, & Rozenblat, 2010; Nuttman-Shwartz, 2013). Moreover, in the context of CTS, intrusive thoughts are likely to be future-oriented concerns

such as worries about imminent missile attacks. Similarly, an attempt to probe the motivation behind avoidant behaviors may be diagnostically useful. As mentioned, avoidance symptoms in PTSD may aim primarily to protect against reexperiencing the memory of the trauma. In contrast, avoidance behaviors in the context of ongoing traumatic stress may be more rational and aim to protect against real current and future danger. The occurrence of ongoing traumatic stress responses depends on whether anxiety symptoms are resolved once the individual is out of danger. Accordingly, Diamond et al. (2010) noted that individuals with CTS resulting from continuous exposure to missile attacks showed fewer symptoms of traumatic stress when the intensity of the external trauma was lower. In addition, Diamond et al. and other researchers (e.g., Marshall et al., 2007) have argued that these symptoms of PTSD should not be considered in terms of psychiatric diagnoses. Rather, they may be better understood as responses to CTS and ongoing danger than as a pathological consequence of past exposure to trauma. In their clinical study, they found variations in the onset, constellation, and robustness of symptoms across contexts and argued that these differences may represent two distinct psychological phenomena, which differentiate CTS from PTSD.

In another study on chronic and acute traumatic responses among a normative nonclinical population who had been exposed to rocket attacks, Sagy and Braun-Lewensohn (2009) found that levels of psychological distress were higher among those who had been chronically exposed to frequent rocket attacks than among a matching sample that had been exposed to acute attacks. The results indicated that among persons living under conditions of ongoing exposure to rocket attacks and constant threat, the overall severity of PTSD was higher. The evidence also indicated that the PTSD symptoms mainly consisted of hyperarousal and avoidance rather than intrusion. In addition, Sagy and Braun-Lewensohn (2009) reported that in situations of CTS such as ongoing terror, many individuals showed symptoms and behaviors that appeared to be consistent with a diagnosis of PTSD.

In sum, with regard to the responses of individuals in CTS, there is a need to adopt a perspective that is more complex than simply identifying whether they respond with PTSD, probable PTSD, or extreme distress. Because individuals living under conditions of ongoing traumatic stress are *currently* in danger, their responses to the emergency situation, including avoidance and hyperarousal, can be understood as natural, protective, and adaptive.

CTS—A Circular Model

Individuals who live in contexts of CTS have often experienced prior exposure to traumatic events, including multiple events in many cases. However, in these situations, they are mainly concerned with their current and future safety rather than with past events. When the primary focus of traumatic awareness is on anticipated danger, one's thinking is likely to be dominated by fantasies of what might occur and ways of avoiding it. Thus, the preoccupation with safety is likely to be more prominent than intrusions in cognition (Diamond et al., 2010). However, it is possible that for some individuals with prior trauma exposure, intrusive memories and reexperiencing of prior traumas may accompany preoccupation with current safety concerns and may therefore influence that preoccupation (Pfefferbaum, North, Pfefferbaum, Jeon-Slaughter, & Houston, 2014). In addition, instead of attempting to process and detoxify the images and feelings aroused by previous traumatic experiences, emphasis is placed on preparing for future traumatization and on developing the ability to distinguish stimuli that might pose a real, immediate, or substantial threat from other everyday stimuli.

The ongoing, recurrent events highlight the unstable and changing nature of CTS. The first type of responses, *internalizing responses,* include anxiety, fear, withdrawal, and somatization. These responses mark the baseline of the personal encounter with subsequent traumatic events that frequently occur as a result of continuous exposure to threats. The second type, *externalizing responses*, depend on the first type; and both types can change from positive to negative and vice versa. Although individuals can recover from the first type, the encounter with a second event might trigger a response in the opposite direction (i.e., an externalizing response). The second type may represent an entrenched defensive style of dealing with the distress associated with internalizing responses (Roach, 2013). Yet it is also possible that taking the position of aggressor (as opposed to victim) becomes personally and socially reinforced (Weierstall et al., 2013). Hence, its efficacy over time is limited (Gelkopf et al., 2013).

The uncertainty aroused by continuous exposure to trauma requires an ongoing assessment of the responses of individuals and their environment in an attempt to identify populations at risk. Over time, responses to the traumatic situation become more complex. For example, Gelkopf et al. (2013) reveal that the development of late-onset cases and severe symptomatology seem to be linearly associated with the amount of time that has elapsed since the traumatic event occurred. However, there has also been evidence of spontaneous recovery from probable PTSD and severe posttraumatic symptomology over time (Shalev et al., 2012). Concomitantly, many persons who were not identified with probable PTSD have, over time, developed or retained severe posttraumatic symptomatology. Thus, prolonged exposure may increase levels of symptomatology and are more likely to disrupt one's daily life and routine than they are to trigger new PTSD cases. Hence, continuous efforts need to be invested in enhancing resilience and strength in order to promote effective coping and enable individuals to live with CTS and in the routine of emergency (Ursano et al., 2014).

In conclusion, in cases of CTS, previous traumatic events play a role together with potential future traumatic events and/or with the actual traumatic events that individuals and communities are regularly exposed to.

Practical Implications for CTS

Owing to the complexity of CTS, as described previously, there is no single operative concept for the treatment of individuals

who have been exposed to these situations. High-quality trauma treatment takes into consideration the individual's history of traumatic exposure and an assessment of which past event(s) are driving current symptoms, all within the broader context of the individual's strengths, weaknesses, and environment.

CTS should not be treated as if the trauma is historical or related to a single event (Straker, 2013). Having said this, however, it is clear that events from the past do affect individuals in the face of CTS. But it is also worth noting that as their survival depends on using all of their psychic resources to manage the present and work through the current dangers they are exposed to, emphasis on the past is often counterproductive. Some individuals who have been exposed to CTS may use cognitive distortions regarding trauma exposure (e.g., self-blame), which can serve to maintain symptoms and can be processed even in the face of ongoing threat (Cohen, Mannarino, & Murray, 2011). By contrast, individuals who have been exposed to CTS may in fact respond better to distraction, distancing (e.g., leaving the confrontation zone for a short period of time), supportive interventions, psychoeducation, or no treatment at all (Diamond et al., 2010; Gelkopf et al., 2013). The message that their responses are understandable, natural, and even normal reactions to abnormal, dangerous, anxiety-producing circumstances can be depathologizing and empowering and may contribute to strengthening the therapeutic alliance. As such, the goal of treatment is to help individuals exposed to CTS to manage the stress created by the abnormal situation rather than work through or reprocess a past traumatic event, the remnants of which continue to impact on the present. Furthermore, as in cases of PTSD, CTS can significantly impair everyday functioning and quality of life (e.g., difficulties at work, isolation, demoralization and shame, and marital problems). Most importantly, in CTS, the challenge is to help individuals learn to distinguish between reality-based adaptations to an actual threat (e.g., "the alarm sounds; when it sounds missiles fall; I'm going to run to a sheltered room") versus symptomatic reactions to trauma reminders during a CTS (e.g., "a motorcycle makes noise on the street; this reminds me of the alarm, which is often a sign of missile attacks; I leave the place due to my anxiety about a possible attack"). Hence, Diamond et al. (2010) recommend that treatment for individuals who experience CTS should focus on developing day-to-day coping skills and managing the physical symptoms of anxiety rather than on reprocessing past traumatic events, as therapists often do with clients who have PTSD.

One of the main problems in offering treatment in cases of CTS is the difficulty involved in creating a physically and emotionally therapeutic space. Hobfoll et al. (2007) recognized that for individuals who face an ongoing threat (such as active combat soldiers), the ability to create a safe place may be curtailed. As a result, researchers have suggested that in the face of environmental constraints and pressures, it is important to identify and cultivate safe spaces, even if those spaces are limited (Kaminer, du Plessis, Hardy, & Benjamin, 2013; Murray, Cohen, & Mannarino, 2013). In some instances, safety may have to assume more symbolic or internal characteristics, such as the ability to evoke protective mental images. For example, when the therapeutic space is found to be inevitably connected with the traumatic reality outside of it, both therapist and client are forced to address concrete issues, including the destructive consequences of CTS. This constraint impairs the ability of therapists to create a "safe space" in which clients can make a spontaneous transition between the internal and external worlds (Dekel & Nuttman-Shwartz, 2014; Kretsch, Benyakar, Baruch, & Roth, 1997). For this reason, Dekel and Nuttman-Shwartz (2014) highlight the need for therapists working in CTS to show more flexibility in the concepts, theories, and intervention methods they employ. In addition, they highlight the need to develop therapeutic settings for provision of treatment in those situations.

Findings have revealed that when individuals face ongoing stress and life-threatening situations, core elements of stress management therapy can include relaxation, breathing exercises, stress inoculation training, acceptance-based interventions, and mindfulness-based practices (Dekel & Nuttman-Shwartz, 2014; Meichenbaum, 2007; Walser & Hayes, 2006). Moreover, it has been argued that the biopsychosocial approach, which is based on cognitive behavioral methods, is the most effective way of dealing with CTS (Hamblen, Barnett, Hermann, & Schnurr, 2012).

Treatment for CTS should also emphasize therapeutic interventions at the macro level as a critical first step prior to discussing individual therapy approaches (Hobfoll et al., 2007). Ungar (2008) has suggested that counselors need to take an active stance in helping individuals develop realistic threat appraisals as well as capacities for discrimination of environmental threats and strategies for managing them. For example, there are universal interventions such as psychoeducation about common reactions to chronic, intermittent traumatic exposure. These interventions include practical guidelines about what to do if an individual is struggling, as well as distribution of accurate and timely information about current risks and associated safety measures taken by the state (e.g., Hobfoll et al., 2007). Psychoeducation, encouraging the activation of social support structures, and resilience building are also important aspects of intervention. Toward that end, counselors may need to work in conjunction with community activists who seek to build social cohesion and bring an end to the conflict. Furthermore, it has been argued that when communities are exposed to CTS, there is a need for community and systems-oriented therapy, which is based on a broad perception that includes prevention, acute intervention, and ongoing problem-focused therapy in addition to the encouragement of resilience. The model includes interventions at two levels: the clinical level, which focuses on identifying and treating posttraumatic distress in adults and children; and the community level, which focuses on building resilience among members of the community and in community systems. These interventions include social treatment, that is, efforts to increase solidarity and sense of belonging; community development; and social action, that is, legal reform efforts to promote the right to security and suggested changes in the education system (Nuttman-Shwartz, 2015).

Several researchers have claimed that in CTS cases, prevention and intervention may best be administered at the community level. Community-based interventions not only attend to large numbers of individuals simultaneously but also reduce the potential stigmatization and pathologization of anxiety responses. In fact, research findings have shown that a sense of belonging to the community and to the country can enhance feelings of connection and support among community members (Boss, Beaulieu, Wieling, Turner, & LaCrus, 2003) and can mitigate pathological responses (Nuttman-Shwartz & Dekel, 2009).

With regard to therapists, researchers have emphasized that they also need to manage their own anxieties and cope with challenges to their ideological and existential beliefs, especially when they are part of the same pathological social structures as their clients and risk being overwhelmed by those structures (Dekel & Nuttman-Shwartz, 2014; Shoshani, Shoshani, & Shinar, 2010; Straker, 2013). Thus, counselors need to develop their own internal and external support mechanisms in order to continue functioning effectively under such circumstances.

Unsurprisingly, Dekel and Nuttman-Shwartz (2014) reported that therapists prefer to use the therapeutic methods that they have experienced as effective ways of regulating their own emotional arousal. Further, the therapists who participated in the 2014 study reported that they had learned to make use of moments of extreme anxiety in order to promote therapy and benefit their clients instead of viewing those moments as harming or threatening the therapeutic process. The therapists' optimism, flexibility, and creativity contributed in two ways—both as personal resources that mitigated the negative consequences of exposure to trauma and as a means of promoting the therapeutic process by adapting the therapeutic process to the new, dynamic situation (Dekel & Nuttman-Shwartz, 2014).

Although the number of individuals with traumatic symptomatology continues to increase in CTS, care must also be taken to give individuals who have been exposed to trauma an opportunity to recover without treatment. Nevertheless, we wish to emphasize the importance of making available wide-scale interventions.

Conclusions

The contribution that this article makes to the literature is the presentation of a new conceptualization of CTS as a circular process; it is in fact the circularity of it which distinguishes the CTS phenomenon from other traumatic experiences. The new conceptualization offers a wider professional knowledge and understanding of the effects of CTS on civilian populations living in ongoing situations of political violence and national security threats. It is imperative that these effects be addressed in clinical and social settings (Dubow et al., 2010).

This conceptualization of CTS offers one possible framework for describing the psychological impact of living with the real threat of present and future danger, as opposed to experiences of past traumatic events. This conceptualization also highlights the difficulty of examining past exposure in the context of the real potential for current and future harm. This construct of CTS or similar conceptualizations could broaden existing perspectives of trauma, its effects, and the amelioration of such effects. Chronic stress has an incremental impact, and it has been argued that most of the factors affecting mental health in cases of nonchronic exposure also affect individuals exposed to chronic trauma. That is, posttraumatic symptoms can be disruptive even if they do not correspond with the categories of diagnosable disorders. The CTS concept described in this article suggests that screening for traumatic reactions should also include screening for symptoms beyond PTS symptoms, such as fear, sense of danger (Kimhi et al., 2010), depression, aggressive behavior, and alienation from community (Dubow, Huesmann, & Boxer, 2009; Dubow et al., 2010).

In the current article, we stressed that prolonged exposure to threat in CTS is a circular process resulting from repeated traumatic experiences over an extended period of time as a result of political violence situations and national security threats. In these situations, the cumulative effects of these experiences are expressed in symptomatology and/or in impaired functioning. The ability to carry on with everyday life under these circumstances raises questions about the ways in which individuals adapt or function in the face of prolonged exposure to continuous threats. In this regard, it is important to bear in mind that the ability to adapt and function in these situations does not minimize the rates and impact of symptomatology in the affected populations. Thus, it is also important to take into consideration that perceived threat, fear, and anxiety reactions in the face of CTS are a result of coping styles that individuals have chosen to adopt in previous events. Moreover, there is a need to consider the personal and environmental resources of individuals, and take into account a broad, dynamic spectrum of pathological and salutogenic responses that constitute the basis for future responses in the face of frequent and continuous exposure to trauma.

Additionally, owing to the linear increase in the number of new PTSD cases in CTS, there is a call for investing at least as much effort in strengthening resiliency as in treating new PTSD cases (Hobfoll et al., 2009). In light of the expectation that there will be future attacks or danger, resiliency and resistance-oriented interventions should incorporate techniques for coping with loss of resources, working through major life events, creating a sense of security, and avoiding dissociative responses. It is essential to focus on enriching the coping repertoire, because it is almost impossible to work through past traumatic events while simultaneously anticipating future ones. All of these steps must be taken together in a constant effort to improve and strengthen existing therapies (Berger, Pat-Horenczyk, & Gelkopf, 2007; Gelkopf & Berger, 2009). Finally, a holistic perspective should be adopted in these situations, with a view toward bolstering optimism and a sense of meaning both at the personal and national levels.

These suggestions highlight the need to develop interventions for different populations at different stages of exposure (Berger, Gelkopf, & Heineberg, 2012; Gelkopf, Silver-Cohen, Berger, & Bleich, 2012). Interventions aimed at ameliorating the impact of

CTS call for changes at the societal and community levels as well as for changes in existing therapeutic approaches to working in trauma-related conditions. Those levels might be a burden in times of ongoing situations of political–national violence such as war and terror. In addition, special emphasis needs to be placed on training local professionals in an attempt to build local capabilities for coping with situations of continuous trauma. These interventions should be accompanied by further theoretical and empirical research on the concept of CTS.

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