

Parent's Place

Parent's Place Sderot was developed as a response to the ongoing threat to the development of the children as a result of continual rocket attacks since 2001. In collaboration with the Jewish Family and Children's Services of San Francisco, a comprehensive service package of support for young families was initiated. This report describes the program, its evaluation and results, and future directions.



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"Parent's Place" in Sderot: Putting parents in focus

Program Summary and Evaluation

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Mission statement: Parents' place in Sderot was built with the vision to strengthen the capacity of parents living under continuous threat of missiles attacks. The center in Sderot is based on the model of Parents' Place developed and supported by Jewish Family and Children Services in San Francisco, and aims to provide services for parents coping with the challenges of raising children in times rapidly alternating between normal routine and emergency states.

Background: The Israel Center for the Treatment of Psychotrauma (ICTP) has been providing various interventions for parents, children, and educational staff in Sderot and its' surrounding areas since 2004. Through the experience gathered by implementing the different interventions, and better familiarity (attunement) with the local needs, the ICTP staff realized that in order to provide young children in these areas with the best care we needed to address their parents' needs. Collaborating with parenting professionals in Israel, the ICTP staff developed unique programs focused on providing parents with knowledge and practical tools of coping with stressful and traumatic experiences as parents of young children.

Through the "Parent's Place" program five different modules of intervention with parents, children and educational staff have been developed.

- A parent-child playgroup program in collaboration with Dr. Esther Cohen of the Hebrew University.
- A training program for educational staff based on a program by Prof. Pnina Klein of the Bar Ilan University.
- A parental therapy group in collaboration with the local psychological services at Sha'ar Hanegev, utilizing their local experience and therapists.
- Bi-weekly question & answer sessions with the local project coordinator for parents and staff, addressing personal issues and questions regarding parenting issues.
- Monthly lectures provided by professionals and experts, discussing issues of parenting and child development, which are open to the general public.

The “NAMAL” Program - Make Room for Play

SUMMARY

The NAMAL (the Hebrew initials for "Make room for Play") program helps parents practice playful interactions with their child. Its aim is to promote and aid the development and adjustment of children under continual trauma.

The program is based on several main principles:

1. Free imaginative play is a central tool for cognitive, emotional and social development for all children.
2. Play is a central and effective tool in promoting resilience and avoiding risk for children undergoing traumatic events and living in conditions of distress and crisis.
3. Play is a central tool for treatment of children with developmental and emotional problems.
4. Incorporating parents into a child's playful activity significantly improves the parent-child relationship, the child's adjustment, and the child's progress in various developmental domains.
5. It is possible, economical and efficient to help parents become the child's agents for change by training them in a group to play with their child.
6. In order to promote parents' motivation and ability to be involved in a playful activity with their children, there is a need to provide them with a setting of a symbolic, enjoying and emotionally significant group activity. This is in addition to the enhancing of their comprehension regarding the contribution of play for the child and to the practice they get in interacting in a playful manner with the child, which sends him a message of acceptance and encourages his creativity.

The NAMAL program was developed based on the "Child Parent Relationship Therapy" program (Bratton et al, 2006), which is a filial play therapy program, in which the practice is done in the setting of a parents group. The NAMAL program emphasizes experiential learning of the parents, together with the child. In addition, it has been adapted for parents and children living under tense security conditions and socio-economic stress. Also, the NAMAL program specifically addresses the effects of stress on children's play (post-traumatic play). It is especially important to make room for play under stressful conditions, since the stress can impede the child's ability to play. Furthermore, children often process distressing material through the use of play and it is often their way of processing trauma.

The "Namal" program consists of 10 afternoon group meetings in which parent-child dyads participate. The meetings consist of playful and fun music, craft, drama and movement activities which have been suited for children ages 2-4 years old and their parents. The concepts presented during each meeting are based on themes conceptualized and written by Dr. Esther Cohen of the Hebrew University, a well known professional on the subject of parenting. Together with her, these themes have been integrated into playful parent-child activities by the

project's staff. The themes are presented by a phrase of the day which allow the facilitators to introduce the rationale of the activities. At the end of each session, summary sheets including a summary of activities, song lyrics, and a simple explanation of the content that was introduced through the activities are handed out to the parents. Following the activities, dinner is served for all the participants at no cost to them (they pay 10 nis for every session).

Session Themes:

The main themes of the program are:

- The **Parent-child bond** as a secure, and protective base
- Promotion of **independence and self esteem**
- **Playfulness**, humor and creativity
- **Expression** and reflection of feelings (emphasis on fear and anger, as well as the shift between positive and negative feelings)
- **Playing** through trauma

Theme 1: Parent-child bond as a secure base

*Phrase: "Something looked upon with love,
becomes beautiful"*

Main message : "I, your parent, love you and take care of you, I am here for you"

Activities: Scarf rhyme: "I am inviting you to our special meeting..."; Balancing ball: Emphasizes the parents role in watching over and protecting the child ; Joint relaxation: Relaxation with balancing ball and calming music



Theme 2: Promotion of independence and self esteem

*Phrase: "All a child needs is an adult
that believes in him"*

Main Message: "Don't do for your child, what he can do for himself"

Activities: Colorful brush, Tunnel



Theme 3: Playfulness, humor and creativity

Phrase: "All that is needed in order to play is a good imagination and a pile of junk"

Main Message: The importance of using creativity and humor to alleviate stress and develop flexible thinking; Creativity can be incorporated into every activity

Activities: Building from scraps; Decorating Mom with stickers; Being playful with our body parts



Theme 4: Reflection of actions and intentions

Phrase: "Focus on the bagel and not the hole, otherwise there won't be anything to eat"

Main Message: Focus on what the child can do and create by reflecting his actions and intentions

Activities : Child-parent mirror games; Verbal mirroring of child's play with prop



Theme 5: Expression and reflection of feelings

Phrase: "If you hold things in, you might end up with a stomach"

Main Message: The importance of acknowledging emotions, even the bad ones

Activities: Identifying emotions in music: *The 3 dwarfs rhyme, Kuka Metuka*



**Theme 6: Play under trauma
(post-traumatic play)**

Phrase: "There are 2 things that we can give our children- one is roots and the other is wings"

Main Message: Helping the child create a narrative for fragmented and frightening experiences; Enforcing the parent's and child's feeling of having a support system; Emphasizing what must be done in times of danger; Use of imagination for relaxation

Activities: Green Light Go, Red Light Stop!
The story of the Five Balloons;
Special box the parent made for the child



Background of each year:

Year	# groups	# Dyad
2009	2	20 dyads
2010	4	45 dyads
2011	4	41 dyads

25% percent attrition rates

Current Status:

Total 106 dyads have participated in Namal.

Groups 9 and 10 begun April 2011.

NAMAL Program EVALUATION

We are conducting the evaluation of the NAMAL project in 4 ways:

- (A) Pre and Post questionnaires
- (B) Parental Feedback, collected during the last group meeting
- (C) Evaluations of the group facilitators
- (D) One-year parent follow-up interview by telephone

A) PRE & POST QUESTIONNAIRES¹

Prior to and following participation in several of Namal groups, mothers filled out questionnaires. These included the following:

PSOC - Parental sense of competence questionnaire (Johnston & Mash, 1989²). This questionnaire includes 17 items, and defines the parental sense of competence as a combination of two constructs: parental satisfaction and parental efficacy. Our results indicate that following the intervention mothers' sense of competence increased ($t(24) = -1.8, p = .04^3$).

CBCL - Child's behavioral checklist (Achenbach, 1991⁴) which measures the child's emotional and behavioral functioning, before and after the participation in the program. We found that the scores in the overall scores of the CBCL were lower, indicating less externalizing and internalizing symptoms, following the participation in the NAMAL program ($t(12) = 3.34, p = .003^5$).

PARQ - Parental acceptance, rejection/ control of the child (Rohner, & Khaleque, 2005⁶), questionnaires are currently being collected , with the expectation of an increased ability for parents to accept and to be less controlling/ rejecting of their child.

¹ The pre & post assessments of NAMAL were conducted by Dr. Esther Cohen, Liat Reggev, Michal Geta Moria Efrat Harel from the Hebrew University of Jerusalem.

² Johnston, C., & Mash, E. J. (1989). A measure of parenting satisfaction and efficacy. *Journal of Clinical Child Psychology*. 1989 Jun Vol 18(2) 167-175

³ One-tailed

⁴ Achenbach, T. M. (1991). *Manual for the child behavior checklist/4-18 and 1991 profile*. Dept. of Psychiatry, University of Vermont. Burlington, VT.

⁵ One-tailed

⁶ Rohner, R. P., & Khaleque, A. (2005). *Handbook for the Study of Parental Acceptance and Rejection*. Fourth Edition. Rohner Research Publications. Pp. 137-183.

B) PARENTAL FEEDBACK

During the final group meeting, mothers were asked to provide feedback on their experience in the group.

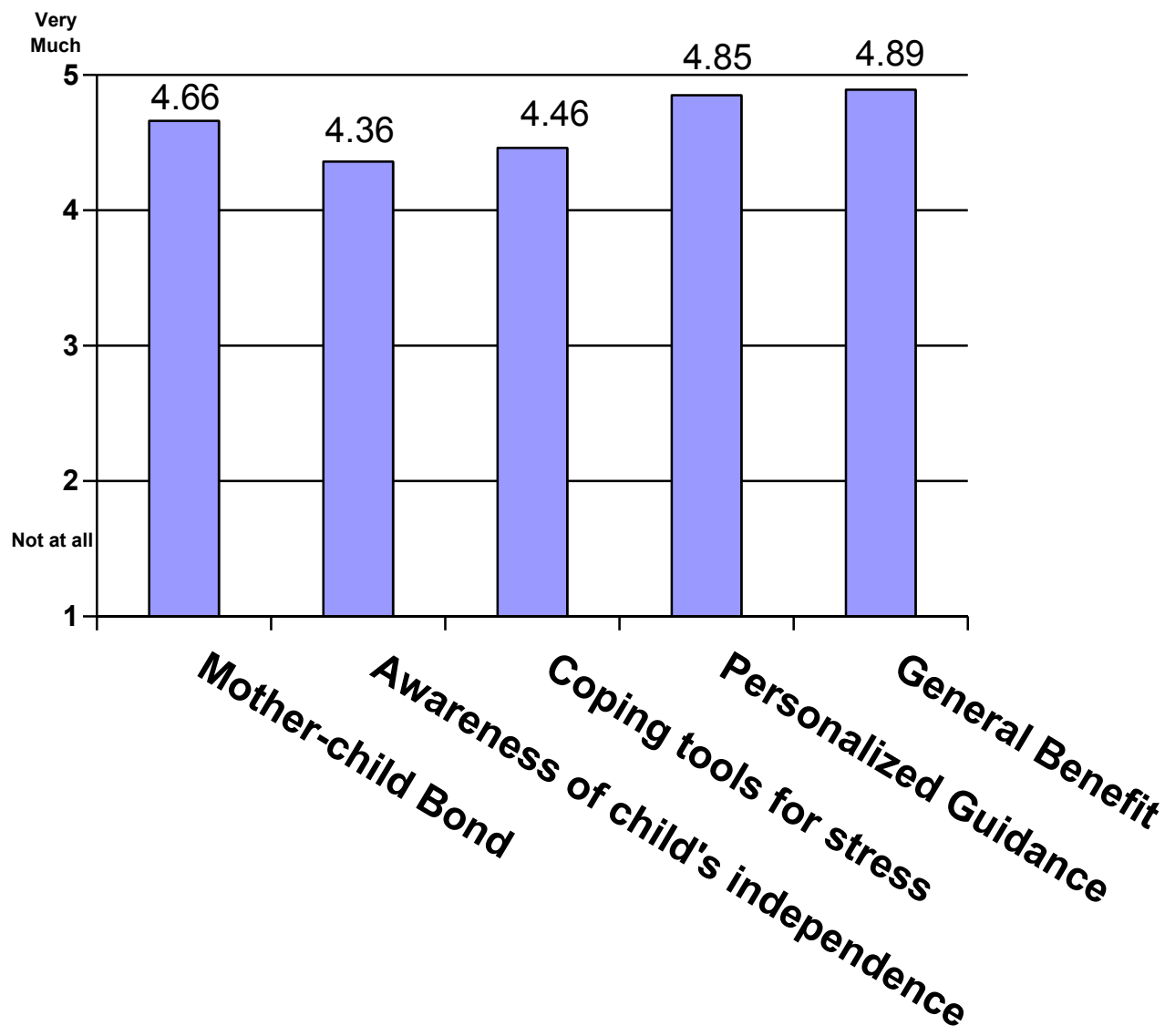
Below are the collective results from feedback given by 39 mothers who participated in six NAMAL groups during 2009-2011.

Mothers were asked to report, on a 5-point scale (1= "did not help me at all", 5= "helped me very much") to what degree did the program contribute to their parenting abilities. The mean scores were as follows:

To what degree did the program contribute to: (1 = not at all, 5 = very much)	Mean score (SD)
Strengthening the bond between you and your child	4.66 (.53)
Increasing your awareness to the importance of encouraging your child's independence	4.36 (.84)
Increasing your ability to address and reflect your child's feelings	4.51 (.72)
Broadening your knowledge and practical tools for dealing with the difficulties children face under continuing stress	4.26 (.78)
Increasing your ability to identify stress and difficulty in your child	4.08 (.77)
Having more creative tools for reducing the level of stress, following the participation in the program	4.46 (.64)

How important were the following components of the program to you? (1 = not important at all, 5 = very important)	Mean score (SD)
Verbal messages	4.59 (.75)
The use of sayings	4.41 (.82)
Experiential activities with the child	4.90 (.31)
Relaxation	4.56 (.75)
Summary handouts	4.41 (.78)

To what degree do you feel that (1 = not at all, 5 = very much)	Mean score (SD)
The sessions were conducted in a way that suited you?	4.90 (.31)
You received answers for the unique needs of you and your child from the project coordinator?	4.85 (.54)
To what degree do you feel that the participation in the program contributed to you, in general?	4.89 (.31)



For the second part of the parental feedback, mothers were asked to report:

- 1) Which activities were the most meaningful for them
- 2) Were there any changes at home, following participation in the program, and if so- what were they?
- 3) Do they have recommendations for future changes in the program?
- 4) Do they have any general comments.

Below are some of the comments given by mothers.

1) Most meaningful activities:

- "Quality time with my child, activities that strengthened the bond between her and I, such as: the scarves, or recitations – in which my child approached me. I was moved to see just how important these activities were to her, every Monday she reminded me that 'We have a class with Dafna and Rinat (Namal Facilitators).' "
- "The activity with the Bagel – I think its true for life in general, not just for the child. Focusing on what the child is doing, and being able to say something nice about it, because sometimes we focus on the small things instead of focusing on the fundamentals, on what's really important."
- "Participating in the program was a chance for me to have a joint experience, and quality time with my child."
- "I liked every activity, and the most meaningful thing was the saying- 'All a child needs is one adult who believes in him.'"
- "It was a time when I could let go of everything and just focus on him. For my child, the activity was something he looked forward to all week long and was excited about it. The program gave him tools for relaxation, joint play with me, and the opportunity for closeness with me"

2) Changes at home following the program:

- "My daughter seemed happy at the end of the program and excited before every activity"
- "I have more patience for my child. I understand him better in different times of stress"
- "How to approach the child during different situations, how to respond in times of stress and in general"
- "My child hugs and kisses me more, and has been getting closer to me"
- "I was impressed with how much my daughter was influenced by the program – through the way that she would very much anticipate it. I had no idea just how strong and good of an influence it has had on her".
- "I learned how to be with him more and watch him play"

- "Paying attention to the small things at home, and being able to incorporate them for play with my child"
- "We would repeat the songs at home. Also, as a mother, I am now giving more room for my daughter's independence"
- "The program is contributing to the personal development of my child and of the relationship between him and I, which due to the situation there was very little opportunity to set aside time for"

3) Recommendations for future changes:

- "I would not change anything, except to add sessions, so there could be more than eight. I would also recommend to make the program suitable for older ages, up to six years old. I would also add an activity with music, perhaps with drumming – something that both the parent and the child could appreciate together."
- "I would recommend connecting between the sessions and the home, things that are familiar to the child, mentioning stories that they know, and to add more meetings."

4) General Comments:

- "Thank you for our time together! I have learned allot (**We** have learned allot)."
- "My daughter and I feel as though we have a place which is like a family, to go to once a week."
- "This was very helpful for my daughter, and I, to meet new people and children."
- "The facilitators were delightful! Well done on the effort you made on preparing and developing the activities. May god help you continue to assist more parents and children"
- "Thank you for creating a space for us and for our young children. You have wrapped us with a scarf of joy and security, and helped us strengthen the bond of love. Thank you!"

C) NAMAL FACILITATORS' FEEDBACK

Following each group of NAMAL, the facilitators of the groups filled out a questionnaire in which they are requested to report on their experiences, thoughts and feelings. The following statements are from the feedback given by three NAMAL facilitators.

- "I think mothers enjoyed this quality-time with their child, despite being tired and having little time for availability. In every meeting, they were experiencing the special bond"
- "It seems to me that during the meetings, mothers realized more and more, why it was important that they come with just one child. Some mothers, following the participation in the program, started to have exclusive time with their other children. For example, one mother told me she started to take her older child for a bike ride every week- just the two of them. I was happy to notice that participation in the group also affected time outside the group, as well as the rest of the family."
- "I saw mothers that were trying hard to understand: 'What speaks to him/her?', 'What does he/she like to do?', 'What is he/she afraid of?' understanding that every child responds differently and has unique preferences."
- "I think that the combination between the groups and the talks with the program coordinator created a process in which you could see a change in the approach of the mother towards her child, and in the relationship between them."
- "I feel that following the program, joint play is taking more room in their lives."
- "One mother described her young daughter as 'easy', and as a child who doesn't demand much attention, compared with her older daughter. Following the program, the young child started to ask the mother to play with her – something she hadn't done before. The mother said it helped her to see this child's needs, and that she was happy to learn that she could be a partner for her child to play with. We encouraged this mother to initiate more play time with this child".
- "One mother described how recently she had been so busy with the practical chores of feeding, bathing, and diapering, and only in the meetings she started to remember what it is like to be with her child in a space of play and imagination – something she had known, but forgotten."
- "Some mothers brought up memories of their own favorite childhood games that were of low cost or simple preparation. The idea that you can play and be creative with simple 'junk' was meaningful for the mothers, and gave some proportion of what really matters in life, and what the child really needs."
- "This is where you see the amazing power of the group – There are usually one or two mothers who are, at first, embarrassed and hesitate to play, move, and use imagination. Once they see that the other mothers are doing it, and that we, the facilitators, enjoy it – they are drawn to it, and let themselves loosen up. When these mothers see how much their child enjoys them like this – this makes all the difference."
- "I feel that importance of encouraging independence got stronger for many mothers. When we asked the children to put on a coat or spread cheese on their bread (tasks that

many children do not do by themselves at home) – the mothers looked at their children with pride and joy, and I believe that this helped them understand why it is important to let the child do more things on his own. I sense that this understanding will stay with them."

- "The box with the soothing objects that the mother made for the child was a very good tool. One mother told me that when her child was hospitalized, they took the box, and she felt that it gave him a sense of security. I think that being able to use this tool gave mothers a good feeling about their ability to emotionally help their child."
- "When mothers see the response of the children to the reflection and understanding of their emotions, it opens a door for them. This is something that requires more and more practice."
- "What was important was the legitimization of having fears and negative emotions (of both the mother and the child), and yet, the understanding that the mother has an important role as a secure base for the child."
- "It is difficult for all of us to deal with bad feelings of our own, and even more so, of our child. It takes a lot of practice and obtaining new skills."
- "One child was doing the moves for a recitation he had heard the meeting before. The mother was thrilled – she was sure he didn't listen at all. She looked at me and said – 'It's true, all a child needs is just one adult who believes in him.'"
- "One mother almost gave up because her daughter did not cooperate and kept rejecting her. One time, during the relaxation part of the meeting, the child began to cuddle with her mother and they became very close to one another. Before the program, the child would not touch her mother, just her father. Following the program, the hugs came back into their lives."
- The major difficulty facilitators report is the recruitment of the mothers: "Many mothers hear about the program, and want to commit to it, but they find it difficult, because of their schedules and fatigue. Recruitment requires some courtship, and a lot of effort, but it is very rewarding when a mother joins and benefits. I learned that it is very important to maintain a constant and meaningful relationship with the mothers in order for the group to hold, despite the every-day difficulties."

D) ONE-YEAR PARENTAL FOLLOW-UP INTERVIEW BY TELEPHONE

We initiated one year follow-up telephone interviews after the end of the first two groups of NAMAL, in order to get longer term effects of the participation in the program. So far, we have obtained the follow-up data of ten mothers, as presented below.

Mothers were asked to rate three questions on a 5-point scale (1= not at all, 5= very much).

Means and standard deviations are presented:

To what degree do you (1 = not at all, 5 = very much)	Mean score (SD)
Remember the activities and discussions that took place in the group?	3.7 (1.06)
Use the techniques or tools you learned in the group?	3.4 (1.17)
Feel that the participation in the group contributed to you?	4.5 (.71)

Mothers were asked specifically about six concepts that were dealt within the program – if they remembered it, and was it meaningful to them (yes/no).

Concept	Remembered	Meaningful to them
The parent-child bond	90%	90%
Providing a sense of security and independence for the child	70%	60%
Developing childs' creativity and imagination	80%	60%
Dealing with situations of stress and crisis	67%	67%
Working on empathy and reflection and expression of feelings	80%	80%
Confidence to speak to the child about difficult subjects	44%	44%

Mothers were also asked some open ended questions about participation in the program. Some of their answers are presented below:

What do you recall the most about the program?

- "I remember how much he wanted to go to the meetings. He was really looking forward to it. The magnets with the sayings are still on our door, and it helps me to remember. I discovered how the participation in the group was good for our relationship".

- "I remember the connection between me and him. He loved being together. A couple of months ago he remembered how we did things together in the group and he said he enjoyed it and misses it."
- "I was able to keep something good from these meetings. The relationship between me and my daughter got stronger. It made me think of my son as well. Most of the time we are not together. Now I think that the times that he is with me are important, it strengthens the bond between us."
- "Dealing with the parent-child relationship was very meaningful to me. I had many insights: listening to my child's needs, and being able to fulfill them, things I hadn't thought of until then."
- "I remember all of the activities, crafts, playing with 'junk', things I hadn't thought of before."
- "I remember the activity with the scarves... honestly, we sometimes do it together at home now."

Which tools or techniques do they use following the program:

- "The box I had made for her. She was surprised that mommy had invested in the box... It was nice to surprise my child. She kept the box and put all kinds of things in it."
- "I loved the songs. Her and I sing the songs together."
- "We kept the scarf activity – She puts the scarf on my head and rhymes."

Did you notice any changes at home following the program, if so what were they:

- "Thanks to the program I felt that as a new mother, I have more tools for coping with situations we don't always know how to deal with, in terms of feelings and thoughts. It gave me an opportunity to encourage my child to express herself. I can see that today she shares her feelings and fears more, especially regarding the security situation- she has questions, and I feel that I can answer her in a way that relaxes her. It seems that following the program I manage to not silence the fear but to open it."
- "I feel that I am more attuned to my daughter and her feelings. I speak more about feelings and give more encouragement to my child."
- "Today I think more about his feelings in certain situations. This was something that needed to be sharpened for me and that's what I got from the program."
- "Today there is more closeness between us. Before, she would not come close to me – only to her father – today she does. The program has brought us closer to each other."
- "In the past, there were times when we would both insist on something, and get into a fight. In the program I had learned that there are things that she enjoys and nothing bad would happen if she would try and explore them. Following the program I can let go more. I used to say "No!" about everything. I learned that I can let go and let her explore, she is only a child!"

Q&A Sessions

SUMMARY

During the bi-weekly question and answer sessions, the "Parent's Place" project co-coordinator, a developmental psychologist, is available to answer parents questions regarding their child's development and psychological well being.

The forum allows parents to receive information regarding general developmental issues, alongside specific information regarding the special considerations unique to parents and children living under constant threat of missile attacks.

The aim of the Q&A, is to create together with the parents, a reflective space in which the difficulties they meet as parents may be conceptualized. During the session, tools for overcoming the hardships are thought up and suggested. The Q & A hour gives parents an open and easily accessible place to receive information about topics related to parenthood in Sderot, including stress management. Many of the parents who have participated the workshops of this project have joined as a result of this hour and the personal acquaintance they made there with the project coordinator.

In these sessions a wide variety of topics come up:

Sleep problems, toilet training, adapting to a new baby in the family, speech development, attachment issues, feeding problems, separation anxiety and more.

During the session, the coordinator gathers information about the child's development and obtains a picture of the child and parent's emotional well being and parent-child bond, especially in light of the ongoing stress situation in Sderot. Different perspectives about the nature and origins of problems are raised and in an open conversation different methods for coping are discussed. Throughout this process there is emphasis on familial risk protecting factors.

A mutual assessment process takes place in which parents are encouraged to reflect upon the issues they face.

The project coordinator receives supervision by a team of professionals at the Israel Center for the Treatment of Psychotrauma, and referrals are made to the ICTP for cases that require further consultation, with senior professionals, in order to give the most appropriate clinical and professional care.

QUESTIONS & ANSWERS

Session Example - Potty Training

When should I start potty training my toddler?

Many parents wonder when the right time is to start potty training.

Current research shows that there is no "right" age to start and that different children reach the stage of maturity needed for this training at a range of ages. It has become quite clear that families who begin the process of potty training upon the child's sense of readiness, achieve effective results in a quick and successful manner. On the other hand, initiating the process when the child is not ready may cause tension and conflict, leading to a prolonged process.

How will we know if our child is ready? How can we find signs from him or her?

The signs we are looking for are of physical, cognitive and emotional maturity:

- From a physiological perspective, it is important that the child has gained control over bladder functioning- can the child "hold it in"? This control will help the child wait until he can relieve himself in the toilet. How will I know that the muscles have matured? If the child's diaper remains dry for longer periods of times. You can also evaluate whether the child has sufficient motor skills to reach the potty on his own and if he is able to remove his pants without help.
- In the cognitive arena, we aim to see the child's awareness of having relieved himself in his diaper. He may report having done so verbally or behaviorally. Another sign of readiness is the child's understanding of a toilet's function and an interest in what other children or adults do in the toilet. Some toddlers show that they are ready by asking to be changed right after they go in the diaper.
- In the emotional realm, we want to see that the toddler shows an interest in giving up the diaper. This may become apparent verbally or behaviorally by the child's positive response to being introduced to the potty.

When is it not advisable to start the training process?

It is unadvisable to begin the training during times of change for the child and family. Examples of such transitions are birth of a sibling, moving to a new residence or a new kindergarten, illness in the family, and so on.

I have observed my child and he is showing signs of readiness for potty training. What should I do now?

One can bring their child along to choose a potty. Alternatively, if a potty is already available, one can offer the child a chance to decorate the potty with stickers or paints. Allow your child time to play and become acquainted with the potty.

Explain that soon the child will be saying goodbye to the diaper and that he/she will be going to

the potty like big children do. Some parents prefer to begin the process in the beginning of the weekend, so that the child has a couple of days at home before returning to kindergarten.

Try to include your child in the process by allowing him to decide how to proceed with some of the training steps. For example, he can choose from two-three options of where he would like the potty to be placed in the bathroom. You can also ask him to pick out his underpants.

Choose a children's book you like that talks about potty training and read it with your child.

After you part from the diaper, explain to your child that when he/she feels the need to go, he/she should tell you and you will go to the potty together. At first, one can sit beside the child and after a few times, the child can go on his/her own.

Praise and encourage your child on his/her success even if they succeed only partially. If a child missed, one can say, "When you felt you had to go peepee you told Mommy straight away. Next time you will make it".

There is no need to have a "festival" every time the child succeeds. Being able to go to the potty by one's self is rewarding in itself for the child.

Include the kindergarten staff in having started the process and continue the training also there.

Please bear in mind – all children miss at first. It is important not to be angry. Anger may cause unwanted tension and stress, making the training process more difficult. In these instances, try not to make a big deal and give your child the feeling that you know he/she can do it next time.

It is also important that both parents be "on board" with the process and come to an agreement regarding the child's readiness to begin potty training.

Day Care Center Trainings

SUMMARY

Having developed training workshops on resilience building for professionals in the educational system throughout Israel, the ICTP adapted their programs for day care centers. In addition to professional trainings there are parental meetings.

The workshops evolved over time and are now oriented for empowering the educational staffs in their dealing with various types of complex events (terror attacks, war, missile attacks, socio-economical stress, family crisis, etc.).

Goals:

1. Empowering caregivers by emphasizing the important role in the lives of infants.
2. Providing psycho-education and broadening the staff's knowledge about ongoing stress, coping, and building resilience.
3. Developing the staff's ability to support children and their parents in times of ongoing stress, by creating an empathic supportive environment and an atmosphere of open communication within the DCC.
4. Creating a toolbox of coping and resilience building techniques for staff.

Concepts:

The program focused on four elements that are considered in the literature as building resilience:

1. The mind-body connection – teaching techniques for regulation and relaxation.
2. Developing personal resources.
3. Processing of emotions (especially fear).
4. Providing meaning and hope for the future.

Workshop Description:

Additional specific units can be added, such as: dealing with loss and grief of children, violence and risk-taking behaviors, working with parents, etc.

The learning in the workshop is mainly experiential, with some theoretic elements. As a part of the training, staff members are required to implement what is taught, between the third and fourth sessions. The first three sessions are held within consecutive weeks, and the fourth and final session is two or three weeks afterwards, in order to provide enough time for the implementations. The beginning of the final session is devoted to feedback from the practical implementation experience.

The ideal number of participants in each group of the workshop is 12-15, and no more than 18 staff members. The length of each session is 3 hours.

Lecture Series

SUMMARY

Once a month Parent's Place would hold a lecture for the parents and day care center staff in Sderot, which was open to the general public as well. These lectures were provided by experts in their field and would address topics which were related to parenthood under stress, such as:

- Sleeping problems in children during times of stress
- Child nutrition, eating, and feeding
- Why do babies cry?
- Aggression in young children and how to set limits in an effective manner
- How to talk to toddlers about their stress
- Children's games and the importance of parent-child play

After each lecture the parents would receive a short summary of the lecture that included practical examples. Parents were also encouraged to meet with the project coordinator for more elaboration on specific needs.

Lecture Series

PARENTAL FEEDBACK

Comments from parents who participated in the lectures:

- ❖ "It was good to hear and to know that there are things we can change in our everyday life. I enjoyed the explanation about how to encourage my child to share."
- ❖ "The lecturer gave me a lot of useful tips and coping methods. There was a good atmosphere. The lecture was interesting and the dialogue with the audience was important since it allowed me to hear other parents and to learn from situations similar to mine as well as those that were different."
- ❖ "I got a lot of information about my kid's needs in terms of his cognitive and emotional development as well as his coping methods. The lecture has brought to my attention that I might not be giving my son enough space for his feelings, and that maybe he is regressing because of this situation."

Lecture Series

Sleeping Problems In Children During Times Of Stress

Handout from the lecture on children's sleeping problems

<i>Child's age</i>	<i>Recommended amount of sleep</i>	<i>Tips for better sleeping</i>
Babies, 1-2 months	01.5 -18 hours, dispersed throughout the course of the day and night	<ul style="list-style-type: none"> · Pay attention to the baby's sleep patterns and try to identify signs of tiredness · Put the baby in bed when drowsy and not when already asleep · Encourage sleeping at night
Babies, 3-11 months	9-12 hours during the night in addition to short sleep periods (naps) of 1/2-2 hours during the day	<ul style="list-style-type: none"> · Develop a fixed sleep time table of night and day sleep · Create a relaxing sleeping "ritual" every evening · Create a pleasant sleeping atmosphere · Encourage the baby to fall asleep on their own.
Toddlers, 1-3 years	12-14 hours of sleep, at about 1.5 years they will be satisfied with one night sleep and a nap of 1-3 hours during the day	<ul style="list-style-type: none"> · Sustain a fixed sleeping time table of sleep · Create a pleasant and relaxed sleeping atmosphere every evening · Set fixed limits to sleeping habits · Encourage use of a security object such as a small blanket or a teddy-bear · Do not have child nap closer to the evening
Pre-school children, 3-5 years	11-13 hours at night. Child will gradually stop daytime napping.	<ul style="list-style-type: none"> · Sustain a fixed sleeping time table of sleep · Sustain a relaxing sleeping "ritual" every evening in the child's bedroom · Put child to sleep every night in the same bed in a cool, quiet, and dark room (without a television)
School children 5-12 years	10-11 hours	<ul style="list-style-type: none"> · Teach the child about healthy sleeping habits. · Sustain a fixed sleeping time table of sleep · Keep the child's bedroom appropriate for sleep: cool, quiet, and dark · Do not put a television or a computer in the child's bedroom
Young teenagers 12-14	9-10 hours	
Older teenagers 14-18	8-9 hours	

Future Directions

Parent's Place for Ethiopian Community

While the implementation of the five modules has been met with success in addressing the needs of parents who participate in Sderot, it became evident that there is a gap of service for Sderot's Ethiopian community.

Israel's Ethiopian Community

Many of Israel's 120,000 Ethiopians underwent traumatic events in order to reach Israel. Long journeys by foot across deserts and through refugee camps often involved illness, murder, disappearance, and rape. Once in Israel, not only did trauma experienced go unaddressed, but acculturation was often also a traumatic event. Due to cultural and language barriers, services from the government were often not offered or compatible for the community, and the experiences they had gone through. Currently many families still live in small, overcrowded conditions with a high level of unemployment or low paying jobs. 70% of Ethiopian families have no incoming salary, 6.2% of Ethiopian students drop out of school between the ages of 14-17, double the national average. 45% of Ethiopian parents cannot speak even basic Hebrew.

Ethiopian Community in Sderot

The Ethiopian community makes up 2% of the population in Sderot, with 500 Ethiopian residents, many having come in the early '80s and '90s. The compounded traumatic experiences of the Ethiopian migration, difficult acculturation to Israel, and the ongoing rocket attacks in Sderot have resulted in increased needs for trauma, and post trauma interventions. This work needs to be geared specifically for the Ethiopian community, according to Bat-Sheva Tamano director of 'Independence Center', a local center of various interventions for the Ethiopian community in Sderot.

Having recognized and addressed the need for trauma services for families and parents in Sderot, the ICTP has become aware of the need to provide localized services adapted and accessible for Ethiopian families and parents in Sderot.

PROGRAM PROPOSAL

Goals of Extending Parent's Place for the Ethiopian Community

Through the original success of Parent's Place Sderot, the ICTP aims to develop a service package geared for the Ethiopian community in order to

- Provide appropriate services and interventions for the underserved Ethiopian community and families, addressing previous and ongoing trauma.
- Strengthen and empower parents and childcare providers to build and support resilience within themselves, families, and children.
- Gain further insight into parenting and early childhood under trauma through research and evaluations of program and intervention effectiveness.

Parent's Place – Package of services

The five modules of intervention we aim to adapt from the original Parent's Place for the Ethiopian extension will be:

- *The "NAMAL" Program - Make Room for Play*
- **Group Work for Parents**
- **A Public Monthly Lecture Series**
- **Weekly Q & A session**
- **Training for DCC staff**

Program Implementation

We intend to gradually implement the different modules for the community within three stages. The intention of the first stage intervention is professional training of local Sderot staff i.e. training the trainers. The second stage is focused on expanding services in a broader scope and incorporating the parents and children. The third stage will further develop programs for parents, and the care provided by the local staff for sustainable teams and systems of care.

Stage One: Training the Trainers

- **Training for facilitating the Parent –Child Play Group (NAMAL).**
A group comprised of 8-10 local professionals will be trained to conduct the NAMAL groups. These workshops will train participants (who are already working within the Ethiopian population) to conduct the protocol-based treatment program. The workshops will be conducted by ICTP staff members.
- **Training in Building Resilience**
Training workshops will be conducted by ICTP staff members for professional who have prior experience working in the Ethiopian community. The participants will be trained in a variety of skills for building community resilience
- **Training for DCC staff**
The unique program developed at the Bar Ilan University will be implemented in two DCCs in Sderot while adapting the focus of the program to the Ethiopian community.
- **Adaptations of Materials, Methods and Protocols**
The adaptation of materials, methods and protocols will be made with the help of our cultural consultant (A senior social worker from the Ethiopian community working at the ITCP).

Stage Two: Implementation

- Two parent-child NAMAL playgroups will be conducted during the first year of the program. We will recruit about 12 dyads of mothers and young children (between 2-5 years old) for each group. The program will consist of 10 weekly meetings and will touch upon issues concerning parenting young children in general and during ongoing stress situations in particular.
- Two training groups in Building Resilience geared for the educational & day care centre staff will be conducted during the first year of the program. In each group there will be up to 16 participants. Groups will be conducted by the trained facilitators from stage one.
- Evaluation: All groups will be evaluated using pre and post questionnaires and interviews with the participating parents.

Step Three: Further Community and Clinical Work

- Monthly lectures for parents regarding a variety of developmental challenges.
- Bi-weekly question & answer sessions with the local project coordinator for parents and staff, addressing personal issues and questions regarding parenting issues.
- Parental therapeutic groups, developed in collaboration with the local psychological services, utilizing their local experience and therapists.

We believe that the most effective way to build resilience in children is to empower their parents, and to develop community programs starting in early childhood.

The ICTP is committed to developing, adapting, and implementing programs for parents within the Ethiopian community. We are working with professionals from the community in order to build local capacity. Our priority for these programs is to establish the sustainability of such programs in the community through the support of the municipal and national governments for the long term.

Growing Up Under Fire:

Building Resilience in Young Children and Parents Exposed to Ongoing Missile Attacks

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Growing Up Under Fire: Building Resilience in Young Children and Parents Exposed to Ongoing Missile Attacks

Abstract

This article presents data from a project in Sderot Israel designed to build resilience for 255 young children and their families. During the time of the project the area was under continual exposure to missile attacks and resulting traumatic events. The phenomenology of living under continual exposure to missiles attacks, as well as the impact of the ongoing fear and uncertainty on both the children and their parents, are presented through voices of the parents. The clinical picture for young children and their parents coping with ongoing terrorism indicated a high level of posttraumatic distress for children 33% and for mothers (28%). An integrative model was developed and implemented with three major components: clinical screening and treatment with an adjusted dyadic therapy for peri- and post-traumatic circumstances; building resilience intervention by workshops for both parents and teachers; and building local capacity and sustainability by training local therapists, parents and teachers.

GROWING UP UNDER FIRE:

Building Resilience in Young Children and Parents Exposed to Ongoing Missile Attacks

The impact of disaster, war and terrorism on children has been the focus of a growing number of studies (Fremont, 2004; Pine, Costello & Masten, 2005; Salomon and Lavi, 2006; Wexler & Kerm, 2007; Pat-Horenczyk et al 2007; Chemtob, Nomura & Abramovitz, 2008; Sagi & Schwartz, 2008). Others studies focused on building resilience, within the school systems, in the aftermath of trauma and war (Toll et al, 2008; Baum et al. in press). A special emphasis has been put on young children by Laor and his colleagues (1997, 2001) who studied preschool Israeli children and their mothers in the context of the Gulf War, by Tabet, Karim & Vostains (2006) who examined Palestinian young children in Gaza, and by Chemtob et al. (2010) in the aftermath of 9/11 attacks.

However, little is known about the impact of living under continuous ongoing threat on parents and young children, a situation which differs in essence from war or isolated traumatic events and involves peri- and post traumatic experiences and living under emergency routine (Pat-Horenczyk, 2006). The purpose of this study conducted between the years 2004-2006 was to explore the posttraumatic distress of parents and young children exposed to frequent and recurrent missile attacks and a way of helping the families cope by building resilience.

Life under ongoing threat raises unique challenges with regards to trauma and resilience in early childhood. In order to provide a comprehensive picture of the complex phenomena of raising young children under continual threat, we present voices of parents talking about the reactions of their young children and their own difficulties as parents raising their children under prolonged ongoing attacks.

The ongoing situation led us to develop and implement a new model for clinical and community services for treating trauma and building resilience in early childhood. In this article we describe the integrative model we used for building resilience in early childhood which includes the following components: (a) *A clinical intervention* comprised of screening for traumatic related distress and the development of adjusted dyadic treatment for per-post traumatic circumstances; (b) *A building resilience intervention* that included workshops for both parents and day care teachers; (c) *A building local capacity intervention* by training local therapists -- thus creating sustainability for long term provision of such services.

Living under fire

With the outbreak of the Second Intifada, in September 2000, Israel was exposed to frequent terrorist attacks. The Sderot area, which is adjacent to the Gaza strip, has recurrently experienced more than 9000 missiles (according to Home Front Command as of July 2007). In addition to the physical injuries and loss of life during the time period of the study (13 Sderot civilians, including 4 children, were killed since 2001, and 435 were wounded), the psychological, social, and economic impact on the population has been vast. The level of direct exposure to missile attacks was assessed based on a sample of 255 children and their mothers in the Sderot area. According to the parents' report, 67.8% of the mothers and 64.3% of their young children were exposed directly to Qassam missile attacks.

As the residents of Sderot live with the constant threat of impending missile attacks, the Israeli government instituted a "Red Alert" radar detection system for the region surrounding Gaza, in which a female voice proclaims over a loudspeaker "Color Red, Color Red" to warn the residents. The alarm provides only a 10-to-15 second warning before the missile hits. Although this system provides some level of security, it does not work in inclement weather, and the 10-15 seconds notice it provides is often insufficient time to reach a protected shelter. During the time of the study more than half of the schools in Sderot were not located within 10-15 seconds from a shelter. The psychological effect of these alarms has been severe. During the period of our project, a Color Red alert was heard, on average, about every three hours. When the alarm sounds, residents must rush either to a shelter or to a "bomb-secure room" inside the house, and panic may ensue. The alarm itself has become a trauma reminder and a trigger for anxiety and stress reactions.

The following voices of parents from Sderot exemplify their experiences with their young children facing the ongoing exposure to missile attacks.

"A few weeks ago a Qassam missile fell near our house at 9:30. Since then every night at 9:30 my son starts to scream..."

"My daughter would not come out to play in the garden. When I asked her what would help her, she told me she needed an umbrella to protect her from the Qassam missiles that are falling from the sky."

"In the summer in Israel sometimes fruit is sold in the street and the merchant announces his produce with a loudspeaker for people to come out and buy fruit: 'red watermelon, red watermelon...' Once my child was happy hearing that and he was

running to the street. Today he is frightened hearing him shout. It reminds him of the alarm of the missile: 'Color Red.'"

"When she hears 'Color Red' again everything freezes. She regresses back to behaving like a baby, bedwetting and asking for a bottle, or pacifier."

"She has nightmares; she thinks about the security situation all the time. She even stores her backpack in the bomb-secure room... she won't go anywhere alone; even within the house she needs someone with her."

The unique situation in Sderot area has challenged the existing models for the treatment of psychological reactions to trauma. Currently, the paradigm for "post-traumatic stress disorder" (PTSD) is that a traumatic event, well-defined in time, precipitates chronic psychological distress. The term "survival mode" was first used by Chemtob (1988) referring to the instinctive physiological/emotional reaction of fight/flight/freeze, which has adaptive value in situations of threat and danger. In PTSD, the pattern of "survival mode" continues even when the threat is over. Psychological treatment involves helping the affected individual realize that the situation has passed and that he or she may return to a normal way of life.

The situation in Sderot requires a different paradigm for both assessment and treatment. As traumatic events can be expected to continue indefinitely, the term "post-traumatic" is too limited. Daily life is simultaneously pre-, peri-, and post-traumatic. Further, in a situation of constant exposure to missile attacks, "survival mode" is a rational and even adaptive reaction, as parents are called upon to enter the fight-or-flight state every time the alarm sounds. Nonetheless, the trauma-related symptoms can come to permeate all aspects of daily life and cause damage to the psychological health of both parents and children. For this reason, Sderot's residents require a new approach to treatment, one that can minimize the negative effects of trauma while acknowledging the ongoing threat and the necessity of protecting oneself and one's children.

Challenges in the diagnosis of PTSD in children

Assessing the diagnostic criteria for PTSD in young children is challenging since most of the criteria depend on individuals being able to give verbal accounts of their emotions and experiences. In addition to the problem of self-report, children also exhibit different symptoms based on their developmental stage. The fact that young children are likely to react to trauma differently from adults was recognized in the DSM series only in 1987, and the awareness regarding the unique features of PTSD specific to young children lagged for a few more years (Pat-Horenczyk, 2008).

Scheeringa & Zeanah (1995) proposed criteria for PTSD in preschool children that are based not on children's verbal report, but rather on behavioral observations and information provided by their primary caretaker. Differences in symptoms reflect the differences in children's cognitive and emotional processing level. For instance, children's symptoms may not be as obviously related to the trauma: adults tend to have nightmares about the traumatic event, while children tend to have general nightmares and trouble sleeping. Children also react to trauma in ways appropriate to their developmental stage. For instance, they may express "intrusion" symptoms (recurrent unwanted thoughts about the traumatic event) by reenacting the traumatic event in play, rather than in re-experiencing or flashbacks. Psychologists have also noted symptoms that are specific to children: regressions in important developmental areas, such as toileting, speech, and motor skills, newly developed separation anxiety and aggression, and phobias unrelated to the trauma (Scheeringa & Zeanah 2003).

The relationship between parental symptoms and child distress

The parental relationship is recognized as the most influential risk or protective factor for young children's mental health in the face of trauma (Pat-Horenczyk, Rabinowitz, Rice & Tucker-Levin 2009). There is consistent evidence regarding the high correlation between parents' distress and the PTSD symptoms of their children. For instance, Laor (1996, 1997), who studied Israeli children aged 3-5 during the Gulf War, found a clear correlation between the mothers' mental health and PTSD symptoms, and the intensity of post-traumatic distress of their children. Conversely, the parent-child relationship can be a central protective factor in building resilience in children exposed to traumatic events (Gewirtz et al. 2008).

One possible explanation is that parental distress affects the ability of the parents to mediate the world for their toddler by helping the child process his or her experiences, and by providing a sense of safety and security. Especially in times of stress, parents play a crucial role explaining scary events, protecting children from their worst manifestations, and modeling ways of coping. Given children's dependence on parental care, parental distress presents a major risk factor for children's mental health.

Hyperarousal symptoms may affect parents' care of their children in several ways. Anxious and over-reactive parents are less able to soothe their children and to provide a sense of security. Parents' lack of emotional regulation may lead to angry outbursts and to "flooding" the child with excessive talk about traumatic events. In addition, hyper-vigilant parents are likely to become over-protective, which can provoke anxiety in the child. Through these manifestations and others, parental hyperarousal may impair parental attunement, or sensitivity to the needs and feelings of the child, and add to the child's emotional burden when facing a traumatic event.

On the other hand, parental avoidance symptoms can affect parental support and availability. When parents become unresponsive and withdrawn, they are less able to tend to their child's basic needs and safety. Laor (1997, 2001) suggests that maternal avoidance and emotional numbness harm the mother's ability to mediate traumatic events for the child. Parental avoidance symptoms hinder communication, leaving the child with less support in the task of learning to regulate and control his or her emotional responses. Further, parents' desire to avoid any trigger of the traumatic event can cause difficulty in coping with signs of distress on the part of the child. All of these avoidance-related factors can leave the child more vulnerable to distressing events.

Taken together, the evidence indicates that the most effective interventions for building resilience in children should be directed toward parents. Helping parents by strengthening their coping strategies, increasing their awareness of the impact of the situation on their parenting and on their children, and providing treatment when indicated are the most effective ways to help children and to build family and community resilience.

The following voices of parents in Sderot illustrate the experience of parenthood in crisis

"I sent him out of Sderot for school and other than that I can't do anything, certainly not stop the Qassams... I feel like a bad mother, I know I'm destroying my kids... I don't blame him, I blame myself."

"I felt as if I was a child – exactly like her, like what do I do? Where is our security, where? But wait, I am the mom- I should show her that... my head was confused, I felt like her, I felt like she should be the mother now."

A model for building resilience in toddlers and families

Recognizing the unique threat and great need present in Sderot, the team from the Israel Center for the Treatment of Psychotrauma intervened. We sought to implement an integrative model to provide treatment for young children and parents with post-traumatic symptoms, enhance community resilience, and empower the community with tools to help itself in the future. The model was composed of interventions at two levels: On the clinical level, we focused on identifying and treating posttraumatic distress in parents and their young children; on the community level, we dealt with building resilience among parents and other caretakers in the educational system and the community. In addition, special emphasis was put on building local capability for handling the situation by training local early childhood professionals.

Clinical level:

PTSD in children and mothers

On the clinical level, we reached out to 305 children and their parents through the day care centers and preschools in Sderot. In the first stage, we conducted a brief screening of 255 children (83%) to identify those families in which either a young child or a parent was suffering from posttraumatic distress).

Screening of the children was done by the mother filling out the Child Behavior Checklist (CBCL), an assessment tool that has been shown to correlate with PTSD in young children (Dehon & Scheeringa 2006). The CBCL (Achenbach 2000), aimed at the pre-school years, has 100 items rated on a 3-point Likert-type scale from 0 (not true) to 2 (often true). Test-retest reliability for the behavior scales (emotionally reactive, depressed /anxious, withdrawn, somatic, sleep problems, attention and aggression) ranges between .68 and .92. Total externalizing and internalizing problems scores were obtained.

In our sample the most prevalent symptoms of the children (based on the CBCL) were low tolerance of frustration (52% of the children), demanding immediate attention (51%) and sleep disorder (44%). There were 57 of the children (22%) who scored at the clinical level of internalizing behavior problems on the CBCL, and 29 (11%) who scored at the clinical level for externalizing problems. When we identified a child whose distress reached a clinical level on the CBCL, we conducted a second screening stage, using the parental clinical interview developed by Scheeringa, Zeanah & Meyers (2003) for diagnosing PTSD in young children. Eighty three children (33%) of the sample scored as partial or full PTSD.

We also assessed posttraumatic reactions of the mother by using the Posttraumatic Stress Diagnostic Scale (PDS) (Foa, 1995). The PDS is recommended for use in clinical or research settings to screen for and measure severity of PTSD symptoms related to an identified traumatic event. The PDS yields a total severity score (ranging from 0 to 51) that largely reflects the frequency of the 17 symptoms of PTSD. A high rate of internal validity has been reported (Cronbach alpha of 0.85). The questionnaire's

validity was also found to have a correlation of 0.94 with the SCID measure (Structured Clinical Interview for DSM-IV). It is among the most widely used research tools for measuring adult PTSD symptoms and traumatic exposure and has been used extensively in Israel in clinical and research contexts.

Seventy mothers (28%) were classified as partial or full PTSD. To understand the relationships between maternal pathology and types of the young child's pathology (internalizing and externalizing behavior problems as measured by the CBCL), we compared the percentage of symptomatic children of mothers with PTSD with the percentage of symptomatic children of mothers without PTSD. Symptomatic children were those who scored above the clinical level on the CBCL. The Z score test was used to determine the significance of differences (see Table 1).

The results indicated that more than 34 % of the children of mothers high in post traumatic distress (either full or partial PTSD) had a clinical level of internalizing problems compared to 18 % of the children of low distress mothers. Similarly, 19% of the children of high post traumatic mothers had clinical level externalizing problems compared to 8% of the children of low distress mothers. Significant differences were found in internalizing and externalizing symptoms in children of mothers with and without posttraumatic distress. A high level of maternal distress approximately doubles the child's chances of having a behavior problem at clinical level.

Table1: Percentage of Children at Clinical Level of Internalizing and Externalizing Problem Behavior of Mothers with and Without PTSD (N=255)

Child CBCL	Mother with No PTS (n=185)	Mother with Partial/Full PTSD (n=70)	Z Score (Difference of proportion)
Internalizing	17.78%	34.29%	3.41**
Externalizing	8.33%	18.57%	2.55 *

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

Treating traumatized children and parents: Dyadic Treatment

Families in which a child with PTSD was identified were referred to a center for psychological care in the area. They received therapy using a model called dyadic therapy for trauma. This treatment model was developed by Chemtob and Abramovitz (2004) for young children who suffered from posttraumatic symptoms relating to the September 11 terrorist attack in New York. We trained and supervised local therapists, who then adapted the guidelines of dyadic therapy to the unique context of constant threat in Sderot

Dyadic therapy, in the context of trauma exposure, focuses on rehabilitating the parental skills that become damaged by exposure to trauma, and educating parents about the psychological consequences for their children. It is conducted with the parent and child together thus enabling the therapist to put the emphasis of the intervention on the relationship. The therapy focuses on helping parents free themselves from a "survival mode" by increasing their awareness of their own feelings and by learning tools for self-regulation of their arousal reactions and fears. These skills may enhance their strategies for coping with stressful situations and improve their self-control and parental competence. Subsequently, the therapy focuses on restoring the parent's ability to mediate the child's experience of the world, to understand the child's experience and reactions, and to be attuned to the child's needs. Finally, the therapy helps parents create a sense of security for the child by means of the bond between them.

The dyadic therapy adapted to the context of continual threat consisted of 14 sessions on average. The parents were assisted in the developing of the ability to move back and forth fluidly between "survival mode" and routine care, managing to find secure moments and places of calm and routine amidst the rocket attacks. These "islands of resilience" are meant to replace a situation in which the child's entire world is threatening and scary (Lahad & Ben Neshet, 2000).

Another unique aspect of the therapy in Sderot is that the therapy itself took place under the ongoing threat of rocket fire, thus providing a live opportunity to implement the principles learned in therapy. When an alarm sounded during a therapy session, both the therapist and the patient had to transition from the calm of therapy to the emergency situation, and then back to therapy and the process of introspection. Under these circumstances, the therapists were able to serve as models for self-regulation and self-controlled reactions to the alarm.

Below is an example of dyadic treatment that was provided in the course of the project.

G. is a two and a half year old girl, an only child. She was born in Sderot, after the mother went through 7 years of fertility treatment. When G. was 9 months old, the "Red Alert" sounded while the family was on the street. Her father held her in his arms and ran to find a secure place to hide. The Qassam missile fell only 20 meters

away and following this event G. and her mother developed post-traumatic symptoms and G. refused to be held by her father. The toddler suffered from delayed emotional, linguistic, and motor development and showed separation anxiety. She cried constantly and refused to separate from her mother and stay at the day care. After several days, the mother decided to stay with G. at home. They hardly separated from each other and rarely left their home. The mother reported that when the family visited relatives outside of the Sderot area, G behaved, played and seemed to be a happy child.

In the course of dyadic treatment with G. and her mother, the therapist tried to provide the mother-daughter dyad with a secure, structured, containing environment. In treatment, emphasis was put on helping the mother to be aware of her "survival mode" reactions, and on helping the dyad to recover the sense of safety. By means of containing, encouragement, and modeling of a more regulated self-management, the therapist practiced co-regulation of arousal responses and fear, and facilitated mother-daughter play that was age-appropriate, creative, and with shared fun.

We planned to conduct evaluation on all dyadic treatments; however, we were only able to administer evaluation forms to a small sample of families. The therapists were low in compliance in using the evaluation forms as they declared a preference for committing all their time to therapy rather than research. We therefore were able to obtain pre and post questionnaires only from a sample of 12 out of about 50 families who received dyadic treatment.

Building community resilience

Our purpose was to build resilience among the entire community, not just the families that already exhibited symptoms of distress. To that end, we held "Building resilience" workshops, whose aim was to enhance self-regulation in stressful situations, for all parents and educational staff in preschools and kindergartens. The workshops were based on extensive experience and practice with the community model of building resilience developed by Lahad and Ayalon (2000). This model teaches and practices the mapping and enhancing of coping strategies. During the workshops, we first presented the various coping mechanisms of both parents and children, encouraging participants to accept and explore different ways to cope with trauma. We then discussed specific tools to cope with common problems of preschool-age children, such as sleep problems and separation anxiety. The workshops allowed dialogue between

parents and teachers, thereby creating a feeling of mutual support and reinforcing a sense of community, two key factors in resilience (Lahad & Kaplanski 2004).

In the interest of empowering the community to assist itself in the future, we trained local facilitators to carry out these resilience building workshops for teachers and parents. The parents' verbal responses to the workshops appear in the following statements.

"The workshop helped me a lot as a mother whose confidence plummeted as a result of the situation... the workshop balanced me and helped me understand more deeply the situation I'm in."

"I felt less alone in my coping as a parent."

"I learned that there are other things than the sentence 'This is just the way it is,' that there are more possibilities and alternatives."

Teachers' voices:

"The workshop provided tools for coping in a different and healthier way, and see things with open eyes and more effectively."

"I learned how to cope in a stressful situation, and got practical tips for dealing with many different situations."

We evaluated the effectiveness of these groups using a project designed pre and– post questionnaire measuring the change in knowledge and skills regarding post trauma interventions with young children. Forty parents and 66 day care teachers rated their level of knowledge and skills, on a scale from 1 (very little) to 10 (very much). The results (see Table 2) showed a significant improvement from pre to post workshops for both teachers and parents on coping with stress (their own and with the child), acquiring self-regulation and self control skills, and knowledge about trauma and resilience. In addition the parents also reported on improvement in self awareness.

Table 2: Evaluation of Building Resilience Groups (pre and post intervention)

	Parents (N=40)		$t_{(39)}$	Day Care Teachers (N=66)		$t_{(65)}$
	Before Mean (SD)	After Mean (SD)		Before Mean (SD)	After Mean (SD)	
Coping skills with stress	6.82 (1.55)	7.65 (1.24)	4.74***	7.08 (1.54)	8.23 (1.17)	6.96***
Change in reactions to child's distress	5.88 (1.89)	6.75 (1.69)	3.57**	7.11 (1.96)	8.06 (1.72)	3.79***
Self-relaxation techniques	4.39 (2.91)	5.57 (2.65)	2.87**	5.95 (2.93)	7.38 (2.55)	4.11***
Ability to control anger	5.62 (2.65)	6.24 (2.10)	1.54	6.68 (2.52)	6.50 (2.39)	0.610
Self-awareness	8.03 (2.90)	8.85 (1.71)	2.12*	7.48 (1.83)	7.94 (1.76)	1.81
Knowledge of trauma and resilience	6.91 (1.73)	8.94 (1.25)	6.04***	5.96 (1.81)	8.59 (1.21)	10.71***

* $p < .05$; ** $p < .01$; *** $p < .001$

Lessons Learned

Despite the vast experience that has been gathered over the years in working with people who have experienced traumatic events, there is still a dearth of models for building resilience in the face of ongoing traumatic experiences. The early childhood building resilience project is an innovative attempt to respond to the needs of the residents of Sderot and surrounding areas who have lived under fire for years. The need for a response to these issues only grows over the years, as the resources of the community become more strained. The message to policy makers is twofold: 1) the importance of considering the community as a whole, when addressing the needs of both clinically affected and resilient children and adults, and 2) the necessity of building local capacity for enhancing community resilience within an integrated framework.

The need to integrate community and clinical approaches for building resilience

The project provides guidelines for intervention at various levels in a community in chronic distress. In order to empower a community under fire, we must intervene preventatively, on a community level, and not merely treat individual psychological problems as they appear. The project was developed and presented to the community as a resilience-building service that would empower parents to provide better care for their young children. Its positive and forward-looking orientation resulted in a high participation rate of parents.

The dyadic treatment showed promising effectiveness in reduction of the child's symptoms of distress and may protect children from further exacerbation of traumatic distress. Similarly, the building resilience workshops assisted both parents and teachers in developing their coping skills, as shown in our preliminary results. The long term goal being the prevention of future clinical-level problems among the children and their caregivers.

The need to build local capacity and create sustainability

One major lesson that we learned over the course of the project was the importance of collaborating with local professionals. By involving the local population, we increased the success of the intervention and extended its scope beyond its time-limited implementation. The establishment of the project also helped to create a new discourse surrounding community resilience among the local mental health organizations, especially with regard to the needs of children under five, an age group that is often neglected in clinical services.

As part of the project, we trained local therapists in dyadic treatment, and they were able to practice the skills they learned and adapt them to the context of Sderot. These experiences contributed greatly to the professional development of local therapists, who learned skills for building resilience and developed fruitful relationships with one another. We believe that the training and supervision provided to the therapists, parents, and teachers will spread into the different levels of the community and thus increase both personal and community resilience. We hope that the project increased the community's ability to respond to the threat of rocket attacks and to take care of its children.

The project has expanded our existing knowledge of post-traumatic distress in young children. There is a need for longitudinal follow-up and prospective studies in order to address the long term impact of ongoing terrorism on the developmental course – or trajectories – of children growing up under fire.

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