Work with trauma in southern communities in Israel

David Amias

This article is based on the author's interviews with specialist trauma practitioners offering systemically informed treatment to young families in the town and environs of Sderot, an Israeli city which for many years has borne the brunt of rocket barrages that periodically flare up in the region in the absence of any progress towards peaceful coexistence between Israelis and Palestinians living in the Gaza strip.

The interviews explore how a bespoke, trauma-informed treatment with parents, children and whole families has made a significant difference to familial functioning in the face of ongoing threat of bombardment. Michal Finklestein, coordinator of the graduate programme on children and youth at risk at Zefat Academic College, and Ornit Rozenblat, head of clinical psychology and manager of the Sha'ar Hanegev psychology service in the Sderot area, describe how families are encouraged to develop a shared narrative, a coherent non-self-judgmental account which steers clear of victimhood. This systemically-informed therapy helps people understand their experience in the context of being members of an affected community whose resourcefulness they can draw upon to strengthen their coping mechanisms, and see their responses to traumatising events as normative and understandable rather than irrational or a product of their own inadequacy.

Before presenting these interviews, I must acknowledge my personal connections. 1) in the summer of 2005 our 22-year-old niece was killed when a shell from a Hamas rocket hit her home in Netiv Haasara, a village situated close to the Gaza strip. 2) I lead on refugee work in Camden CAMHS and have worked with traumatised children and families for many years.

Michal Finklestein and colleagues have adapted the 'families over-coming under stress' (FOCUS) model developed by Saltzman *et al.* (2011) to their work with families who had suffered psychologically from the border conflict. This is a Family Narrative Reconstruction and Resilience Enhancing Programme originally developed to support families of American military personnel serving in Afghanistan and Iraq. The model adopts a relational approach to resilience which is seen as a dynamic process, fluctuating across time, rising to different challenges, which posits that *"family members provide opportunities for multiple dovetailing levels of supportive transactions"* (ibid p. 215). The aims are to reconstruct a shared family narrative about the traumatising experience of being targeted by rockets, improve family empathy and communication, foster confidence and hope, and enhance family resiliency. Michal has written about risk and resilience in families and noted how organisational patterns, belief systems and communication channels are often disrupted in families under ongoing fear of terror (Finklestein, 2016).

Michal: *Prior to the adoption of this model the training which had been offered to workers in Sderot and the small towns and villages close to the Gaza border practitioners rarely used whole family interventions, when all family members meet the same therapist during the course of an intervention. They had tried an eclectic range of individually focused approaches, but they then felt they needed to include the whole family and requested supervision to help them do so. The 'families over-coming under stress' model was different from the way they had been working where up to three clinicians were working with different members of the same family. While there are clear differences between civilians in an ongoing situation of stress and soldiers who had come away from a war zone, the professionals I was supervising felt there were sufficient similarities to warrant adopting the model and adapting it to their local circumstances.*

I ask Michal to describe an example of a family she worked with using this model.

Michal: *Three children aged seven, five and two, were playing in the local park while father was out of town at work. A 'Colour Red' siren warning sounded giving them 15 seconds to seek cover. The mother gathered her children and ran to the bomb shelter only to discover she had forgotten the seven-year-old. They were soon reunited but this incident damaged the mother-child relationship. Mother found she could no longer communicate effectively with her daughter who was crying at night. The hurt they all felt made it difficult to return to everyday routine. The 'families over-coming under stress' programme was offered to help rebuild their resilience and construct a family narrative of that traumatic event.*

The mother expressed guilty feelings and anxiety was very high in the family. Anger was particularly directed towards the father whom the girl regarded as having abandoned them. The couple were offered a reflective space and tools to develop parenting capacity. What was missing was their capacity to talk and share feelings about the traumatic event, each one from their own different perspective, nor was there understanding of what their partner had been through. Their communication had been poor as they had never before talked about these issues openly, nor had they ever shared their thoughts and feelings of the dangerous experience they had endured together. They had neither been able to perceive nor contain the other's experience.

In two meetings with the parents the therapist asked about roles, who calms the children and how each parent contributes to the children's daily lives. A 'feelings thermometer' was used to measure emotions before and after the traumatic incident, noting differences between the parents.

In this example the mother acknowledged feelings of helplessness towards her daughter as well as guilt about leaving her. The father had an opportunity to learn about the devastating situation his family had been through while he was not with them. They heard the father sharing his tremendous worry for his wife and children.

The therapist contains the distress of each family member and stops any judgmental and accusatory comments between them, stressing how each of them is vulnerable and needs acknowledging. The aim is to help them understand how their reactions were completely understandable, given the abnormal circumstances. It then becomes important to encourage family members – and the children in particular – to vocalise what they did and felt during the incident in as much detail as possible, e.g. "I felt scared and I held on to my big sister's hand as we ran to the shelter... I forgot my coat, but we could not go back to fetch it etc."

Family sessions typically take place about six weeks after a traumatic event. This way it remains fresh in the memory, but enough time has passed to enable useful working through of the experiences without becoming overwhelmed with emotion. It is an opportunity to reflect, normalise, contain and appreciate what each family member had experienced.

The daughter held on to her feeling of being abandoned and anger towards her mother for some time but gradually let it go when she saw that her mother was learning to listen to her. The therapists supported the mother to hear her daughter meaningfully and facilitate emotional regulation.

A Narrative stance was taken to help family members develop a coherent story about what had happened to each of them and what strengths they already possessed to manage any future trauma. The differentiation of the experiences is key, so a parent can understand that their child has experienced the incident in their own unique way. It is by appreciating these differences that a family narrative can be produced that has meaning and coherence for each of them.

I ask Michal to say more about the importance for traumatised families of verbalising feelings and developing a shared narrative. How did this make a difference at the community level?

Michal: *There has been a significant shift in how treatment for trauma is accepted in southern communities exposed to bombardment from Gaza. Whereas in the past people were dismissive of professional help, such a 'macho' culture is no longer dominant and therapy has gained legitimacy and respect. People now have fewer qualms about seeking help.*

I ask if they use the same programme of work for each family, or did they deviate at any point?

Michal: *The team is currently researching whether it is necessary to stick to the guidelines of Saltzman's original model (Saltzman et al., 2011) in order to achieve efficacy in each case. The model has been adapted specifically in southern Israel to take account of the particular circumstances of the population where there is perpetual fear of further outbreak of hostilities and prolonged exposure to community trauma. How to develop resilience and continue normal family functioning in such circumstances?'*

I was keen to explore how professionals in the region help people develop such resilience and so I spoke to Ornit Rozenblat, the manager of the local psychology service in Sha'ar Hanegev an area which borders the Gaza Strip.

In the same centre sits the Social Services Department of Shaar Hanegev and a team of family therapists in a Resilience Centre. Other Resilience Centres have been set up in several local areas including Sderot and Ashkelon (see map).

These Resilience Centres started in 2007 when the Coalition for the Treatment of Trauma was established by the Israeli government to give therapeutic support to people who had suffered trauma following the shelling of their towns and villages by Hamas rockets fired from Gaza.

In emergencies, members of Ornit's team join with first responders to offer immediate treatment. They triage cases to decide the level of urgency and which cases require referral for therapy. This means working in people's houses or in local centres if houses have been damaged.

People are on duty 24 hours a day in shifts. When a 'colour red' emergency siren is sounded a member of Ornit's team checks whether people in the affected area are in a state of high anxiety and require psychological support. During this encounter they offer an initial assessment and mention the help the Resilience Centre could offer including an emergency helpline number.

Some observations have been of parents feeling flooded by frightening thoughts that their family members are in permanent life-threatening situations; exaggerated concern for their children's well-being, a decrease in parental reflective capacity; lack of attunement to their child's experience, poor emotional regulation; over-reaction or under-reaction to distress; continual anxiety, excessive fatigue, helplessness

and uncertainty. Many parents also feel ashamed that they have no economic means to leave the area.

One example was of a family who were suffering from acute stress as a rocket had fallen close to their house. She visited them and found a mother in a heightened state of anxiety. She sat with the whole family using eye movement desensitisation and reprocessing (EMDR) techniques such as tapping and mindfulness to reduce symptoms of distress.

All the workers in the centre are trained in either EMDR, or the Somatic Experiencing approach of Peter Levine (Payne *et al.*, 2015) or other trauma-informed therapies. During the assessment, psychoeducational tools are taught the parents to help them calm their children and themselves.

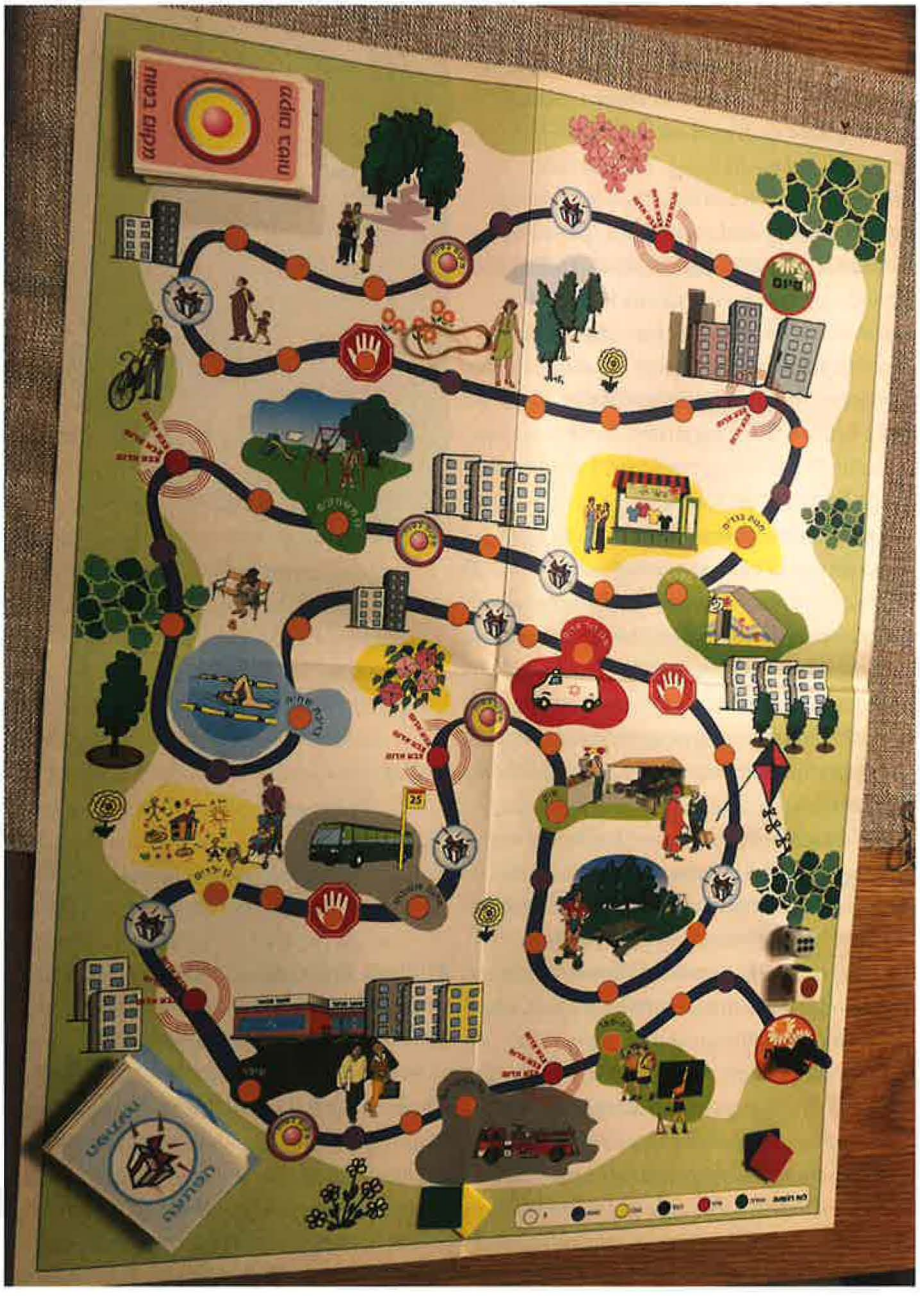
With children they use a game called "safe place", developed by Ornit and her colleagues, which takes players round a board getting them to pick cards and answer questions, earning tokens as they go. (See photo) If you land on a 'colour red' square the player has go to a 'safe place' and take a card with a question. The questions gently open up conversations, for example to complete the sentences: *"Daddy and Mummy think that I am...."* or *"Tell us about three good things that happened to you this year"*. As the game develops other questions probe more difficult emotions, for example *"Tell me about a scary moment that you had to cope with"* or *"When there was a colour red alert and my heart was beating fast I realised I was able to.....and then I felt better"*. Certain squares require participants to throw the 'feelings dice' which have a range of colours symbolising different emotions:

Green	Red	Black	Yellow	Purple	White
Joy	Fear	Anger	Sadness	Pride	Any other feeling

The child is then asked to say when or where they felt the emotion and tell a story about it to the group.

Through the game the child is able to work through traumatising moments and achieve a sense of control. Parents are encouraged to participate actively in the game and reflect upon any pre-occupying feelings, for example their guilt for exposing their children to trauma.

Other methods include giving children a 'security box' in which they symbolically lock up all the things that frighten them, and also all those things that help them overcome their fears. For example, literally cutting the child's fear down to size by taking a large piece of paper inscribed with the word 'fear' and then folding the paper until it is as small as a stamp. These ideas are influenced by the work of Claude Shemtov who worked with people traumatised by the Twin Towers disaster.



Clinicians draw on a range of methods including the notion of a 'safe place' taken from EMDR and Van der Kolk's (2014) ideas on brain-body connections. What Ornit has taken from these methods is the importance of strengthening inner resources to counteract feelings of fear and despondency.

When I ask Ornit for an example, she mentions a woman with a six-year-old daughter during the brief but intensive conflict in May 2021 between Israel and Hamas when at least sixty houses in the coastal town of Ashkelon were hit by rocket fire. Her husband insisted on carrying on with normal life, refusing to enter the 'Mamad' strong room with his family driving to work in Tel Aviv. His daughter expressed great worry about her father and stopped drawing, something that had formerly given her great comfort. During therapy she destroyed a picture she had made of her grandfather's house and expressed the fear that her father's car would be hit by a rocket. Painstaking work ensued using Shemtov's safe deposit box and the safe place game which helped the little girl gather her strengths to overcome her fear about her father. She then began to draw benign pictures again.

As I end the interview, Ornit and I reflect on how one important aspect of living and working in a region where conflict may break out at any moment is that workers are in the same boat, prone to the same apprehensions and worries as their clients such as guilt feelings, exhaustion, fear of renewed hostilities and burn out. Ornit says these common experiences draw people together and lead to feelings of compassion and mutual respect.

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