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CHAPTER 8

Play and Adaptation in Traumatized Young Children and Their Caregivers in Israel[1]

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Playing ... is the activity through which the human subject most freely and intensively constitutes himself or herself. To play is to affirm an "I", an autonomous subjectivity that exercises control over a world of possibilities; at the same time, and contrarily, it is in playing that the I can experience itself in its most fluid and boundaryless state . . . (Rubin, 1994, p. 280)

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THE CONTEXT OF THE PROJECT

This chapter presents a project that I initiated in the context of the escalating number of terrorist incidents in Israel, during the second Palestinian "Intifada." This violent "uprising," which began in September 2000 and is still rampant, resulted in many casualties on both sides of the Israeli–Palestinian conflict. The project focuses on the psychological effects of these events on young Israeli children who were exposed to the violence of terrorism. One must recognize, however, that similar, and even worse, ill effects have been experienced by Palestinian children and families (Lavi, 2003; Hazboun, 2003; Thabet, Abed, & Vostanis, 2004). My concern for the future psychological development and mental health of young children caught in violent political conflicts around the globe is the driving force behind the project.

The Scope of Terrorism, Trauma, and Repeated Traumatization

The unique characteristics of acts of terror make them potentially more traumatic than other life-threatening events. Terror is a man-made threat, targeting innocent civilians and seeking to spread fear and panic among the targeted population to achieve political or ideological goals. It is cruel, unpredictable, indiscriminate, and difficult to prevent (Klingman & Cohen, 2004). In the case of suicide bombers, the gruesomeness and inherent negation of the sanctity of human lives implied in the act are particularly bewildering. During the current Intifada the frequent terrorist incidents in Israeli cities and villages have included devastation caused by explosions and suicide bombings in busy public places. Residents of the settlements in the West Bank (Judea and Samaria) have additionally become victims of frequent ambushes of vehicles, involving stoning and shootings, as well as of infiltrations into homes by terrorists and consequent shootings of their inhabitants. Some outlying settlements and city neighborhoods (e.g., Gush Katif nearing the Gaza district and Gilo in Jerusalem) have suffered extended periods of mortar and rocket attacks.

According to the December, 2004, data of Israel's Social Security Administration, since September 2000, Israeli civilians have been exposed to 7,622 terrorist incidents, resulting in 725 deaths and 6,897 injuries. Children under the age of 17 comprise about 15% of all casualties. Other sources report that about 50% of adults and about 45% of children were exposed to a terror event through personal involvement (Manenti, 2003).

The impact of these direct traumatic exposures is multifold, as they often entail subsequent life-changes and continuing stresses, such as coping with a serious injury, living with a recently disabled parent, dealing with loss of attachment figures, and moving. The psychological effects of direct exposures may further be aggravated through indirect exposures to additional terrorist events via the media, which often serve as "reminders" of the original trauma and may complicate the recovery process. Moreover, living in a community with a high level of exposure to terrorism may involve mechanisms of "secondary traumatization," that is, being exposed to the reactions of others who have been traumatized by a terrorist event (Klingman & Cohen, 2004; Galovski & Lyons, 2004). This combination of stressors may present a high risk to the development, adaptation, and mental health of the children involved (Allwood, Bell-Dolan, & Husain, 2002; Joshi & O'Donnell, 2003).

The Risk

In the last 2 decades we have witnessed a major change in the understanding of the relationship between trauma and child psychopathology. Growing evidence (Pine & Cohen, 2002; Perrin, Smith, & Yule, 2000; Silverman & La Greca, 2002) shows that children are not immune to the effects of trauma, as was previously assumed, and are in fact at risk for developing post traumatic stress disorder (PTSD) (American Psychiatric Association, 1994, 2000), or PTSD-related symptomatology. Additionally, children who are victims of trauma are found to be prone to various behavioral problems and emotional difficulties (including anxiety and depression), and they may suffer from more general mal-effects to their brains, interpersonal relationships, and developmental course (Wright, Masten, Northwood, & Hubbard, 1997; Smith, Perrin, & Yule, 1999; Joshi & O'Donnell, 2003). Furthermore, although studies on the incidence of PTSD in children vary greatly (depending on the nature of the trauma and on the measurement tools and procedures), most of the evidence (including meta-analytical data) suggests that children may even be at a greater risk than adults to develop the disorder.

A close examination reveals that the majority of the epidemiological studies do not include young children in their samples (Hoven et al., 2002). Moreover, the majority of intervention programs that have been developed in recent years to prevent and treat post-traumatic difficulties have focused on adolescents and on latency children (Goenjian et al., 1997; March, Amaya-Jackson, Murray, & Schulte, 1998; Perrin et al., 2000; Chemtob, Nakashima, & Hamada, 2002; Saltzman, Steinberg, Layne, Aisenberg, & Pynoos, 2002). In a recent review of studies evaluating treatment of children suffering from traumatic stress, only one out of the eight studies reviewed targeted young children below the age of 8 years (Taylor & Chemtob, 2004). This paucity of information relating to young children has been repeatedly pointed out in

the literature (Scheeringa, Zeanah, Drell, & Larrieu, 1995; Almqvist & Brandell-Forsberg, 1997; Yule, Perrin, & Smith, 1999; Salmon & Bryant, 2002; Joshi & O'Donnell, 2003) and some of its sources have been attributed to the inadequacy of currently available criteria, tools, and procedures for diagnosing young children's post-traumatic disorders.

It is, however, this state of affairs that poses a risk for neglecting the identification of the needs of young children. This neglect is particularly worrisome since many clinical reports document the severity of post-traumatic reactions in young children (Terr, 1990; Gil, 1998). Existing research on young traumatized children, albeit limited, supported by extrapolations from related developmental research, suggests that the immaturity of young children in emotion regulation, social cognition, information processing, as well as language and memory, may result in diminished means of coping with trauma (Salmon & Bryant, 2002; Almqvist & Brandell-Forsberg, 1997; Scheeringa, Peebles, Cook, & Zeanah, 2001). It may especially affect the ability to create a coherent and clear trauma narrative, which helps in the integration of the traumatic memory into the self-schema of the victim (Wirgen, 1994). Magical thinking, typical at this age, may increase guilt, and the inability to comprehend the concept of death may lead to anxiety and confusion. Multiple exposures may place youngsters at higher risk for developing post-traumatic symptoms because children may merge similar incidents into a single representative memory (Howe, 1997).

The Challenges and Obstacles to Intervention

Given the above-mentioned risks to the mental health of young children exposed to terror, the relatively limited use of outpatient mental health services by children and their caretakers in Israel is striking: All treated children above age 4 years constitute only 12% of the outpatient population, although they make up 25% of the general population (Lerner, 2003). Young children in particular are very rarely referred to therapy, although free mental health services are available for victims of terror. What we have observed, prior to and throughout our project, were the workings of massive denial mechanisms in relation to young children's post-traumatic difficulties, in parents, school personnel, community leaders, and mental health professionals. This impression is supported by a number of studies, both in Israel and elsewhere, that have demonstrated that parents tend to underestimate PTSD-related distress of their children (Osofsky, 1995; Perrin et al., 2000). As Terr (1990) described based on her experiences in following up on the kidnapped children from the Chowchilla incident, it seems that defenses go up very fast after trauma strikes. The affected youngsters, their families, and the community erect walls of suppression, since people do not want to think of themselves as abnormal, hurt, or changed.

This suppression or denial may also be seen as a defense against the general anxiety invoked in adults when exposing young, vulnerable, and "innocent" children to the grim realities of life and the ensuing guilt experienced by adults for their inability to protect them. Such feelings may need to be denied more intensely by Israeli parents whose ideologically based decisions (such as living in the settlements) may put their own children at an increased risk for physical and mental health hazards. Osofsky (1995) has commented, in a similar vein, on the public tendency to believe erroneously that young children who are exposed to violence are too young to know or remember what has happened, in spite of clear findings on the post-traumatic effects of exposure to violence among very young children.

In addition to denial due to guilt, we have observed a neglect of children's psychological needs and emotional difficulties in families and schools in Israel. These systems appear overburdened by growing needs, mounting stresses, and psychological burnout. Many families are large and are struggling with economic, physical, and functional survival needs while coping with repeated losses and insecurities related to their future. Although everyday life for most people continues in a seemingly usual manner—unlike in war times—it still requires major daily adaptation to enhance safety and constitutes a vigilant way of coping, referred to in the local culture as "emergency routine." This routine allows very little energies for reflecting upon children's mental health or for taking action related to it.

Given the mentioned parental dynamics and the ongoing stresses, families, as well as social and educational systems, seem to activate processes of habituation and normalization as an adaptation to the helplessness experienced in facing repeated traumatic exposures and their impact. These adaptations, including an increase in tolerance for behavior problems, risk-taking behaviors, lack of concentration in schools, and regressive behaviors in the families, appear necessary and useful in the short run. However, they create some new risks. We know from the literature (Perrin et al., 2000; Joshi & O'Donnell, 2003) that the difficulties of young children in processing trauma are often expressed in a range of behaviors that are vague and that may mask the magnitude of the distress and its origin. These include somatic complaints, sleep difficulties and nightmares, clingy and regressive behaviors, fears, inability to concentrate, avoidance of talking about the event, irritability, hypervigilance, acting-out behaviors, and repetitive play. Under these circumstances parents and teachers often appear more concerned with daily coping and attempt to

either ignore or shape the disturbing behaviors, rather than being concerned with their origins or long-term developmental consequences.

These tendencies to ignore, deny, belittle, or tolerate the post-traumatic difficulties of young children are supported by a wider context related to community defensiveness and political ideology. In light of the continuous political conflicts and mounting pressures in regard to dismantling the settlements, the population in these areas, driven by a strong ideological commitment to prevent this move, is extremely sensitive to their public image. Their struggle involves the projection of a strong coping stance, both internally and externally, to the media and to Israeli and international public opinion. They are therefore very suspicious of research projects or mental-health services, which may tarnish their coping image. The communities therefore support internal natural support systems and the use of faith and religion as resources rather than professional interventions.

In spite of the mentioned obstacles to the possible identification and treatment of traumatized young children, a major consideration driving the careful introduction of this project is a recognition of the central importance of the significant adults in a child's life in mediating the effects of the traumatic experience on children (Klingman & Cohen, 2004). Available knowledge demonstrates that parental suppression of awareness of their children's suffering, conflicts, and symptoms has deleterious effects on children's adjustment (Laor, Wolmer, Mayes, & Gershon, 1997; Scheeringa & Zeanah, 2001). Keeping in mind the dynamics of parental avoidance behavior, it became clear that a respectful, nonthreatening, and nonburdening way to reach out to caretakers was needed. In practical terms it meant that we had to travel to their areas of residence, rather than expect them to come to us. A major goal of the project was to invoke interest in caregivers in their children's inner experiences, and to help them realize their important role in their children's processing of trauma.

THE PROJECT: RATIONALE, PROCEDURE, AND TOOLS

The project was designed as a study and pilot intervention focusing on the inner experiences of young children (4–7 years old) identified as having been directly exposed to terrorism. After securing parental permission, a videotaped individual play-therapy session was conducted with each child. The session (45 minutes in duration) was child-centered and nondirective, and was carried out in a private, quiet room, close to the child's classroom, by a skilled adult (the project director and her two graduate students, or the involved school psychologist in a small number of cases), using a set of toys and materials traditionally used in play therapy.

Given the shortage of adequate assessment tools for the identification of post-traumatic problems in young children, we adopted the current recommendation, embraced by trauma specialists (American Association of Child and Adolescent Psychiatry, 1998; Yule, 2001; Salmon & Bryant, 2002), to use multi-modal multi-source information in assessing the clinical status of the children. Therefore, in addition to a videotape of each child's play, independent ratings of the children's adaptation by their parents and when possible also by their teachers were obtained. Background information on family stresses and resources (including exposure history and parental PTSD, previous life events, and loss of psychosocial resources) was also collected to help identify children at risk.

We adopted the recommendation of the American Association of Child and Adolescent Psychiatry (AACAP, 1998) to identify and offer treatment to children exposed to traumatic events, even if they do not meet the criteria of PTSD, based on the limitations of the DSM-IV (American Psychiatric Association, 1994) criteria for diagnosing PTSD in young children. We therefore focused on the general adaptation of the traumatized children, using a wide perspective, and targeting post-traumatic distress or functional difficulties, and developmental changes.

With the parents we used an innovative PTSD questionnaire and diagnostic criteria especially adapted to young children and sensitive to developmental changes (Scheeringa, Peebles, et al., 2001; Scheeringa, Zeanah, Myers, & Putnam, 2003), but we were interested in the presence of symptoms and not only in a PTSD diagnosis. In addition we used the Child Behavior Checklist (CBCL) to assess general behavior problems (Achenbach & Edelbrock, 1983). However, we considered play observation as the most important tool, as it allowed more direct access to the child's subjective experience. Because of the limited ability of young children to use self-reports, play becomes a major modality for learning from the children themselves, in their language, about their experience.

Much clinical work shows that play is a central tool for understanding children's inner experience (Winnicott, 1971; Gil, 1998; Ryan & Needham, 2001; Chazan, 2002). The various therapeutic functions of play in helping the child rework unpleasant experiences have been emphasized, including: emotional release; gaining self-efficacy by changing the passive victim role into an active one; making negative experiences more predictable through repetition; reconstructing experiences in order to increase comprehension and

create meaning; and figuring out solutions for unresolved conflicts and for improved coping (Marans, Mayes, & Colonna, 1993). The use of play observation and its analysis does not involve any direct reality-oriented questioning or re-exposure of the child, which may be an important consideration in planning interventions with children subjected to repeated exposures and reminders of trauma, in a context that encourages denial and ongoing coping. As a potential therapeutic intervention it creates a space for caregivers to listen to an individual child's narrative and for symbolically and experientially processing the trauma, without necessarily directly interpreting it.

The parents were offered the opportunity to view the child's videotape and to discuss it with us. Alternatively they could request that we discuss our clinical impressions regarding the child with the responsible school psychologist. These observations, based on the child's play, were considered a relatively nonthreatening, potential basis for invoking parents' interest in the child's inner world, and for reflecting on his or her coping processes and current needs. Both sources of information, the child's play and the parent's reports (on the familial situation, the child's exposure, and the child's symptoms and behaviors), were used together to learn about risk and resilience factors in the processing of trauma, and to clarify children's needs. Prearranged contacts with several trauma treatment centers ensured that children who might be referred from the project for therapy would receive immediate access to services.

Trauma has been demonstrated to affect a child's play activity in various distinct ways, which reduce its inherent psychological usefulness to the child. Terr (1983) and, following her work, a number of other clinicians (Wershba-Gershon, 1996; Varkas, 1998; Gil, 1998; Nader & Pynoos, 2000; Drewes, 2001) have attempted to clarify the pathological aspects of traumatic play, indicating its serious, somber, driven quality; repetitive re-enactments with unresolved themes; increased aggressiveness; fantasies linked with rescue or revenge; increased withdrawal; and reduced symbolization and concretization. It is worth noting that the DSM IV-TR (American Psychiatric Association, 2000) considers as one of its criteria for PTSD in children, the appearance of repetitive play and trauma reenactments in play as evidence for intrusive recollections of the trauma.

Building on this work, we undertook the challenge of systematically observing, documenting, and reliably analyzing the play patterns of children, by using the Children Play Therapy Instrument (CPTI) (Kernberg, Chazan, & Normandin, 1998; Chazan, 2000, 2001, 2002), which we have adapted for post-trauma reactions together with Chazan (2003). The CPTI rating system for traumatic play offers many measures of the affective, narrative,

dynamic, developmental, and social aspects of the child's play. Additionally it enables rating the child's quality of coping with the demands and stresses of the trauma, as revealed through play, along a spectrum of coping strategies ranging from adaptive to increasingly maladaptive and defensive. This focus, which goes beyond Terr's (1990) more categorical classification of traumatic play, allows the identification of resilient as well as pathological mechanisms for coping with trauma, rendering a fuller and more specific description of the child's play activity response to trauma. These mechanisms were organized in the revised version of the CPTI in three clusters (for a more detailed account see Chazan, 2003):

Cluster One: Re-Enactment with Soothing

Children using this cluster appear to re-enact aspects of the trauma and use mechanisms that allow them to gain relief and to achieve some closure. Examples of such coping strategies are: problem-solving, sublimation, affiliation, humor, and altruism

Cluster Two: Re-Enactment Without Soothing

Children using this cluster appear to repeatedly re-enact disturbing aspects of the trauma and use mechanisms that fail to bring relief or satiation. Examples of such strategies are: identification with the aggressor, splitting, omnipotent control, devaluation, doing and undoing, regression, turning aggression against the self.

Cluster Three: Overwhelming Re-experiencing

Children using this cluster appear overwhelmed by their feelings and are either paralyzed to the point of being unable to play or to significantly interact with others, or alternatively, they re-experience such overwhelming feelings while encountering in play reminders of their traumatic experience that they seem to lose control of the play and of their actions, until the play is interrupted. Examples of strategies employed are: constriction, freezing, dedifferentiation, dispersal, and dismantling.

Clinical impressions from the Play Project

In conducting the play sessions with the children we learned not only of the feasibility of this procedure, but also of the interest and eagerness with which most children responded to it. Almost all the children in the study were able to develop some kind of relationship with the unfamiliar attentive adult, and

only two children requested to go back to the classroom prior to the planned termination of the session. Most children, however, seemed hungry for the adult's interest and validation, and none seemed completely dissociated. The majority of the exposed children were able to use fantasy play and seemed invested in re-enacting painful aspects of their experience. Some children showed unusual resilience and coping abilities and managed to sooth themselves successfully, while re-enacting aspects of their traumatic experience. Many children, however, appeared to lack sufficient soothing mechanisms and had difficulty in breaking away from repeated stressful re-enactments. A number of children appeared overwhelmed by their anxiety and pain; they resorted to either intense chaotic play that included sadistic acting-out or risk-taking elements, or conversely, appeared extremely constricted, avoidant, distracted, and unable to play.

MAJOR FINDINGS FROM THE STUDY

Although a detailed and full account of the data analyses and findings of the research part of this project are beyond the scope of this chapter and will be published separately, some major findings are briefly presented as they are pertinent to our approach to risk, identification, and intervention. The data are based on comparisons between a group of 29 children directly exposed to terrorism, and a group of 25 children, of comparable age and socioeconomic background, who were not exposed (except through the media) to a terror event. The research findings confirmed our concern in relation to the heightened mental health risk for young children exposed to terrorism. Children in the exposed group were diagnosed more frequently with PTSD (almost one third as compared to none in the non-exposed group) based on parental reports, and using the criteria for young children. The exposed children also manifested significantly more post-traumatic symptoms, including developmental regressions, and exhibited more behavioral problems (about 25% exhibited behavior problems at a clinical level as compared to none in the non-exposed group). As suspected, we found that these directly exposed young children may also be exposed to secondary traumatization risks including through the effect of their caregivers. Parents of the exposed children were diagnosed more frequently as suffering from PTSD and demonstrated more post-traumatic symptoms than did parents of the non-exposed children. Parents' levels of post-traumatic symptomatology together with their level of loss of psychosocial resources were strongly associated with child maladaptation.

We found that the play videotapes could be analyzed in a satisfactorily reliable fashion by trained observers, using the revised CPTI (Chazan, 2003).

Moreover, the validity of these ratings was demonstrated by the significant differences in the play patterns of exposed children in comparison with their non-exposed peers. The exposed children exhibited in their play activity more intense and frequent negative affective responses, displayed more "acting-out" or externalizing themes, and also exhibited less "awareness of themselves as players" than did the non-exposed group of children.

In a further examination of the group of exposed children for within-group differences, specific indices of play correlated significantly with the level of post-traumatic adaptation. Negative emotional responses in play were associated with the number of PTSD symptoms. In addition, the use of coping and defensive strategies in play typical of the "overwhelming re-experiencing" cluster correlated highly and positively with frequency of post-traumatic symptoms. However, a number of attributes of play activity were found to be negatively correlated with post-traumatic symptomatology, including the use of the "re-enactment with soothing" strategies cluster, the use in play narratives of "care-taking and protection" themes, as well as a warm and cooperative relationship with the adult (therapist).

CLINICAL IMPLICATIONS OF THE FINDINGS

Play Activity as a Measure of Adaptation

The results of the study strengthen our initial assumption that play observation can be used to identify children who are highly distressed or malfunctioning following a traumatic terror event. Although further research may be needed to support our findings, they seem to enrich the available clinical literature on post-traumatic play, and offer a more specific list of measures of play activity based on analyses according to the trauma-adapted CPTI (Chazan, 2003) to be used as signs of risk for posttraumatic maladaptation. These include:

Affective components. Expressions of an overall negative or distressed affect, a narrow range of affects, or affects incongruent with the content of play or the situation (e.g., sadistic laughter); direct and symbolic manifestations of fear and anxiety; anger and aggressiveness; sadness and worry.

Themes. A preponderance of "acting out" and externalization themes, such as: body damage, breaking rules, death, destruction, devouring, falling, messing, revenge, and sadism.

Coping and defensive strategies. An "overwhelmed re-experiencing" pattern of coping, expressed in one of two extremes: either intensely driven,

repetitious re-enactments, which rapidly deteriorate into chaotic play, or severe constriction and freezing, involving the loss of the ability to play or interact (due to anxiety, depression, or hypervigilance).

Awareness of oneself as a player. Signs of loss of boundary between fantasy and reality, feeling victimized by the play, and losing the sense of being the player or the director of the play.

Identification of Post-Traumatic Distress Through Play

The following example from the project demonstrates the utility of conducting a play session with a child as a means of identifying post-traumatic distress, when the parents and even a therapist are insensitive to its presence.

A case-vignette: "Trying to digest the indigestible"

The traumatic incident. The C. family, including father, mother, 5-year-old Saul, and 4-year-old Miriam, were traveling in their car when it was fired upon from behind by a single terrorist, gravely injuring Saul. The boy spent 5 days in intensive care, and a few weeks later recovered amazingly well. The parents came to a trauma center about 5 months after the event seeking treatment for the father, who had stopped functioning both at work and at home. He was diagnosed as suffering from PTSD and depression. Both children were reported to be doing well. The parents' only concern regarding the children was the persistence of Saul's alopecia (sudden hair loss), which developed subsequent to the traumatic incident.

Contact. The father's therapist at the center, who had been working with the couple, obtained permission for me to videotape both children in a play session, as a pretest to the project. Having a play session with both children in a separate room during the parents' session was agreeable to all, as the children would otherwise be playing by themselves while waiting for their parents' therapy to end.

Play sessions. I first conducted a play session with Saul, who exhibited invariable sad affect and traumatic play involving repeated relentless re-enactments of danger, destruction, death, and resurrection, with some soothing abilities.

I then saw Miriam, who waited eagerly for her turn. Miriam showed some adaptive capabilities in her non-verbal affiliation and cooperativeness with the therapist and her adaptation to the demands of the situation. She seemed to be able to use the therapist as a secure base, enabling her to begin to explore and process intense feelings, thus showing some re-enactment with soothing coping mechanisms. However, her mood was somber throughout the play session and her play was by and large surprisingly regressive and worrisome, showing a predominance of coping/defensive mechanisms of re-enactment without soothing, which at times deteriorated into overwhelming re-experiencing. Miriam exhibited silent and repeated engagement in two dominant themes. The first theme involved intentional repeated dropping and dispersal of falling figures and objects, while mimicking nonverbally (with her face and hands) "what happened." The therapist's attempts to find out what happened, and her repeated reflections of the fall of the doll figures, were met with a shoulder shrug, communicating: "I don't care; I don't know." The second theme involved successive indiscriminate mouthing and dismantling of objects including dangerously small ones, human figures, sharp painful utensils (a plastic knife), and extremely large objects (a slinky) that she inappropriately tried to push into her mouth. In response to the therapist's continuous wondering about "what is this mouth that wants to bite on everything?", she finally responded verbally (for the first time) toward the end of the session, announcing "I am the witch and I'm going to eat the children for dinner." She then moved on to throwing the play figures and objects into a dark garage, repeatedly locking the door. She was unable to bring the play activity to a conclusion when the time was up, and needed to be interrupted.

Further intervention. Miriam's play included many indicators of risk: her negative affect, regressive mode, her externalization themes and the use of defensive mechanisms from Cluster Two (turning aggression against the self, omnipotent control, identification with the aggressor) and Cluster Three (de-differentiation and dispersal). This, however, appeared in contradiction to the reports given to the father's therapist by the parents. I shared my concerns with the therapist while also acknowledging the child's strengths, and I asked him to inquire more about the girl's experience and functioning.

Following the next session the therapist contacted me excitedly to inform me that he was surprised to learn from the parents that during the traumatic incident Miriam "was forgotten in the family car." They reported that, when her injured brother was taken out of the car and laid down by the roadside, she was left buckled up in her seat. While they were busy calling for help and tending to Saul, she remained in the car immobile, covered with his blood, for about 15 minutes. Some passers-by, who had stopped to help, noticed her in the car. These strangers volunteered to drive her to her grandmother's home. She saw little of her parents and brother in the ensuing

weeks of her brother's hospitalization and recovery. Soon after her brother's return home, her father's situation started to deteriorate.

It became apparent that Miriam never got a chance to figure out and validate her story of the trauma, and to process the many feelings aroused by it. Only in the session did she begin to "digest the indigestible." A follow-up conversation with her preschool teacher revealed that the teacher too was concerned about changes in her behavior, but she was hesitant to inform the parents as she did not want to burden them. It became clear that therapy needed to accommodate the needs of both children, and to open up a space in this overburdened family to help Miriam process her experience.

This single play session with Miriam can be viewed not only as an assessment but also as a meaningful intervention. Chazan (personal communication, January 2, 2005) remarked in response to viewing the videotape that by identifying with the aggressor within a safe, humanized arena, sensing the strong human holding capacity of the therapist, the child could begin to process the symbolic meaning of the traumatic event. The child gradually allowed herself to approach the evil by playfully becoming the evil.

Play as a Realm for Healing and for Engaging Caretakers

The mental health risk demonstrated in this study subsequent to exposure to acts of terror validates the need to find ways of reaching out to caregivers of exposed young children. Only 1 out of the 29 exposed children or families who participated in our study was receiving therapy—a few were followed upon sporadically by the school psychologist—in spite of the children's apparent distress, regressions, and behavior problems. It is interesting to note that the parents recognized these difficulties in their reports, although we do not know if they under-reported these difficulties. However, this recognition was not translated into help seeking. The finding that the children most at risk are those whose parents have been more impaired psychologically by the exposure to terrorism presents a challenge to intervention strategies. It seems that intervention may need to take into account the parents' impoverished psychological resources by involving additional significant adults to work with the children, while at the same time offering help, in a nonstigmatizing way, to the parents themselves. A nondemanding stance of the availability of a mental health professional for periodical consultations, even by phone, may be a feasible starting point for building a therapeutic helping relationship with these parents. Offering periodic educational and experiential workshops to parents through schools and community centers, which does not constitute a crisis intervention following a terrorist event, as commonly practiced, may

be another way of reaching out to parents. These would focus on resiliency and risk factors related to living under "emergency routine" and their impact on parent–child relations and on children's developmental needs. Establishing contact with the parents to discuss their children's play has proven in our project to be a potential nonthreatening strategy to engage the parents in reflecting upon their children's experiences and becoming more attuned to their needs.

Psychological Consultations with Distressed Caregivers

The following phone consultation, which evolved from our contact with one of the families in regard to the play session conducted with their child, is an example of the reaching-out potential of the procedure and the possibility of gradually building a relationship with parents that will help them help their children.

A Case Vignette: Sublimating Loss

The traumatic incident. About a year prior to our contact with the current family, their van, carrying the parents and their four children, was attacked by a barrage of gunshots fired from another car occupied by two Palestinian terrorists on a West Bank road. Both parents were killed and two of their four children were injured. The surviving children remained immobile in the van for a long time, fearing the return of the terrorists, until one of the children managed to find the parents' mobile phone and called for help. The four surviving children of this family moved in with relatives, who have six children of their own, and serve as their foster family.

Initial contact and its development. After hearing about our project, the foster mother initiated contact with us, sounding very ambivalent and cautious. She was not interested in referrals for therapy but was interested in learning more about the play of the younger children, since she was annoyed and concerned about their play; they were playing incessantly and repetitively the same aggressive make-believe play that she found impossible to witness. We agreed to see two of the younger children in a play session in a room adjacent to their classrooms: 5-year-old Shimon, who was in the attacked car, and 6-year-old Ron, who was one of the natural sons of the foster family.

The foster mother, after much encouragement through phone conversations, filled out questionnaires for us relating to the children's post-traumatic reactions and their behavior problems, but she chose not to respond to the questionnaires relevant to her own post-traumatic reactions and loss of psy-

chosocial resources, arguing that she did not experience any trauma, hence this was irrelevant for her. We mailed her copies of the videotaped sessions with the children and extended an invitation to discuss what we saw, if and when she chose to do so. More than 6 months later she established phone contact with me, asking to discuss over the phone some worrisome issues concerning the children. I agreed and had a 50-minute session over the phone. I will focus here only on one of the two boys discussed.

Information from the play session: Shimon—5 years old. Shimon used the play session in a self-initiated, determined, intense, and continuous manner, with no disruptions or interruptions. While not displaying a wide range of affects, his affective tone was mostly sober and seemed appropriate to the content of his play. We saw him as an aware player dealing with his trauma by re-enactment and using mostly successful coping and soothing mechanisms. At times, however, these Cluster One soothing mechanisms lost their effectiveness and the child enlisted defense mechanisms such as splitting and identification with the aggressor, typical of Cluster Two (re-enactment without soothing).

Shimon immediately chose an art activity, which gradually took on a dramatic quality of a re-enactment. He drew a house with a red roof, a chimney, windows, and a door, which he purposefully colored in black. He then painted a wide area designated as a sky, and added four "baby butterflies" in the top part of the sky and two birds in its lower part. A distinct line in the sky separated the two areas: the lower area that, according to his explanation, could be hit by a rocket from the Arab homes, and the upper, safe zone. He explained that the butterflies managed to escape into the safety zone, were saved, and felt joyous and scornful of their attackers. But the rocket managed to hit the birds, which did not cross back the line in time, and killed them. The butterflies wanted to save the birds but could not do so, because they could not cross the line. He then announced that the butterflies started to cry, and began drawing rain-like tears, pouring down heavily from the sky onto the house.

He then turned to the play therapist, saying: "You know, my father and mother were killed and my older sister cried a lot, but I cried even more because I'm younger." He then added a black flower, painted the house door even darker, and announced that the drawing was finished.

In a following play segment he re-enacted a battle between dinosaurs and other animal figures with many killings. The smart ones, who were also the angry ones and the good ones, were those that triumphed.

Additional information. Shimon did not meet the criteria for PTSD diagnosis, although he showed some PTSD symptomatology, including re-experiencing through play, nightmares, and sleeping difficulties. Neither did he reach a clinical level of behavior disorders.

Intervention with the foster mother around Shimon. The foster mother appeared aware of Shimon's intelligence and social abilities. She was, however, concerned about his constant anger, mood swings, and explosiveness. The anger was not manifested in behavior difficulties, as he responded well to limit setting, but his tone when talking to his siblings and his play seemed to her an expression of constant anger. She was upset that she never saw him express any sadness over his losses.

As she reported in response to my question that she had not found the time to watch the play videotapes I had sent her, I told her about the play session. She was very surprised and touched when hearing about the drawing and the tears. She did not think until then that he liked to draw, and she had never seen him cry. I emphasized his extraordinary sublimation abilities, and I also explained about the connection he may have made in his play between strength, anger, and being smart, which helped him feel safer. In response to her question about ways of reducing the anger I suggested the introduction of a special drawing and story notebook, which she could use while sitting with him privately, paying attention to his drawings, and writing down his thoughts, fantasies, and feelings. She was apprehensive that this procedure may augment his anger, but she then could see how delineating a specific time and place for expressing his feelings and experiencing being listened to may be helpful to the child.

The foster mother then revealed a deeper concern, namely, that Shimon did not accept the finality of the death of his parents and was telling her that he was awaiting their revival when the Messiah arrives. I provided her with some educational input regarding the limitations in preschool children in understanding the concept of death, providing examples from other children. I thought that the idea of looking forward to the unknown time of the arrival of the Messiah, a time everyone was wishing for, could be viewed as a constructive one. She then shared her concern that this may hinder his attachment to her as a mother figure. She listened very attentively to my idea that children can be attached to more than one figure, and that a good previous attachment and memories of a close relationship may provide the basis for a good additional attachment.

I expressed my recognition of her sincere interest in building a meaningful relationship with the child, and I acknowledged her determination and

coping ability in providing a caring and stable home for all the family children. I invited the mother to contact me by phone or to make an appointment whenever she needed to, and she has in fact responded to this invitation by requesting an additional phone consultation regarding the other videotaped child.

CLINICAL IMPLICATIONS FOR COPING AND RESILIENCE

The research data, together with the clinical observations gathered in conducting play sessions with 54 young children (4–7 years old), and especially those carried out with 29 children who had been directly exposed to terrorism, help bring into focus the question of the natural curative processes set forth via play and their essential ingredients. It is our impression that terrorist trauma may be processed in a different manner than trauma from familial abuse. Given a safe place and the presence of an attentive, containing, and validating adult, many children are able to draw on their inner resources (their secure attachment and healthy self-regulation and reflective abilities) and find means for constructing a congruent and empowering trauma narrative. This conclusion is supported by Saylor, Swenson, and Powell's report (1991) on the play and postdisaster adaptation of preschoolers exposed to Hurricane Hugo. Unlike most of the research that focuses exclusively on the risks of exposure to trauma, they noted positive changes in the children, in addition to such negative effects of the disaster as re-enactments, overgeneralization, and new fears. These changes included precocious concern for others, expanded insight, and advanced vocabulary. We agree with their conclusion that some of the more resilient children may be able to be supported by their parents—perhaps with some therapeutic guidance—if the parents themselves are coping well and may not need direct professional intervention.

Our data allow us to look at indicators of children's resilience, and to examine successful strategies that children use to sooth themselves and deal with the toxic materials of the trauma. The data analyses have shown that exposed children who show the best levels of adaptation manage to use re-enactment with soothing coping and defensive strategies and show a preponderance of "protection and care-taking themes," such as body function, help and caring, competence, feeding, grooming, rescue, resurrection, and protection.

Further qualitative analyses of the children's play revealed an array of specific mechanisms employed by the children in order to sooth themselves while re-enacting aspects of the traumatic experience, so as to achieve a reduction in the level of anxiety. The most useful mechanisms included:

Playfulness and amusement: Expressions of enthusiasm in regard to specific toys or evolving play ideas; changing the tone of voice in accordance with chosen roles; joking about mishaps (physically imitating the fall of the "slinky" while laughing); making up rhymes ("whatever comes out—makes me proud"); creatively exploring many ways of modeling the slinky into different shapes.

Affiliation with the adult: Sharing with the adults the play plan, meanings, and affects; requesting assistance; assigning roles ("you guess which song I am playing"); asking to reverse roles (i.e., asking the therapist to pretend that she is the baby and the child is her parent); using the adult for physical comforting (leaning one's head on the adult's knee when disappointed in lotto game); inquiring when the adult may be back for another visit.

Anticipation of danger and planning and constructing "environmental" protective measures: Building fences; blockading houses; blocking windows; preparing arrow-slits; constructing escape routes through steps, slides, and ladders; and planning a move to another country.

Increasing safety by confining dangerous characters: Entrapping the tiger in a cage; locking the bus door against the robber; throwing the bad guys in jail.

Devising magical protective measures; marking a drawing with a line in the sky above which the rockets cannot reach; activating magical forces like telepathy to know what others are planning.

Protecting the body by making it invincible: The soldier's body and heart are made of iron; he has 1000 lives; the hero has a magical body shield.

Using communication technology to enlist help (mostly cellular phones): Calling another truck on the cellular phone for a ride when one's truck breaks down; calling the police for help with a problem; father is calling someone to train together; child is calling mother to bring a new ball because the existing ball was punctured by a dinosaur; calling grandmother to buy milk; calling father to come home for dinner with the kids.

Appointing and enlisting protectors: Mother figure is appointed as prime minister and helps to prevent a disaster on a bus; a heavily armed cowboy is put in charge of protecting the other cowboys; dinosaurs are protecting the good ball players against the bad players; wild animals are added to protect the good soldiers in their camp.

The use of symbolic art to sublimate grief and to resolve guilt (see the above example of Shimon's play activity).

Bolstering of one's self-image by acknowledging or showing off one's achievements and talents, or by boasting about the advantages of one's group.

Using music for soothing: listening to the music from the adjacent classroom; humming; playing the flute; pretending that the play characters are making music; making up lyrics related to the play activity.

Engagement in altruistic and caretaking activities, such as feeding and caring for family members; feeding the therapist; giving immunizations to prevent disease; and offering the wounded medical care.

The following mechanisms employed by the children proved partially useful in soothing and advancing processing:

Attempts to figure out through play re-enactments the confusion regarding abstract or complex questions, such as: What provides safety and what entails danger? (Moving the soldier's camp a number of times to a safe area); Who is alive and who is dead? ("Now he is more dead. . . .", "They were dead but they are alive. . . ."); Who is the enemy and who is the protector? (marking the bad guys as those with helmets).

Exploring language: Repeating and trying to figure out adult statements. For example: A child re-enacts a scene of cowboys and Indians and explains that the cowboy needs to be with his gun at all times because "no one can survive in these 'territories' for more than a year" (alluding to a popular adult statement about survival in the West Bank territories).

Making up language to express unusual experiences (such as those related to morbid content), such as, "here is the 'Bloodery'"—where blood is sold.

Cognitive processing and intellectualization: Discussions of fairness and motives of cruel people; displaying extensive knowledge of a variety of dangerous animals and their hierarchy; making up riddles to feel in control; displaying one's ability to outsmart the stronger but stupid enemy.

Play suppression and play interruptions: Announcing the need for a break from an emotionally charged play theme ("I am tired of this; I will finish it later"), or requests to leave the room to go the restroom or to check on the waiting caretaker. These breaks away from a specific play reenactment allowed some children to later return and complete the play. At times the play remained interrupted, and the child could not engage further in any play activity.

It should be noted that many of the exposed children who used protection and care-taking themes also enacted aggressive and revenge fantasies. These included displays of physical power, destruction, killings, death, and burial, as well as quite sadistic scenes of torture. Symbolic aggression is an understandable, normal reaction to an experience of threat and is usually considered important because it gives an alternative option to actual acting out. It helps the child vent his or her anger against both "the enemy" and also against his or her significant others who failed to protect him or her. Play allows the child to transform the experience of helplessness, anxiety, and vulnerability and to acquire a sense of assumed power and retaliation ability.

The freedom to express forbidden feelings may in itself, however, increase the child's anxiety rather than reduce it (Varkas, 1998). A child in the aftermath of a traumatic event often needs active help from the adult in moving beyond these feelings to a sense of being able to feel protected. Otherwise such externalizing defense mechanisms as "identification with the aggressor" and "omnipotent control" may be crystallized and lead to sadism, masochism, chronic hypervigilance (Frankel, 2002), or risk-taking behavior (Glodich, Allen, & Arnold, 2001).

CLINICAL IMPLICATIONS FOR PLAY THERAPY

Terr (1983, 1990) described traumatic play as dangerous, because if it does not progress and transform over time it creates more terror than was consciously there when the game started. Thus it may leave the child vulnerable and helpless. As we pointed out, our findings reveal a more differentiated picture, showing a spectrum of post-traumatic play patterns ranging from mostly adaptive and resilient through varying degrees and kinds of maladaptation. Only some of the traumatized children, especially those who exhibit predominantly "overwhelming re-experiencing," are similar to the ones described in Terr's work.

Our suggestion is that therapists tailor differential interventions to suit the individual needs of children, and that those may be based on the conceptualizations of their different predominant coping and defensive mechanisms (Chazan, 2003) and on the additional play indicators we found in this project to be significant in processing trauma. Developmental needs (Slade, 1994; Shelby, 2000; Drewes, 2001) as well as stage of trauma and safety issues (Herman, 1997) should also be considered. These considerations may help settle some of the controversial and ambiguous issues apparent in the current literature on play therapy with traumatized young children (Webb, 2004; Gil, 2002; Terr, 2003; Taylor & Chemtob, 2004). These issues include the degree of structuring and directivity of the therapist (Nader & Pynoos, 2000; Ryan & Needhan, 2001), the contribution and risk of psychodynamic interpretations of the play (Terr, 2003; Webb, 1991), and the relative emphasis on exploration, expression, and release of affects (Ogawa, 2004), on object relations (Gallagher, Leavitt, & Kimmel, 1995), on cognition (including correcting distortions and creating a coherent narrative) and behavior, such as overcoming fears and avoidance behavior (de Arellano et al., 2005).

Our findings demonstrate that almost all of the traumatized children we saw exhibited at least some abilities to process traumatic materials by balancing spontaneously re-enacting and soothing, provided there was a safe context and a holding environment. Therapists should be aware of and identify these mechanisms and patiently support and expand them.

When the child appears "stuck" in repetitious re-enactments without sufficient soothing abilities, or even more so, when these deteriorate into overwhelmed chaotic play, the therapist must deal with the question of how much time to allow the play to continue before taking steps to modify it, or help the child regulate his anxiety. Most of the diverse, currently accepted therapy treatments for PTSD include among their interventions relaxation and stress management as a major therapeutic component (AACAP, 1998). This "soothing" component consists of various techniques to monitor and

regulate the patient's level of arousal to advance safely in the "imaginal" exposure and in the processing of traumatic memories without overwhelming the patient. Gil (1998), in addressing this question in relation to post-traumatic play, advocates the use of a range of interventions from least to most intrusive in such instances. Her ideas for interventions include asking the child to make some physical movement to interrupt rigid, constricted reactions (e.g., standing up, moving arms); making a verbal statement that encourages the child to disengage from the play and observe it; asking about the experience of the different characters; and actively wondering about additional possibilities ("what would happen if"). Terr (2003), who has previously advocated similar ideas with regard to therapeutically manipulating repetitive play through "corrective denouement," recently modified her ideas regarding "correction." She now maintains that suggestions may be made and clues given, but in the end a traumatized child should conceptualize the corrective solutions himself or herself.

Indeed, keeping in mind the variety of soothing and protecting mechanisms employed by individual resilient children in our project, the therapist's role may be viewed as that of monitoring the child's use of soothing mechanisms, by reminding and inspiring the child to access the mechanisms which are more fitting for him or her. These actions communicate to the child that he or she is both the player and the director of the play and that possibilities for help and protection can be created. Furthermore, the therapist needs to clearly communicate at times that he or she can serve as an untiring protector, both as a participant and as an observer of the child's play. Our data demonstrated that "awareness of oneself as player" (Chazan, 2002) is associated with soothing ability in play and with adaptation. This awareness may be seen as a precursor for the emergence of reflection, to use Slade's (1994) terms, that is, the point in treatment when the therapist and the child step out of the play together and can share reflections and symbolic meanings.

For children who seem overwhelmed (due to anxiety, depression, and hypervigilance) and therefore unable to use play to process the trauma, a very gentle approach seems warranted, aimed at building a sense of safety and trust. In these cases a direct reconstruction of the trauma, or interpretations of feelings or defenses, seem contra-indicated. Herman (1997) emphasizes the importance of both internal and external safety before the processing can proceed, affirming that without a reasonable sense of safety there is no way of thinking in a symbolic manner. In thinking about a young child whose inner equilibrium has been disrupted by trauma and whose ability to play has been compromised, we may use Winnicott's (1971) observation that "Psychotherapy has to do with two people playing together. The corollary of this is that

where playing is not possible then the work done by the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play" (p. 38).

Slade (1994) develops this idea further, noting that the literature has emphasized the therapist's role in offering interpretation and deciphering meaning, while neglecting his or her role in the process of creating meaning or make-believe. She argues that for immature children, or for children whose capacities for symbolization and abstraction are limited, interpretations of inner feelings and experiences may lead to denial and disorganization. She highlights the importance of the therapist's "simply playing" with the child, and his or her role in leading the child in learning to develop a narrative in play and in gradually integrating affect into it. This co-creation within a growing meaningful relationship helps the development of a reflective self-function. Our suggestion is that the same therapeutic needs may be evident in traumatized children, whose previous developmental achievements may be thwarted by the traumatic experience, which overwhelms their ability to process, represent, and integrate the traumatic experiences into existing schemas.

ADDITIONAL CONSIDERATIONS FOR TRAUMA PROFESSIONALS

Any discussion of interventions with a traumatized population is incomplete without some consideration of the experience of the professionals carrying out the intervention. We touch briefly on a couple of such issues only to emphasize our belief that they warrant more serious reflection and discussion.

Secondary traumatic stress reactions: The risk of negative effects to the psychological well-being of mental health workers due to being exposed to the traumatic experiences of others—termed secondary traumatic stress, compassion fatigue, or trauma counter-transference—has been stressed in recent literature (Figley, 1995; Stamm, 1995; Collins & Long, 2003). In our work we often experienced the witnessing of the children's trauma through their play as very emotionally taxing, and we found that we needed to space our exposure to be able to contain it. There were, however, moments when the level of traumatic exposure was unexpected (just as in a real traumatic event) and therefore emotionally more overwhelming. To demonstrate one such personal experience: A standard questionnaire relating to the parents' trauma exposure and PTSD, received by mail from one of the mothers in our project, caused me a number of sleepless nights. For this mother the structured format of the questionnaire did not suffice and she added a full handwritten page, which fell out as I opened the envelope. The page included a very de-

tailed description of a terrorist shooting in her home, and how she thought that her surviving son was dead because her deceased daughter's brains had covered his face. Our play sessions with unexposed children proved to be a good antidote to the emotional burden of playing with the young children exposed to terrorism. Additional helpful supports involved sharing our work with colleagues, and reminding ourselves of our purpose to help those in more need than we are.

Ethical dilemmas: The ambivalence, suspicion, and apprehension with which this project was initially received by various community representatives evoked in me an array of "counter-transferential" feelings. Some psychological services were worried about being flooded by referrals from the project. Families were worried about possible recommendations for therapy. Boards of education were worried about the public image of their population. This anxiety was contagious and brought forth ethical questions for self-examination: Would the results of this project attack the convictions or tarnish the image of an ideologically committed, exposed population? Could they weaken their defense mechanisms? Could avoidance and denial be working in the service of adaptive coping? Or, conversely, could these reactions in a community suffering from prolonged exposure be viewed as expected post-traumatic effects, needing to be gently confronted and processed?

It was the initial support of a number of mental health workers who are more embedded in this community that helped me get started. The growing interest in the project, however, gives me much hope that we had indeed identified a valid need and a safe procedure for helping.

CONCLUSION

In line with Herman (1997), I believe that recovery can occur only within the context of relationships. This is particularly true for young children, who need to sooth the wounds of their trauma to process it successfully. We have demonstrated through our project how play can become a major arena for understanding the experience of children without intruding or traumatizing, for raising the awareness of parents to their children's inner world, and for therapeutic healing.

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