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The Differential Impact of Terrorism on Two Israeli Communities

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Since well before Israel's establishment as a sovereign state in 1948, its residents and citizens have experienced frequent acts of terrorism in the form of hostage situations, suicide bombings, and most recently, cross-border rocket, missile, and mortar attacks (Weinberg, Besser, Campeas, Shvil, & Neria, in press). As a result, Israel is a "natural laboratory" for studying the effects of stress, trauma, and coping (Lazarus, 1986; Solomon, 1996; Weinberg et al., in press) and, as such, has contributed a great deal to what is known and understood about psychological responses to terror in modern society. In particular, research on Israelis' response to terror has expanded terror research beyond the study of reactions to single incidents (e.g., the 9/11 literature) to include explorations of responses to repeated exposures and chronic threat (e.g., Hobfoll, Canetti-Nisim, & Johnson, 2006).

In 2003, Bleich, Gelkopf, and Solomon published the first nationally representative study of the psychological impact of ongoing terrorism. Based on data collected during a period of intense terrorism commonly referred to as the Second Intifada (which began in September, 2000), they reported that 16.4% of the population had direct exposure to a terrorist attack, over a third of the population (37.3%) had a family member or friend who was directly exposed to an attack, and over 60% had a low sense of safety for themselves and their families. Despite the magnitude of these numbers, only 9.4% of the respondents met the criteria for PTSD, but just over half of the population (58.6%) reported feeling depressed, leading the authors to conclude that the psychological impact of the attacks were relatively

“moderate”. Bleich et al. (2003) also found that there was no reliable association between actual exposure to a terrorist attack and both PTSD and other stress-related symptoms. This finding is noteworthy, because it contradicts the *dose-response relationship* (i.e., increased exposure yields increased symptomatology) that is considered to be well established in the trauma literature (Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003).

Since 2003, other studies of ongoing terrorism in Israel (e.g., Bleich, Gelkopf, Melamed, & Solomon, 2006; Rosenberg, Heimberg, Solomon, & Levin, 2008; Shalev, Tuval, Frenkiel-Fishman, Hadar, & Eth, 2006; Shalev, Tuval-Mashiach, & Hadar, 2004) have also failed to find a dose-response relationship. One notable exception is a study by Palmieri, Galea, Canetti-Nisim, Johnson, and Hobfoll (2008). They found that exposure and exposure-related stressors predicted probable PTSD among a nationally representative sample of residents of Israel immediately following the Israel-Hezbollah War (July 12-August 14, 2006), which involved high rates of civilian exposure to rocket attacks. The authors hypothesized that the relationship between exposure and exposure-related stressors might depend on the nature of the attacks. For example, the Second Intifada involved a diffuse threat for nearly everyone in the country. Palmieri et al. (2008) stated that the chance of being killed was approximately 1 in 10,000, or roughly the chance of being killed in a traffic accident. Furthermore, in the Second Intifada, there were few actions that one could take to minimize the risk of becoming a victim of an attack. As such, daily lives were not significantly altered. Comparatively, the Israel-Hezbollah War involved a month of rocket attacks from Hezbollah to Northern Israel. In this war, there was a very clearly defined threat, and there were specific actions, such as going into a shelter, which could ameliorate the risk.

In this study, we evaluated the impact of exposure to recurrent and chronic terror by examining the most recent chapter in Israel’s encounters with terror attacks: years of mortar and rocket fire aimed at the communities that border Gaza in southern Israel. Since October 2000, over 12,000 rocket and mortar rounds were launched from the Gaza Strip toward southern Israel resulting in casualties, injury, substantial property loss, and significant psychological distress (Bedein, 2009; Intelligence and Terrorism Information Center, 2009). Residents spend significant periods of time in shelters or attempt to remain close to shelters with the knowledge that they only receive a 15-second warning before a rocket hits. Lives of individuals in this area of the country are significantly and meaningfully altered on a daily basis. Because of the similarities to the rocket attacks of the Israel-Hezbollah war, we hypothesized that there would be a dose-response relationship of exposure.

The attacks in southern Israel also present an opportunity to examine the role of community in responding to chronic terror. The communities neighboring Gaza are comprised of the urban, resource-poor, disadvantaged city of Sderot and neighboring collectivistic communities (kibbutzim and moshavim) of Otef Aza, which is arguable much more cohesive and communal. Previous research has compared communities with differing degrees of exposure (Shalev et al., 2006; Somer et al., 2009); however, in this study we compared two communities (Sderot and Otef Aza) with similar exposure but differing communal environments in order to examine the contributions of community-related factors (e.g., differential access to resources, communal support).

Sderot has a long history of social marginalization and economic hardship. Established in the 1950s as a “development town,” Sderot was designed to populate Israel’s tenuous borders with newly arriving immigrants who generally had limited economic and material resources (Friedman-Peleg & Goodman, 2010). During the Second Intifada, some residents believed that they were bearing the brunt of the attacks without commensurate support from the government, and this has only become exacerbated in the years since, as the Intifada has

technically ended, but the attacks on southern Israel have continued. Indeed, many residents with the financial capability and access to resources outside of Sderot have chosen to relocate, leaving primarily the economically and socially disadvantaged (Hadad, 2008) and disenfranchised who have very limited ability to advocate effectively for themselves.

In contrast, the collective communities that comprise Otef Aza have roots in the kibbutz and moshav movements (i.e., small and cohesive agricultural communities often with strong shared ideological values, with the former characterized by mostly collective ownership of property and the latter by private ownership) which, historically, have held significant sway within Israel's leadership establishment. As such, these inherently cohesive communities have access to a network of internal and external resources and supports. Because of Sderot's marginalized social status and history of resource deficits, we hypothesized that its residents would endorse higher levels of psychopathology (e.g., PTSD and depression symptoms) than those living in Otef Aza.

A final aim of this study was to explore predictors of psychological outcomes. Previous studies have demonstrated that trauma-exposed adults who are younger, female, have less education, have a lower socioeconomic status, and have more trauma exposure are at increased risk for PTSD (see Brewin et al., 2000). Other identified populations at risk from Israeli studies include individuals who identify themselves as having a "traditional" (as opposed to "secular" or "religious") background and immigrants (Bleich et al., 2006; Hobfoll et al., 2006; Hobfoll et al., 2008). Additionally, we included a measure of previous trauma history to control for differences in prior exposure levels, and because previous studies have identified lifetime exposure to trauma as a risk factor (see Brewin et al., 2000). We predicted that age, gender, level of education, religiosity, immigrant status, income, marital status, the extent of exposure to terrorism, and perceived threat would be related to distress. Given research that suggests that limited material and psychosocial resources create increased vulnerability in individuals exposed to terrorism (Hobfoll et al., 2006), we also predicted that the community variable (Sderot vs. Otef Aza) would explain unique variance in both PTSD and depression.

Method

Data Collection

Telephone interviews were conducted during August 2009, approximately 7 months after the end of the Gaza War. The preceding year marked a particularly volatile time in the region with over 3,200 rockets fired from the Gaza Strip in 2008 (the largest number per year since 2001) followed by Israel's incursion into Gaza in the winter of 2008/2009 (December 27, 2008 – January 18, 2009), during which residents of the Sderot region experienced an average of seven rocket alerts and four actual explosions a day (Bedein, 2009). Even after the conclusion of Israel's operation in Gaza, some attacks continued with over 200 rockets launched toward Southern Israel between January 18th and the time of our data collection. Thus, terrorist attacks remained a present-moment reality for our sample.

Sampling

Sample recruitment and structured interviewing were conducted by the Dahaf Institute, a major Israeli polling company experienced in conducting survey research. The Dahaf Institute maintains a large database containing basic demographic data on owners of telephones. Phone numbers of residents of Sderot and Otef Aza were randomly chosen using a within-strata random sampling method. Strata among residents of Sderot were defined according to social sector related to immigrant versus native resident status. Among the neighboring towns in the area of Otef Aza, strata were defined according to municipal

affiliation in the region to ensure representative sampling. Numbers were randomly chosen by computer until size criteria of each stratum were fulfilled. Accordingly, 1,851 numbers were telephoned and contact was made with 1,327 (71%) individuals. Five-hundred forty six (29.5%) refused to participate and 274 (14.8%) had no individual available that met inclusion criteria (being 18 years or older, sharing a language with the interviewer). An additional 57 (3.1%) did not complete the interview (hung up during the interview), yielding 450 participants, a 24.3% completion rate (42.7% of those actually reached by telephone with an eligible candidate).

Participants

Participants were 210 men (46.7%) and 240 women (53.3%). Ages ranged from 18 – 83 ($M = 49.50$; $SD = 16.57$). Two hundred and twenty (48.9%) were native Israelis while 230 (50.1%) immigrated from a range of countries, including the former Soviet Union (24.6%) and North Africa (12.6%). The majority of our sample reported that they were married (67.3%), secular (52.4%; as opposed to religious or traditional), and had a lower-than-average Israeli monthly income (57.4%). Two hundred ninety-eight (66.2%) were residents of Sderot, whereas 152 (33.8%) resided in the neighboring areas referred to as Otef Aza. Demographic statistics by location are provided in Table 1.

Procedure

Participants were contacted by telephone. Those who agreed to participate provided oral consent in accordance with the Internal Review Board of Boston University and the Helsinki Ethics Committee of Tel Aviv University before beginning the interview. Participants then responded to approximately 100 survey questions from a structured questionnaire that required approximately 30 min to complete. Telephone survey professionals conducted interviews in either Hebrew or Russian according to the participant's preference.

Measures

All measures were translated from English into Hebrew and then back-translated to English to ensure proper translation. The process was conducted by two bilingual, doctoral-level researchers and one bilingual doctoral candidate, all with expertise in trauma. Translation of each item was discussed by all researchers. An equivalent translation and back translation process was followed to create the Russian version of the measure.

Demographic characteristics—Participants were asked to indicate their age, gender, education, religiosity, country of origin, income level (compared to average monthly income per household in Israel), marital status, and current community. In some instances, categories were collapsed to be consistent with past research (e.g., Bleich et al., 2003; Bleich et al., 2006). For example, education was collapsed into elementary, some high school, and higher education. The community variable was collapsed into Sderot (= 1) and Otef Aza (= 0).

Exposure—Participants' lifetime exposure to potentially traumatic events was assessed using the Life Events Checklist (LEC; Gray, Litz, Hsu, & Lombardo, 2004). The LEC consists of 17 items inquiring about exposure to various types of trauma (e.g., natural disaster, motor vehicle accident). Its response format utilizes a 5-point nominal scale. For each category of traumatic event, respondents are asked to indicate which applies the best: *happened to me*, *witnessed it*, *learned about it*, *not sure*, and *does not apply*. We calculated a sum of the types of traumatic events that each participant experienced (i.e., *happened to me*) and witnessed. To be conservative, we excluded events that a participant only *learned about*. We also excluded events that clearly overlapped with terrorism (fire or explosion, combat or

exposure to a warzone, any other stressful event or experience). Therefore, this variable (labeled *Trauma History*) had a possible range from 0 to 14.

To assess terror-related exposure, we asked a series of questions similar to those employed in previous studies (e.g., Bleich et al., 2003; Bleich et al., 2006). We asked participants whether they had been exposed to a terrorist attack and whether a family member or close friend had been exposed to an attack. Participants were then asked to indicate whether they or their family member or close friend had been injured in an attack, whether they or their family member or close friend lost property in an attack, and whether a family member or close friend was killed in an attack. Participants were asked to respond: *yes*, *no*, or *don't know* to each of those items. We counted the number of *yes* responses to the 11 items to produce a total exposure to terrorism score (labeled *Exposure Level*). To assess a participant's subjective experience of terrorist attacks we also asked: "*How strongly did you believe that your life, or the life of someone close to you, was threatened or in danger as a result of a terrorist attack?*" Response options for this variable (labeled *Perceived Threat*) were *not at all*, *just a little*, *some*, *quite a bit*, and *a great deal*.

Mental health symptoms—Posttraumatic stress disorder (PTSD) symptom severity was assessed using the PTSD Checklist – Civilian Version (PCL-C; Weathers, Litz, Herman, Huska, & Keane, 1993). The PCL has strong psychometric properties (e.g., Blanchard, Jones-Alexander, Buckley, & Forneris, 1996; Ventureyra, Yao, Cottraux, Note, & De Mey-Guillard, 2002) and was found to have good internal reliability in the present sample ($\alpha = .95$). The PCL-C is a 17-item measure assessing each symptom of PTSD contained in the *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition* (DSM-IV; American Psychiatric Association, 1994). Participants are asked to indicate how much they have been "bothered" by a particular item in the past month, 1 (*not at all*), 2 (*a little bit*), 3 (*moderately*), 4 (*quite a bit*), 5 (*extremely*). A symptom was considered endorsed if a participant responded with a score of 3 or higher.

To be consistent with previous studies on the effects of terrorism (e.g., Bleich et al., 2003; Bleich et al., 2006), we calculated the number of symptoms endorsed per cluster (i.e., per cluster B: re-experiencing; cluster C: avoidance; and cluster D: hyperarousal) and the total number of symptoms endorsed. Additionally, we calculated the number of participants who endorsed at least one symptom in each cluster and the number of participants who met criteria for probable PTSD. To receive a diagnosis for probable PTSD, the participant must have endorsed at least one re-experiencing symptom, three avoidance symptoms, and two hyperarousal symptoms.

To assess depressive symptomatology, we used the depression subscale from the Depression Anxiety Stress Scale 21 (DASS-21). The DASS-21 (Lovibond & Lovibond, 1995) is a 21-item measure used to assess three general domains of symptomatology: depression (e.g., *I felt down-hearted and blue*), anxiety (e.g., *I felt scared without any good reason*), and stress (e.g., *I found it hard to wind down*). Each subscale consists of seven items that are rated using a 4-point Likert scale, 0 (*completely not true*), 1 (*somewhat true*), 2 (*very true*), 3 (*very much true*). As suggested by Lovibond and Lovibond (1995), we calculated a total depression score by multiplying the sum of the item scores by two. This calculation is performed to account for the fact that the DASS-21 has 50% fewer items than the full version of the measure. Internal reliability was good in the present sample ($\alpha = .89$).

Data Analysis

In addition to calculating basic descriptives for the demographic, exposure, and outcome variables, we compared the two communities in terms of terror-related exposure, previous lifetime traumas, perceived threat, PTSD symptoms by cluster, PTSD diagnoses, and

depression symptoms using *t*-tests and chi-square tests. Then we tested a hierarchical regression model for each outcome variable (i.e., PTSD diagnosis, total PCL score, and total DASS depression score). We entered the demographic variables (other than community) in the first step, the exposure variables in the second step, and the community variable in the third step. The two nominal variables, religiosity and marital status, were dummy-coded so that the two reference groups were secular and married participants, respectively. All analyses were completed in PASW Statistics 17 (formerly SPSS Inc, Chicago, IL).

Results

Comparisons between the two communities (Sderot and Otef Aza) in terms of exposure items and variables yielded few significant differences. For example, the difference in the percentage of people who reported that they were exposed to a terrorist attack, had a family member who was exposed to a terrorist attack, or had a close friend who was exposed to a terrorist attack was nonsignificant (Table 2). In both communities, endorsement rates for each item were roughly 70%, which are well above national averages (see Bleich et al., 2003; Bleich et al., 2006). Additionally, the difference in the number of categories of lifetime traumas was statistically nonsignificant. Furthermore, the difference in the percentage of people who said that they were injured, had a family member who was injured, or who had a close friend who was injured in an attack was nonsignificant. However, a significantly higher percentage of participants from Sderot reported that they lost property, a family member lost property, and a close friend lost property in a terrorist attack. Additionally, a significantly higher percentage of participants from Sderot reported that a family member was killed in an attack, and the average level of perceived threat was significantly higher in Sderot.

Participants from Sderot endorsed an average of more than two re-experiencing symptoms (cluster B), two avoidance or numbing symptoms (cluster C), and two hyperarousal symptoms (cluster D; Table 3). For each symptom cluster, more than 60% endorsed at least one symptom. All of these averages and percentages significantly exceeded the corresponding numbers and percentages for participants from Otef Aza. Furthermore, over 35% of the participants in Sderot met criteria for probable PTSD using the DSM-IV criteria (i.e., at least one symptom from cluster B, three symptoms from cluster C, and two symptoms from cluster D). This rate is significantly higher than the rate for participants from Otef Aza, $\chi^2(1) = 43.45, p < .001$. It is also substantially higher than the average rates for the country (see Bleich et al., 2003; Bleich et al., 2006; Palmieri et al., 2008).

Community and exposure level (i.e., the sum of the 11 exposure items) were the strongest predictors of PTSD diagnosis, followed by marital status of divorced, widowed, or separated, and the number of categories of lifetime traumas (Table 4). Specifically, the odds of having PTSD were over 8 times greater for the residents of Sderot compared to the residents of Otef Aza. Furthermore, the odds of having PTSD were 27% greater for each additional terror-related exposure item that was endorsed. These findings are consistent with our first two hypotheses (i.e., there would be a dose-response relationship, and Sderot residents would have significantly more psychopathology). In the other hierarchical regression models, the demographic variables (other than community) accounted for 18.6%, $F(9, 311) = 7.87, p < .001$, and 11.3%, $F(9, 315) = 4.46, p < .001$, of the variance in PCL and depression scores, respectively, and the exposure variables accounted for an additional 11.8%, $F(3, 308) = 17.47, p < .001$, and 5.7%, $F(3, 312) = 7.17, p < .001$, of the variance in the two outcome variables, respectively. The community variable accounted for an additional 3.5%, $F(1, 307) = 16.13, p < .001$, and 2.6%, $F(1, 311) = 10.10, p = .002$, of the variance in the two outcome variables, respectively. Besides community, exposure level, marital status of divorced, widowed, or separated, and the number of categories of lifetime

traumas, other significant predictors for the PCL and depression scores included gender, level of education, traditional religiosity, and perceived threat. Surprisingly, immigrant status and income were not significant in any model.

In a post-hoc exploratory analysis, we examined the regression models for the two communities separately (Table 5). For Sderot residents, the strongest predictors of PCL and depression scores were the number of categories of lifetime traumas endorsed and the level of terror-related exposure. Level of education was a significant predictor of depression only. For Otef Aza residents, these three predictors were not significant in either model. However, perceived threat was significant in the model for PCL scores and age, income level, and a marital status of single were significant in the model for depression.

Discussion

Although participants from both Sderot and Otef Aza reported extremely high rates of being exposed to terrorist rocket attacks (roughly 70% for both), the Sderot cohort reported more symptoms of distress. Some of the differences in outcome were attributable to differences in demographics and consequences of exposure. For example, Sderot had a greater percentage of participants who were divorced, widowed, or separated. These individuals may be more susceptible to resource loss. Additionally, a greater percentage of residents in Sderot reported that they suffered property damage and had a family member who was killed. According to the *conservation of resource theory* (Hobfoll, 1989), the impact of stress is determined, in part, by the degree of loss or threatened loss of critical resources (e.g., material resources, such as housing and employment, and psychosocial resources, like social support). We confirmed this model in broad terms because the community variable (which may represent overall level of resources and general sense of belonging) accounted for a significant proportion of the variance in PCL scores and depression scores even after controlling for the other variables. In fact, it was the strongest predictor for all three outcome variables, exceeding other common predictors, such as income, perceived threat, and even exposure level.

Sderot is an unstable community (Hadad, 2008) with high rates of unemployment and limited access to economic and psychosocial resources, making some citizens particularly vulnerable. These conditions are akin to urban areas in the United States that are in decline (e.g., Detroit). On the other hand, many of the Otef Aza villages are kibbutzim and moshavim – two types of communities which share a more socialistic ethos based upon solid economic structure and mutual support. These communities enjoy high solidarity, as the structure is based on a model of social cohesiveness. For example, if a resident of Sderot becomes wounded and missed some time from work, the financial impact could be substantial. However, an equally affected resident of a kibbutz or a moshav would have the immediate support of the community to care for him or her and his or her family. Another factor that may contribute to the high rates of psychopathology is a sense of abandonment or betrayal by the government, which may undermine the resilience of community members (see Diamond, Lipsitz, Fajerman, & Rozenblat, 2010). By contrast, residents of Otef Aza may feel sufficiently supported via its collectivist culture. This support may account for the surprisingly low rate of PTSD compared to the rate in Sderot, despite their equivalent rates of exposure.

Additionally, there appear to be large differences in the risk factors for the two communities. Trauma history and degree of exposure to terror were robust predictors of PTSD among the Sderot residents, but were nonsignificant in the models for Otef Aza. A possible explanation for this finding (and the disparity regarding dose-response within Israeli terror literature) is that these two variables are less relevant for areas with greater resources and general sense

of support. If residents can access financial or psychosocial support, the impact of trauma could be minimized. However, when resources are limited, every additional exposure could confer an additional risk for psychopathology. Therefore, the dose-response relationship (i.e., the relationship between exposure and symptomatology) may be more dependent on the impact of the attacks on resources and morale of its residents than the nature of the attacks, as suggested by Palmieri et al. (2008).

Additionally, age, income, and a marital status of single were significant in the model for depression for the participants from Otef Aza only. It could be that the young, single participants in Otef Aza have a greater minority status than they do in Sderot. Because of the family orientation of the collectivist community, they may feel more marginalized and may lack the support culture. Surprisingly, income was not a significant predictor among residents of Sderot. The mostly likely explanation for this finding is that there is not a lot of variability in income among the residents, which reduces the probability of finding a significant relationship. Roughly two-thirds earn less than the national average (see Table 1). More research is needed to fully explore the risk factors by community.

There are methodological issues that temper the results of this study. First, the contact and participation rates in this study were lower than the rates from national surveys (e.g., Bleich et al., 2003; Bleich et al., 2006). If the reduced rates were because of the nonparticipation of individuals with increased distress, then our estimates could be biased. A second limitation is that the PCL was used to assess probable PTSD. Some researchers have argued that the administration of checklists fails to exclude transient symptoms that disappear when the threat is over and symptoms that are appropriate to the dangerousness of the situation (Hoffman, Diamond, & Lipsitz, 2011; but, for a counter argument, see Hobfoll et al., 2011). A multimethod, repeated measure design might be necessary to ensure accuracy. However, because the rates of PTSD in Otef Aza are extremely low, significant overestimation seems unlikely. A third limitation is that, while the DASS-21 has been tested in a population of Israelis living abroad (Rosmarin, Pargament, & Mahoney, 2009), it has not been used with Israelis residing within Israel. Thus, further studies are needed to validate the measure in this specific population. Finally, we did not delineate periods of exposure. Hence, participants could have answered questions based on exposure to additional missile attacks during their lifetime. Therefore, whereas we were able to control for lifetime exposure to other types of potentially traumatic events, it is difficult to discern whether current or lifetime exposure to terrorism are the better predictor of PTSD and depression symptoms. Future researchers should consider differentiating time periods when measuring exposure in populations likely to have multiple different episodes of chronic exposure.

Despite these limitations, this study makes several important theoretical and clinical contributions. First, the study offers a rare opportunity to examine two populations residing in a relatively small area and facing a clearly defined type of terrorist attacks (i.e., missile attacks). Second, our comparison of two similarly exposed populations adds to our understanding of the key determinants of distress. More specifically, we have discovered that characteristics of the community may be a strong predictor of PTSD and depression, and that the relationship between exposure and distress may depend in part upon variables related to community resources and support. Based on known differences between the two communities, we assume that these characteristics could include the availability of economic and psychosocial resources, the general sense of support from the government, and the level of solidarity of the residents. Future research is needed to test the indirect and direct effects of these factors. In contrast to Shalev et al. (2006), our results demonstrate that it is possible for neighboring communities to have a very different response to ongoing terrorism.

On a practical level, several conclusions can be drawn. It is clear that residents of Sderot are suffering considerably. National estimates of psychopathology appear to severely underestimate the distress felt by residents in this region of the country. Israeli authorities are highly encouraged to allocate considerable resources to this population. While the reach of intervention is limited when it comes to factors of exposure to terror and personal vulnerability, efforts that focus on enriching communal resources are realistic, achievable, and stand to make a significant impact on people's abilities to cope with the realities of their situation (Hobfoll et al., 2006). Additionally, risk factors for Sderot may not apply to communities with greater resources; however, they may apply to other marginalized communities around the world that face terrorism and dangerous borders. These risk factors should be taken into account when shaping social and health policy in such areas.

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Table 1

Demographic Characteristics by Community

Characteristic	<i>n</i> (%) / Mean (<i>SD</i>)		² / <i>t</i> (<i>df</i>)
	Sderot	Otef Aza	
Age	47.35 (16.58)	53.62 (15.81)	3.84 (442) ***
Gender			0.66
Men	135 (45.3)	75 (49.3)	
Women	163 (54.7)	77 (50.7)	
Education			8.59 *
Elementary school only	7 (2.4)	3 (2)	
Some high school	155 (52.4)	58 (38.2)	
Higher education	134 (45.3)	91 (59.9)	
Religiosity			36.51 ***
Secular	132 (45.1)	104 (68.9)	
Traditional	121 (41.3)	20 (13.2)	
Religious	40 (13.7)	27 (17.9)	
Place of Birth			35.04 ***
Israel	116 (38.9)	104 (68.4)	
Outside Israel	182 (61.1)	48 (31.6)	
Income (relative to mean Israeli monthly salary – 12,400 shekel)			25.65 ***
Below mean	182 (65.7)	47 (38.5)	
Similar to mean	54 (19.5)	44 (36.1)	
Above mean	41 (14.8)	31 (25.4)	
Family Status			10.00 **
Single	61 (20.5)	17 (11.2)	
Married	186 (62.4)	117 (77)	
Divorced, separated, or widowed	51 (17.1)	18 (11.8)	

*
p .05.**
p .01.***
p .001.

Table 2

Exposure Items and Variables by Community

	<i>n</i> (%)/ Mean (<i>SD</i>)		
Exposure item/ variable	Sderot	Otef Aza	² / <i>t</i> (<i>df</i>)
Exposure to terrorism items			
I have been exposed...	213 (72.2)	105 (70)	0.24
I lost property...	53 (20.9)	7 (5.8)	13.87***
I was injured...	36 (33.6)	12 (21.4)	2.64
A family member has been exposed...	205 (69.5)	101 (67.3)	0.22
A family member lost property...	92 (36.2)	18 (14.9)	18.01***
A family member was injured...	25 (9.8)	13 (10.7)	0.07
A family member died...	101 (39.8)	22 (18.2)	17.32***
A close friend has been exposed...	209 (70.8)	106 (70.7)	0.00
A close friend lost property...	135 (53.1)	40 (33.1)	13.29***
A close friend was injured...	42 (16.5)	30 (24.8)	3.60
A close friend died...	116 (45.7)	42 (34.7)	4.04
Exposure variables			
Trauma history	2.90 (2.16)	2.99 (1.92)	0.47 (448)
Perceived threat	4.14 (1.25)	3.79 (1.16)	2.57 (370)*

*
p .05.

**
p .01.

p .001.

Table 3

PTSD Symptoms and DASS Score by Community

		Number (%) of participants	
Variable	Mean (SD)	1 Symptom	Met criteria
Sderot			
Cluster B symptoms	2.22 (1.98)	203 (68.1)	203 (68.1)
Cluster C symptoms	2.31 (2.39)	191 (64.1)	120 (40.2)
Cluster D symptoms	2.26 (1.94)	213 (71.5)	170 (57.1)
PCL symptoms	6.79 (5.71)	249 (83.6)	105 (35.2)
DASS score	9.29 (10.17)		
Otef Aza			
Cluster B symptoms	0.76 (1.34)	48 (31.6)	48 (31.6)
Cluster C symptoms	0.82 (1.43)	55 (36.2)	19 (12.5)
Cluster D symptoms	0.82 (1.27)	63 (41.4)	32 (21.0)
PCL symptoms	2.39 (3.47)	82 (53.9)	10 (6.6)
DASS score	3.45 (5.40)		

Note. All of the differences between the two communities are significant at $p = .001$.

Table 4

Linear and Logistic Regression Results

Variable	PTSD diagnosis, OR (95% CI)	PCL score, (SE)	Depression score, (SE)
Step 1			
Age	1.00 (0.98–1.03)	−0.01 (0.07)	−0.05 (0.05)
Female	1.79 (0.97–3.30)	0.14 (1.69) **	0.04 (1.06)
Education	0.88 (0.50–1.54)	−0.06 (1.65)	−0.15 (1.03) **
Traditional	1.86 (0.95–3.66)	0.16 (2.01) **	0.04 (1.26)
Religious	0.50 (0.18–1.45)	−0.03 (2.48)	0.02 (1.56)
Immigrant	1.54 (0.77–3.08)	0.02 (1.93)	0.04 (1.20)
Income	0.82 (0.55–1.24)	−0.10 (1.12)	−0.09 (0.70)
Single	0.53 (0.19–1.48)	−0.07 (2.72)	0.00 (1.71)
DWS	2.54 (1.15–5.61) *	0.16 (2.43) **	0.15 (1.52) **
Step 2			
Trauma history	1.18 (1.02–1.36) *	0.15 (0.42) **	0.13 (0.27) *
Exposure level	1.27 (1.10–1.46) ***	0.20 (0.40) ***	0.16 (0.25) **
Perceived threat	1.29 (0.98–1.70)	0.11 (0.73) *	−0.01 (0.46)
Step 3			
Community	8.35 (3.14–22.22) ***	0.22 (2.08) ***	0.19 (1.3) **

Note. DWS = Divorced, widowed, or separated.

* $p < .05$.

** $p < .01$.

*** $p < .001$.

Table 5

Linear Regression Results by Community

Variable	PCL score, (SE)		Depression score, (SE)	
	Sderot	Otef Aza	Sderot	Otef Aza
Demographic variables				
Age	0.08 (0.10)	−0.20 (0.09)	0.02 (0.06)	−0.24 (0.04) *
Female	0.14 (2.16) *	0.14 (2.35)	0.05 (1.43)	−0.02 (1.14)
Education	−0.04 (2.08)	−0.05 (2.43)	−0.19 (1.38) **	0.05 (1.16)
Traditional	0.17 (2.44) *	0.20 (3.34) *	0.03 (1.62)	0.11 (1.62)
Religious	−0.01 (3.34)	−0.01 (3.07)	0.06 (2.21)	−0.04 (1.49)
Immigrant	0.01 (2.48)	0.03 (2.75)	0.03 (1.64)	0.13 (1.30)
Income	−0.11 (1.44)	−0.17 (1.53)	−0.08 (0.95)	−0.25 (0.75) *
Single	−0.10 (3.33)	0.18 (4.30)	−0.02 (2.20)	0.24 (2.09) *
DWS	0.17 (3.04) **	0.12 (3.77)	0.13 (1.99)	0.17 (1.83)
Exposure variables				
Trauma history	0.21 (0.52) ***	−0.02 (0.63)	0.21 (0.35) **	−0.13 (0.31)
Exposure level	0.24 (0.48) ***	0.11 (0.69)	0.19 (0.32) **	0.03 (0.33)
Perceived threat	0.08 (0.91)	0.23 (1.12) *	−0.05 (0.61)	0.18 (0.54)

Note. DWS = Divorced, widowed, or separated. We did not report the results from the models with probable PTSD diagnosis as the outcome variable because of the unreliability (i.e., abnormally large confidence intervals) of the odds ratios. The unreliability occurred, because very few participants from Otef Aza ($n=10$) met criteria for probable PTSD.

* $p < .05$.

** $p < .01$.

*** $p < .001$.