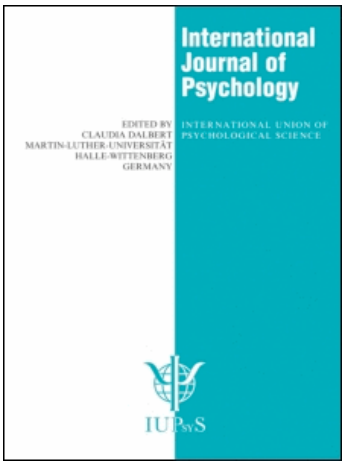

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Managing terror: Differences between Jews and Arabs in Israel

Eli Somer [a]; Shira Maguen [b]; Keren Or-Chen [c]; Brett T. Litz [d]
[a] University of Haifa and Maytal - Israel Institute for Treatment and Study of Stress, Haifa, Israel [b] San Francisco VA Medical Center and University of California, San Francisco School of Medicine, San Francisco [c] University of Haifa, Israel [d] Boston Department of Veterans Affairs Health Care Systems and Boston University School of Medicine, Boston

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Managing terror: Differences between Jews and Arabs in Israel

Eli Somer

University of Haifa and Maytal – Israel Institute for Treatment and Study of Stress, Haifa, Israel

Shira Maguen

San Francisco VA Medical Center and University of California, San Francisco School of Medicine, San Francisco, USA

Keren Or-Chen

University of Haifa, Israel

Brett T. Litz

Boston Department of Veterans Affairs Health Care Systems and Boston University School of Medicine, Boston, USA

Using telephone surveys, we examined exposure to terror, coping, and mental health response in randomly selected Jewish-Israelis (n = 100) and Arab-Israelis (n = 100) living in five Israeli cities affected by terrorism. Jewish-Israelis and Arab-Israelis were randomly selected for study participation and completed telephone surveys in May 2002, following an extended string of terror attacks and hostilities. Although terrorism is designed to target Jewish-Israelis, the rates of exposure were similar in the two groups. Arab-Israelis reported using a wider array of coping strategies, yet also endorsed more frequent PTSD and more severe depression symptoms than Jewish-Israelis. We examined a variety of demographic, ethnic, and religious predictors of different coping styles and found varying results. For example, acceptance coping was best predicted by Arab-Israeli ethnicity, being female, greater religiosity, and lower education. Predictors of mental health response to terror were also examined, with Arab-Israeli ethnicity, being female, adaptation coping and collaborative coping best predicting PTSD and depression symptoms. Arab-Israelis may not have the same access to overarching sources of patriotic support that are readily available to their Jewish compatriots, and civilian and economic inequity experienced by the Arab minority may add to a sense of diminished resources. Our findings justify outreach efforts to overlooked minorities at risk for posttraumatic distress. Women seem to be at particular risk for the development of mental health symptoms following terrorism, which should also be noted for outreach purposes.

A través de la utilización de encuestas telefónicas examinamos la exposición al terrorismo, el afrontamiento y las respuestas de salud mental en una muestra aleatoria de judíos-israelitas (n = 100) y árabes-israelitas (n = 100) que vivían en cinco ciudades israelitas afectadas por el terrorismo. Judíos-israelitas y árabes-israelistas fueron elegidos aleatoriamente para la participación en el estudio y completaron una encuesta telefónica en mayo del 2002, después de una numerosa cadena de ataques terroristas y hostilidades. A pesar de que el terrorismo tenía como objetivo central a los judíos-israelitas, el porcentaje de exposición fue similar en los dos grupos. Si bien los árabes-israelitas reportaron la utilización de mayores estrategias de afrontamiento, indicaron a su vez más frecuententemente que los judíos-israelistas el padecer bajo un transtorno de estrés posttraumático y bajo síntomas depresivos más severos. Diferentes resultados fueron observados durante el examen de una serie de predictores demográficos, étnicos y religiosos de los diferentes estilos de afrontamiento. Por ejemplo, la aceptación como estrategia de afrontamiento fue un mejor predictor del grupo étnico árabe-israelita, así como de personas del sexo femenino, más religiosas y con un nivel de educación inferior. En el análisis de los predictores de respuestas de salud mental ante el terrorismo

Correspondence should be addressed to Eli Somer, PhD, University of Haifa, Haifa, Israel, 31905 (E-mail: somer@research.haifa.ac.il).

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se observó que el pertenecer al grupo étnico árabe-israelita, ser de sexo femenino, así como presentar un estilo de afrontamiento adaptativo y colaborativo eran los mejores predictores del desarollo de un transtorno de estrés posttraumático y de síntomas depresivos. Àrabes-israelitas no tienen el mismo acceso a las vastas fuentes de soporte patriótico, que están a disposición inmediata de sus compatriotas judíos. Además la desigualdad civil y económica experimentada por la minoría árabe puede intensificar la percepción de una carencia de recursos. Nuestros resultados justifican la intensificación de los esfuerzos de vigilancia respecto de las minorías que se encuentran en riesgo de distress posttraumático. En intervenciones futuras se debe considerar, que aparentemente las mujeres se encuentran en mayor riesgo de desarrollar síntomas asociados con enfermedades mentales a causa del terrorismo.

En utilisant des sondages par téléphone, nous avons examiné l'exposition à la terreur, le processus d'adaptation et la réaction psychologique de santé mentale chez des israéliens juifs ($n = 100$) et des israéliens arabes ($n = 100$) vivant dans cinq villes israéliennes affectées par le terrorisme. Les israéliens juifs et les israéliens arabes ont été sélectionnés au hasard pour participer à cette étude et ont complété des sondages par téléphone en Mai 2002, suite à un enchaînement d'attaques terroristes et d'hostilités. Même si le terrorisme est conçu pour viser les israéliens juifs, les degrés dèxposition étaient similaires dans les deux groupes. Les israéliens arabes ont rapporté qu'ils utilisaient un éventail plus large de stratégies d'adaptation. Malgré cela, ils ont eu plus fréquemment un trouble de stress post-traumatique (TSPT) et des symptoms dépressifs plus sévères que les israéliens juifs. Nous avons examiné une variété de prédicteurs démographiques, ethniques et religieux de différents styles d'adaptation et nous avons obtenu des résultats variés. A titre d'exemple, le processus d'adaptation d'acceptation a été le mieux prédit par l'ethnicité israélienne arabe, par le sexe féminin, par une plus grande religiosité, et par un niveau d'instruction plus bas. Un examen des prédicteurs de la réaction psychologique à la terreur a indiqué que l'ethnicité israélienne arabe, le sexe féminin, un processus d'adaptation adaptatif et un processus d'adaptation collaboratif prédisent le mieux le TSPT et les symptoms dépressifs. Les israéliens arabes n'ont peut-être pas accès aux mêmes principales sources de soutien patriotique qui sont plus facilement à la portée de leurs compatriotes juifs. De plus, les inégalités civile et économique expérimentées par la minorité arabe peut exacerber un sentiment de ressources amoindries. Nos résultats justifient le déploiement d'efforts pour rejoindre les minorités négligées qui sont à risque de détresse post-traumatique. Les femmes semblent être à un risque particulier pour le développement de symptômes psychologiques suite au terrorisme, et ceci doit être également noté pour les objectifs visant à rejoindre la minorité israélienne arabe.

Keywords: Coping-behavior; PTSD; Arab; Israel.

The intense 3-year terrorism campaign referred to as the *Al-Aqsa Intifada* began in September 2000, and lasted through October of 2003. During this period, 16% of Israelis were directly exposed to a terrorist attack and 37% had a family member or friend directly victimized by terror (Bleich, Gelkopf, & Solomon, 2003). Little is known about how terror affects the ethnically diverse groups living in Israel, particularly Arab-Israelis. Although Arabs and Jews live side by side, there are distinct differences in demographics, culture, religion, background life experience, adversity, and various sources of support, factors that have been shown to impact response to trauma (e.g., Pole, Best, Metzler, & Marmar, 2005) and terrorism specifically (e.g., Galea et al., 2004). We know little about how rates of exposure and the mental health impact of terrorism differ between Jewish and Arab-Israelis, or about how Arab-Israelis cope with terror.

Arab ethnicity may be a risk factor for trauma-related distress, with underclass status creating a dual coping burden (Bleich, Gelkopf, Melamed, & Solomon, 2006; Hobfoll, Canetti-Nisim, & Johnson, 2006). Conversely, political ideology may serve as a protective factor in the face of continuous terror for both Jews (Laor et al., 2006) and Palestinians (Punamäki, Qouta, & El-Sarraj, 2001). However, Arab-Israelis may struggle to make meaning of their plight; they may neither identify with the Palestinian cause because random terror poses a threat to their lives, nor the Israeli ethos because it represents the negation of the national aspirations of their people. This blockage of meaning making could contribute to unique stress (Park & Folkman, 1997).

Freedy, Hobfoll, and Ribbe (1994) applied the Conservation of Resources (COR) theory to the Middle East conflict, which predicts that resource loss is central to the experience of psychological distress. Hobfoll's COR theory (1989) suggests that people who invest resources towards a desired goal experience less distress compared to those who spend their resources without achieving a

desired return. Consequently, psychological distress among Arab-Israelis may be elevated due to resources lost by the armed conflict and the extent to which their distress failed to provide meaning or promote their aspirations.

Divergent worldviews may also play a role in how the two groups cope with terrorism. While those operating from an individualist worldview (e.g., Jewish-Israelis), may perceive themselves to be independent and autonomous, collectivists (e.g., Arab-Israelis) may perceive themselves as being intrinsically part of a larger group. These fundamental differences inherently impact coping style, with collectivists more frequently employing strategies aimed at protecting the family, garnering strength through religion, or rallying political involvement (e.g., Dwairy, 2002; Sagy, Orr, Bar-On, & Awwad, 2001).

In this study, we examined exposure to terror, coping, and mental health response in Jewish-Israelis and Arab-Israelis living in the same areas affected by terror. We hypothesized: that Jewish-Israelis would report greater exposure to terror events, given that Jews are the targeted group for terrorism; that Jews and Arabs would differ in their coping styles, with Arabs reporting greater utilization of collectivist coping related to the family, community, and religion; and that Jews would be more resilient to psychological distress, given that they have majority status, more national support, and a greater national ethos.

METHOD

Procedure

Data for this study were collected for two consecutive weeks during the month of May 2002, following an extended string of terror attacks and hostilities. During this period, we interviewed Jewish and Arab Israelis residing in the three major cities most highly affected by terrorism (Jerusalem, Tel Aviv-Yaffo, and Haifa), and in two smaller, ethnically mixed cities (i.e., Acre and Nazareth). The volatile situation in Israel warranted rapid data collection to ensure equivalence in terms of participant exposure to terrorism and media coverage.

In order to ensure appropriate selection of participants in the Jewish-Israeli and Arab-Israeli groups, we used a computer-generated, random telephone list (Telepathy Survey Software, courtesy of Dvash Software Systems). Bilingual trained interviewers were instructed to call consecutive numbers until the phone was answered by an individual. Only consenting adults (i.e., over 18 years of age) were interviewed.

TABLE 1
Demographic variables of Jewish-Israelis and Arab-Israelis

Demographic characteristics	*Jewish-Israelis (n = 100)*	*Arab-Israelis (n = 100)*	*Statistic comparing the two groups*
Age (years)	M = 43.60 (SD = 16.76)	M = 36.62 (SD = 13.02)	F = 10.82**
Sex			
Male	24%	34%	χ^2 = 2.43
Female	76%	66%	
Marital status			
Married	60%	73%	χ^2 = 3.79
Not married	40%	27%	
Education (years)	M = 13.39 (SD = 2.36)	M = 12.48 (SD = 3.15)	F = 5.21*
Religion			
Jewish	100%	0%	χ^2 = 200**
Christian	0%	72%	
Muslim	0%	27%	
Druze	0%	1%	
Religiosity			
Religious	10%	18%	χ^2 = 32.66**
Traditional	26%	58%	
Secular	64%	24%	
Birthplace			
Israel	60%	99%	χ^2 = 46.66**
Other	40%	1%	

*p<.05; **p<.01.

Participants

Participants were 100 Arab-Israelis and 100 Jewish-Israelis (see Table 1). Participants were an average of 40 years (SD = 15.37), with 71% of participants being female. The majority were married (66%), about a quarter were single (26%), and the remainder were either divorced (6%) or widowed (2%). Participants were Jewish (50%), Muslim (36%), Christian (13%), and Druze (1%). Fourteen per cent of the study group endorsed being religious, 42% identified themselves as "traditional," and 44% as secular.

Measures

The phone survey included items and scales that measured: (1) demographic characteristics; (2) degree of exposure to terror attacks; (3) modes of coping; and (4) mental health impact (PTSD, depression, and somatization).

Demographics. Participants were asked to report their age, sex, ethnicity, marital status, level of

TABLE 2
Factor loadings for Coping with Terror Scale ($N = 200$)

	Factor loadings				
Item	*Adaptation*	*Avoidance*	*Acceptance*	*Collaborative*	*Enhancement*
Take actions directly	*.65*	.04	.08	.21	.31
Design survival plans	*.74*	.02	.01	.02	.14
Engage in entertainment	.16	*.63*	.03	.04	.37
Self-care	.09	.04	.03	.12	*.84*
Avoid certain activities	*.81*	.09	.12	.14	.05
Spend time with friends and family	*.65*	.04	.33	.18	.18
Less exposure to news	.03	*.71*	.02	.05	.11
Accept the situation	.06	.18	*.75*	.16	.07
Pray	.25	.03	*.76*	.15	.03
Keep busy	.21	.21	.38	.16	*.48*
Ignore the situation	.25	*.70*	.20	.80	.17
Get involved politically	.04	.23	.03	*.80*	.12
Engage in humanitarian activities	.03	.09	.07	*.48*	.07
Avoid travel to "enemy" communities	*.64*	.03	.03	.11	.22
Seek counseling	.24	.39	.05	*.49*	.17
Eigenvalues	2.71	1.98	1.79	1.36	1.3
% variance	18.08	13.24	11.91	9.08	8.67

Factor loadings over .40 appear in italic.

education, religion, degree of religiosity, and birthplace.

Exposure to terrorism. Participants were asked to report the extent to which they or their loved ones had been exposed to terrorism via a six-item dichotomous questionnaire (see Table 2 for a list of scale items). These items reflected multiple aspects of exposure to terrorism including direct exposure, exposure to the aftermath of terrorism, and secondary exposure to terrorism via loved ones and friends. A sum score was derived, with possible scores ranging from 0 to 6.

Coping with Terror Scale (CTS). The series of terror attacks that were the context for this study created an acute climate of ongoing threat and destruction to which Israelis reacted with distinct ways of coping (e.g., planning escape routes when dining out); however, no specific scales were readily available to capture these terror-specific ways of coping. Because existing coping measures were limited, we attempted to compose a *culturally relevant, situation-specific* coping scale in order to obtain the most valid measure of types of terrorism-specific coping, and we attempted to index the measurement of coping to the specific context of the Al-Aqsa Intifada. The items comprising the Coping with Terror Scale (CTS) were based on the outcome of two focus groups with 12 Israeli citizens residing in Haifa, one of the ethnically mixed terror-afflicted cities. Participants were asked to address the following question: "What are you doing that helps you cope with the current threat of terrorist attacks?" An analysis of the transcribed verbalizations of the focus groups yielded 15 ways of coping with the stress of ongoing terror. In the second phase, the first author and an Arab graduate student separately read the two groups' transcribed discussions and systematically coded and sorted the material into key themes by means of cross-case analysis and constant-comparison method. Finally, core themes were identified and compared, and analytical categories were later illustrated by specific quotations (Krueger, 1994). These 15 themes were worded as the final items in the coping instrument.

The final instrument included the following coping tactics: (1) direct coping, (2) planning, (3) mental distraction, (4) personal care, (5) careful restraint and avoidance of risk (e.g., avoidance of public places), (6) spending more time with family and friends, (7) deliberate avoidance of exposure to the news, (8) acceptance of the situation, (9) prayer, (10) investment of attention and energy resources in constructive activities (i.e., work, studies, house chores, etc.), (11) ignoring the situation, (12) political activism, (13) humanitarian activism, (14) avoidance of travel to or visits of neighbourhoods of the rival ethnic group, and (15) seeking professional help. Each of these strategies for coping with terror was evaluated on a 5-point Likert scale; participants indicated how much each statement reflected their coping tactics during the previous month, ranging from 1 (*not at all*) to 5 (*very much*).

TABLE 3
Jewish-Israeli and Arab-Israeli reports of exposure to terror events

Exposure items	*% Jewish-Israelis endorsing item*	*% Arab-Israelis endorsing item*
Have you ever been in an area where a terror attack occurred?	5%	9%
Have you ever been injured due to a terror attack?	0%	1%
Did you escape being hit due to luck?	19%	20%
Did you ever pass by the location of an attack shortly after it happened and see evidence of the attack?	23%	28%
Were you involved in providing physical or emotional help following the attack?	6%	6%
Do you have relatives or close friends who were injured by the Palestinian attacks or by the Israeli Army in the occupied territories?	24%	22%

We conducted an exploratory factor analysis on the entire sample to extract potential latent variables from the scale (see Table 2). A five-step approach was utilized in determining the number of factors in the coping measure. First, we employed the Kaiser-Guttman rule for eigenvalue magnitude, which stipulates that the number of factors is equal to the number of eigenvalues greater than one. Second, given that using Kaiser-Guttman alone may overestimate the number of factors, we employed a scree plot of the eigenvalues against the corresponding factor numbers. Additionally, we took into account the cumulative proportion of the variance and the magnitude of the residual correlations. Finally, we were guided by theory and ensured that the internal consistency or interpretability of the factors was theoretically intact.

A Principal Component Analysis using a Varimax rotation revealed five factors, accounting for 61% of the variance were found: (1) Adaptation (items 1, 2, 5, 6, 14; $\alpha = .77$), (2) Avoidance (items 3, 7, 11; $\alpha = .58$), (3) Accepting fate (items 8, 9, $\alpha = .52$), (4) Enhancing personal resources (items 4, 10, $\alpha = .46$), and (5) Collaborative coping (items 12, 13, 15, $\alpha = .36$).

Posttraumatic stress symptoms. Posttraumatic symptoms were measured by the Impact of Event Scale-Revised, indexed to exposure to terror events (IES-R; Weiss & Marmar, 1997). The IES-R is a 22-item self-report instrument used to assess current subjective distress following traumatic events with three subscales: avoidance, intrusion, and hyperarousal. The IES-R scores provide a mean item score ranging from 0 to 4 (for both the subscales and the entire scale), and the measure is scored on a 5-point Likert scale ranging from *not at all* to *extremely*. The authors reported high test–retest reliability, criterion, content, and construct validity of the IES-R (Weiss & Marmar, 1997). The Cronbach's alpha for this sample was .92.

Depression and somatization symptoms. Depression and somatization symptoms were measured using subscales of the SCL-90-R (Derogatis, 1977), a widely used 90-item multidimensional self-rating scale measuring symptomatology and distress in the last week. There are nine symptom clusters, and respondents indicate the amount of disturbance caused by a particular item on a 6-point Likert scale ranging from 1 (*not at all*) to 6 (*extremely*). The SCL-90-R has been found to have good reliability and validity (e.g., Buckelew, 1988), and has been normed on multiple groups, including nonpatient adults. The Cronbach's alpha for this sample was .84 for the Depression subscale and .91 for the Somatization subscale.

RESULTS

Rate of exposure

Jewish- and Arab-Israeli participants did not differ on rates of exposure, $F(1, 195) = 0.74$ (see Table 3 for items and percentages).

Coping style

We compared Jewish- and Arab-Israelis participants on each of the five coping styles, and we found that while there were no differences in adaptive coping style, Arab-Israelis tended to endorse greater use of acceptance, avoidance, collaborative, and enhancing personal resource coping (see Table 3).

In a post hoc analysis, we examined demographic predictors of each of the four coping styles that differed between Jewish-Israelis and Arab-Israelis in order to understand some of these differences better. Each of the demographic variables: age, sex, ethnicity, marital status, level of education, degree of religiosity, and birthplace were entered into a

TABLE 4
Coping and mental health outcomes in Jewish-Israelis and Arab-Israelis

Outcome Variable	*Jewish-Israelis (n = 100) M (SD)*	*Arab-Israelis (n = 100) M (SD)*	*Statistic comparing the two groups*
Coping			
Adaptation	2.97 (1.14)	3.04 (1.24)	$F = 0.19$
Accepting fate	2.30 (1.14)	3.52 (1.36)	$F = 46.61$**
Avoidance	1.98 (0.91)	2.63 (1.13)	$F = 19.60$**
Enhancing personal resources	2.55 (1.20)	2.94 (1.23)	$F = 5.09$*
Collaborative	1.50 (0.66)	2.06 (0.78)	$F = 29.55$**
PTSD Symptoms			
Avoidance	0.87 (0.84)	1.64 (0.87)	$F = 39.52$**
Intrusions	1.19 (1.01)	1.87 (1.04)	$F = 21.37$**
Hyperarousal	1.19 (0.96)	1.75 (1.26)	$F = 12.63$**
Depression	0.86 (0.60)	1.58 (0.80)	$F = 51.62$**
Somatization	0.72 (0.79)	0.78 (0.97)	$F = 0.24$

*$p<.05$; **$p<.01$.

regression equation, with each of the five coping styles as dependent variables.

1. The following demographic variables accounted for 34% of the variance in *acceptance coping*, $F(7, 186) = 13.95$, $p<.01$: ethnic group ($\beta = -.33$, $p<.01$), religiosity ($\beta = -.26$, $p<.01$), education ($\beta = -.18$, $p<.01$), and sex ($\beta = .14$, $p<.05$). Those who were Arab-Israelis, more religious, less educated, and female were more likely to use acceptance coping.
2. The following demographic variables accounted for 14% of the variance in *avoidance coping*, $F(7, 185) = 4.32$, $p<.01$: age ($\beta = -.24$, $p<.01$) and ethnic group ($\beta = -.22$, $p<.01$). Those who were Arab-Israeli and younger in age were more likely to use avoidance coping.
3. The following demographic variables accounted for 10% of the variance in *enhancement of personal resource coping*, $F(7, 187) = 2.89$, $p<.01$: sex (female; $\beta = .25$, $p<.01$) and ethnic group ($\beta = -.14$, $p = .09$). Those who were female and Arab-Israeli were more likely to endorse enhancement of personal resources.
4. The following demographic variables accounted for 18% of the variance in *collaborative coping*, $F(7, 186) = 5.99$, $p<.01$: ethnic group ($\beta = -.44$, $p<.01$) and sex ($\beta = .25$, $p<.01$). Those who were Arab-Israeli and female were more likely to use collaborative coping.

Mental health

Jewish-Israelis and Arab-Israelis were compared on three mental health outcomes related to terror events: PTSD, depression, and somatization symptoms.

1. *PTSD symptoms*. Arab-Israelis endorsed more frequent PTSD symptoms than Jewish-Israelis, $F(1, 167) = 28.34$, $p<.01$ (see Table 4 for breakdown by symptom cluster).
2. *Depression symptoms*. Arab-Israelis also endorsed significantly more intense depression symptoms than Jewish-Israelis, $F(1, 198) = 51.62$, $p<.01$.
3. *Somatization symptoms*. There were no significant differences in somatization symptoms between Jewish- and Arab-Israelis, $F(1, 198) = 0.24$, *ns*.

Predictors of mental health

We examined demographic and terrorism-related predictors in order to understand differences in mental health outcome better between the two groups. Before conducting regression analyses, a number of potentially related demographic variables were correlated with each of the significantly different mental health outcome variables (i.e., PTSD and depression). These variables included ethnic group, age, sex, education, religiosity, marital status, and birthplace. If a correlation was significant, then the appropriate demographic variable was included in the regression equation (see Table 5). For each of the subsequent regression models, significant demographic characteristics were first entered in Block 1 to partial out the variance attributable to these background variables. In Block 2 we entered the exposure variable and each of the five coping

TABLE 5
Correlations among variables in regression models *Correlations Among Variables in Regression Models*

Variable	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
1. PTSD	—									
2. Depression	.77**	—								
3. Somatization	.58**	.66**	—							
4. Group	− .38**	− .46**	− .04	—						
5. Age	.03	− .03	.19**	.23**	—					
6. Sex	.21**	.23**	.20**	.11	.05	—				
7. Education	− .22**	− .23**	− .27**	.16*	.06	− .05	—			
8. Religiosity	− .20**	− .21**	− .09	.34**	.10	− .03	− .26**	—		
9. Marriage	− .13	− .12	− .09	.14	− .47**	− .04	.05	.15*	—	
10. Birthplace	− .15	− .21**	.02	.48**	.45**	.11	.08	.19**	− .07	—

Group: 1 = Arab-Israeli, 2 = Jewish-Israeli; Sex: 1 = male, 2 = female; Religiosity: 1 = religious, 2 = traditional, 3 = secular; Marriage: 1 = married, 2 = not married; Birthplace: 1 = born in Israel, 2 = born outside of Israel. *$p<.05$; **$p<.01$.

variables. In Block 3, we entered ethnicity by coping interactions in order to better determine if ethnicity moderated the effects of coping on PTSD and depression. Prior to testing interactions, the ethnicity and all coping variables were centred. However, because for both regressions, the ΔF statistic was not significant for Block 3, regression results are reported for models re-run with only Block 1 and Block 2, which comprise the more parsimonious model. In the final model, variables were not centred since the interaction terms were not included.

Predictors of PTSD symptoms. In the regression model predicting PTSD symptoms (see Table 6), The model specified accounted for 43% of the variance, $F(10, 149) = 11.07$, $p<.01$, and the ΔF statistic was significant for Block 1 ($p<.01$) and Block 2 ($p<.01$). In the final block, ethnic group, sex, adaptation coping, and collaborative coping each significantly predicted PTSD symptoms. Those who were Arab-Israeli and female reported greater PTSD symptoms, as did those employing greater adaptation and collaborative coping.

Predictors of depression symptoms. In the regression model predicting depression symptoms (see Table 7), the model specified accounted for 45% of the variance in depression symptoms, $F(11, 175) = 13.12$, $p<.01$, and the ΔF statistic was significant for Block 1 ($p<.01$) and Block 2 ($p<.01$). In the final model, depression symptoms were predicted by ethnic group, sex, adaptation coping, and collaborative coping. Arab-Israelis, females, and those employing greater adaptation and collaborative coping reported greater depressive symptoms.

TABLE 6
Summary of Hierarchical Regression Analysis for Predictors of PTSD (N = 149)

Variable	*B*	*SE B*	β
Step 1			
Group	− .67	.14	− .37**
Sex	.53	.14	.27**
Religiosity	− .06	.11	− .04
Education	− .05	.02	− .15*
Step 2			
Group	− .38	.14	− .21*
Sex	.28	.13	.14*
Religiosity	− .01	.10	− .01
Education	− .04	.02	− .12
Exposure	.03	.05	.04
Adaptation Coping	.19	.05	.25**
Acceptance Coping	.07	.05	.10
Avoidance Coping	.05	.06	.06
Collaborative Coping	.30	.09	.25**
Enhancing Resource Coping	.07	.05	.09

Model statistics for the PTSD symptom index equation is: $F(10, 149) = 11.07$, $p<.01$. R^2 for step 1 is .24; $\Delta R^2 = .19$ for step 2 ($p<.01$); R^2 for step 2 is .43; Group: 1 = Arab Israeli, 2 = Jewish Israeli; Sex: 1 = male, 2 = female; Religiosity: 1 = religious, 2 = traditional, 3 = secular; Education: years of formal education. Participant numbers may vary slightly due to missing data. *$p<.05$; **$p<.01$.

DISCUSSION

There were no differences in exposure to terrorism between Jewish-Israelis and Arab-Israelis. Although terrorism is designed to target Jewish-Israelis, the effects are far-reaching and undiscriminating.

We also found that Arab-Israelis reported more frequent PTSD symptoms and more intense depression symptoms, as compared to Jewish-Israelis, which is consistent with previous findings (Bleich et al., 2006; Hobfoll et al., 2006). Because Arab-Israelis are a minority in Israel and often

TABLE 7
Summary of Hierarchical Regression Analysis for Predictors of Depression (N = 175)

Variable	*B*	*SE B*	β
Step 1			
Group	− .71	.11	− .45**
Sex	.49	.11	.29**
Religiosity	− .04	.08	− .04
Education	− .04	.02	− .13*
Birthplace	− .01	.04	− .02
Step 2			
Group	− .57	.12	− .37**
Sex	.36	.10	.21**
Religiosity	− .01	.07	− .01
Education	− .03	.02	− .10
Birthplace	− .01	.03	− .01
Exposure	.01	.04	.02
Adaptation Coping	.20	.04	.30**
Acceptance Coping	.04	.04	.08
Avoidance Coping	− .04	.05	− .05
Collaborative Coping	.19	.07	.19*
Enhancing Resource Coping	− .03	.04	− .05

Model statistics for the PTSD symptom index equation is: $F(11, 175) = 13.12$, $p<.01$. R^2 for step 1 is .31; $\Delta R^2 = .14$ for step 2 ($p<.01$); R^2 for step 2 is .45; Group: 1 = Arab Israeli, 2 = Jewish Israeli; Sex: 1 = male, 2 = female; Religiosity: 1 = religious, 2 = traditional, 3 = secular; Education: years of formal education. Birthplace: 1 = born in Israel, 2 = born outside of Israel. Participant numbers may vary slightly due to missing data. *$p<.05$; **$p<.01$.

burdened by greater economic adversity and social strain, it is not surprising that they experience greater mental health impact. Jewish-Israelis have more community and social resources that arguably buffer the impact of terror.

Our results suggest that Arab-Israelis attempt to employ a wider array of coping strategies, which might arise out of greater demands and greater overall adversity (e.g., Somer, Ruvio, Soref, & Sever, 2005; Spurrell & McFarlane, 1993). Arab-Israelis may need to call on a wider range of coping strategies, including collectivist collaborative coping, because they do not have the same access to the overarching sources of patriotic and cultural support that are readily available to their Jewish compatriots. The national ethos and shared meaning may enhance the resilience of Jewish-Israelis when faced with terror-related challenges. Stigmatization and ethnic discrimination are considered liabilities in the development of PTSD in minority groups (e.g., Loo, 1994). Being aligned with the enemy, facing discrimination, and having their mental health and other needs placed as a lower priority, may all contribute to resource loss, disillusionment, and an exacerbation of mental health symptoms in the face of terrorism.

Adaptation (i.e., employing a variety of problem-solving strategies) and collaborative coping (e.g., employing social action) were predictors of psychological distress, while the more emotion-focused ways of coping (acceptance, avoidance, and personal care) were not. The uncontrollability of the random terror campaign rendered employment of problem-solving strategies ineffective and might have put those who adopted them at further psychological risk. Israelis were either unaware of or were unable to distinguish between those aspects of their terror-stricken environment that were controllable and those that were not. This finding is in line with earlier findings that demonstrated a relationship between decreased controllability awareness and increased threat appraisal under the threat of terror (Somer, Zrihan Weitzman, & Todrank Heth, 2004).

This study has several noteworthy limitations. First, this study was conducted with an Israeli sample and may not generalize to different cultures. Second, it focused on citizens from five specific cities and, as a result, cannot necessarily be generalized to all Arab- and Jewish-Israelis. Third, this study is cross-sectional, so the direction and temporal relationship of associations cannot be determined, nor can the unfolding causal trajectory of adaptation to terror, which requires longitudinal study. Fourth, some of the measures were created to measure terror-related variables (e.g., coping) and may not be as empirically sound as existing validated measures. Finally, there may be a number of third variables (e.g., personality, prior trauma histories, genetic predispositions, religiosity, etc.) that may account for some of these findings and should be measured in future studies.

Nevertheless, several important findings can be gleaned from this study. First, being an Arab in Israel is a risk factor for posttraumatic distress and depression following exposure to terror attacks. This study has implications for welfare and mental health agencies operating among civilians victimized by armed conflicts. Our findings justify outreach efforts to overlooked minorities at risk for posttraumatic distress. Second, women seem to be at particular risk for the development of mental health symptoms following terrorism, which should also be noted for outreach purposes. Finally, coping seems to be related to levels of distress in an Arab-Israeli sample. Further research should help clarify this complex relationship between coping and psychological distress, especially detangling whether coping functions as a buffer against distress or whether it is an epiphenomenon of distress.

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