The Braman Institute for Emotional Wellbeing

Early Intervention Program | Beit Issie Shapiro

Emotional Intervention in Infancy and Early Childhood (0-3) in Rehabilitation Day Care Centers

A Work Model

Beit Issie Shapiro
Changing the lives of people with disabilities
On the Willie & Celia Trump Campus

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Writing and professional content
Shafi Mashiach, Director, Dual Diagnosis Unit
Professional Director, Early Childhood Emotional Intervention Program

In collaboration with the Early Intervention Emotional Therapy Staff: Orit Bichler, Anat Langbord, Anat Tzur

Knowledge management, structuring and editing
Dr. Benjamin Hozmi, Ms. Lital Shani and Ms. Yael Yoshei

Library science
Ms. Tova Eliasaf

Beit Issie Shapiro's Knowledge Resource Management

Editing of the Hebrew Version: Ms. Efrat Shachar
Translation and Editing: Ms. Karen Gilbert
Layout: Nili Goldman
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This Work Model is dedicated to Norman and Irma Braman and their daughter Debbie, from Miami, Florida. Norman, Irma and Debbie have been friends and faithful partners of Beit Issie Shapiro for over 35 years. They established the Braman Foundation, and, through its activities, they demonstrate the great importance of emotional therapy for children, adolescents and adults with disabilities, as an important factor in their development. We are grateful to the Foundation for its support in the establishment of the Institute for Emotional Wellbeing, which includes emotional therapies for infants and toddlers with disabilities, a Dual Diagnosis Unit and a center for emotional therapy for adults with disabilities, as well as research, outreach and training in the field.

Michal Aharonoff Ben-Rei was a clinical psychologist who dedicated her life to helping those in need, via a number of social and community projects. Her friends and family decided to fulfill her vision to improve the emotional wellbeing of children with disabilities and their families, by the founding of the pioneering Early Childhood Emotional Therapy Center. This Guide translates this vision into a working model that documents and articulates Beit Issie Shapiro's work in this field.

With Thanks to the leading staff at the Braman Institute:
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Content

Executive Summary

"Early intervention" is a concept that refers to the provision of support that is adapted to the needs the preschool child, to help him advance in his first years, in all areas of development. This intervention approach emphasizes the child's domestic and educational environments, which enable him to develop as well as possible, despite the inherent challenges with which he arrived in the world.

In the case of infants and toddlers with developmental disabilities, early intervention is all the more critical. Their functioning in the various developmental areas is substantially determined by the genetic and neurological profile with which they were born, or by impairments incurred around the beginning of life (traumatic birth, premature birth, etc.) However, the young child's environment also has a considerable impact on his development. Hence, an adapted environment that is attentive to the child's developmental needs, combined with an early intervention approach, can significantly affect his development. In addition to adapting the environment to the child's functioning, the role of a multi-disciplinary staff is to provide emotional support to the family members.

Based on this approach, the Braman Institute developed an **integrative biopsychosocial intervention model** for rehabilitative day care centers for children with developmental disabilities. At the center of this model is an approach that calls for early and comprehensive intervention in the young child's life and their environment. This intervention includes an expanded component, in addition to the standard "basket" of tools that already exists at rehabilitative day care centers, and is a response to the emotional needs of the child, and his relationships with his parents and staff members. Thus, the educational, rehabilitative and emotional spheres are firmly intertwined and complement each other. The emotional support provided by the day care center is provided to the child himself, his parents and the professional staff, as they are a central part of the child's life. This is provided in addition to educational and rehabilitative support, and helps the child to achieve optimal physical and emotional development.

The theoretical model underlying this approach is based on extensive literature in the fields of Attachment and Theory of Mind, which refers to the ability to attribute ideas, feelings and intentions to another person. Hence, the work of the emotional therapist, with both the families and the staff, relies on theories of **mentalization and reflective functioning**.

We also use additional theoretical conceptualizations, which have been developed from knowledge accumulated over years of providing emotional therapy to people of all ages with disabilities. This includes knowledge regarding mental processes, such as coping with anxiety, loss-related grief, becoming a special needs parent, the impact of challenging parenting on parental relationships, and an understanding of family dynamics, including the influence of siblings. The emotional therapists employ all of this knowledge to empower the parents' reflectivity in coming to terms with their child's disability, and with being parents to a child with a disability. In this way, the contribution of the emotional therapists, via the interaction and exchange of information with the therapeutic team, leads to more inclusive, valuable and effective functioning of the multidisciplinary team.

The first part of this Guide includes a theoretical review of the subject of early intervention in early childhood, and emotional development among young children with disabilities. It presents the key elements of the integrative approach that forms the basis of the working model in the early childhood emotional treatment program.

The second part presents the model and how to implement it. It describes the different stages of implementation, starting from the transdisciplinary evaluation meeting, through mapping the emotional needs of the child and his family and formulating the treatment plan, to implementation of the model via a broad range of individual and group interventions: one-on-one therapy with the child together with parental guidance; emotional therapy for the parents; parent-child therapy (dyadic or triadic); and supervision for the staff members.

The third part presents challenges and dilemmas that arise when implementing the model, and suggests ways to handle them.

The fourth part sets out the personnel infrastructure required to implement the model, including specifying the various roles and professional backgrounds

required, and their areas of responsibility. It also sets out the physical infrastructures that facilitate the provision of optimal treatment.

The fifth and final part of the Guide presents insights gained from both a formative assessment and a quantitative study that examined the model's effectiveness. Findings indicate that the intervention contributed to increased reflective functioning among parents. The study also found that the higher the reflective functioning after the intervention, the higher the increase in proactive coping and the coping style of support and emotional ventilation. The study's findings among kindergarten assistants show that there were no differences in the assistants' reflective ability before and after the intervention. It may be that the assistants' high initial level of reflective functioning explains why there was no significant change in their reflective ability following the intervention.

This Guide has been produced with the aim of describing the components of the working model of emotional therapy at the rehabilitative day care center, including the methods of implementing it and the functions required to do so. The purpose of the model is also to suggest ways to implement and integrate it at all rehabilitative day care centers in the State of Israel.

This model can be reproduced at any rehabilitative day care center. Given the importance of the emotional sphere, we call on the Ministry of Welfare, which is responsible for the operation of rehabilitative day care centers, to include the emotional element in the array of treatments provided to infants and toddlers.

Introduction

The Braman Institute for Emotional Wellbeing

Beit Issie Shapiro is an organization that develops services and models for interventions for people with disabilities, for whom satisfactory support has not yet been found. The purpose of the organization is to develop evidence-based practices and to distribute them to the wider public, so as to increase the pool of people who can benefit from these developments, thereby leading to improved quality of life for this community.

The Braman Institute for Emotional Wellbeing was founded at Beit Issie Shapiro in 2019 as an all-inclusive service, which brings together all the emotional intervention services that have been developed in the organization, while also working to develop new solutions and models for people with disabilities, all based on evaluation and research. The Braman Institute was established in order to gather, standardize, expand and develop the work in the field of emotional support that has been taking place at Beit Issie Shapiro for three decades, at the Emotional Therapy Center, the Dual Diagnosis Unit and the Aaron De Lowe Early Intervention Center. The Institute also aims to make an impact on policy changes in the field of disabilities, and to expand the emotional support provided to people with disabilities. The Institute works to provide solutions for people with all kinds of developmental disabilities, of all ages, from infancy to adulthood.

The Braman Institute working model consists of six key components, as shown in Figure 1:

Figure 1: Braman Institute Operating Model

The Early Childhood Program (Michal Aharonoff Foundation) - Overview and Rationale

In 1983, Beit Issie Shapiro founded the De Lowe Center, a pioneering rehabilitative day care center, as a comprehensive framework for early intervention for infants and toddlers with disabilities. Since the first rehabilitative day care center in Israel was established at Beit Issie Shapiro, dozens of similar centers have opened up across the country, providing young children with an educational framework that includes a broad range of services in the healthcare field.

Oftentimes, whether at rehabilitative day care centers or in other frameworks, mental health among young children with physical disabilities is considered a

low priority issue. This is due to the heavy workload, and the time and resources spent providing other important developmental-rehabilitative solutions. However, a young child's emotional development has implications for his self-perception in adulthood, and for his relationship with his environment. Hence, the organization's management identified a serious need to include emotional interventions in the selection of support services provided to infants and toddlers with disabilities and their families.

After 25 years of early intervention in the lives of infants, toddlers, children and adults with disabilities at Beit Issie Shapiro, when the Braman Institute was established in 2018, it was decided to focus the Institute's activities on the field of early intervention in infancy and early childhood (0-3) for children with disabilities. The decision to focus on this age group was based on Beit Issie Shapiro's decades of experience of early intervention in early childhood, and on studies that show that emotional investment at these ages is the most significant and has long-term effects. This is true for young children both with and without disabilities. The development of the Early Childhood Program at the Braman Institute was intended to structure and deepen the extensive knowledge and experience accumulated at Beit Issie Shapiro in the field of mental health in early childhood.

As part of the program, an emotional therapist was added to the day care staff of each kindergarten class. Her role was to support the children and their families and to give them tailored emotional therapy as part of the services in the program. In addition, the emotional therapist supports the day care staff with respect to issues relating to the emotional aspects of the children's lives, and provides emotional therapy as an integral part of the rehabilitative day care center's biopsychosocial approach. The emotional therapist's role is described in detail later on.

The Early Childhood Program was implemented at Beit Issie Shapiro's De Lowe Early Intervention Center, and was accompanied by evaluation, information gathering and research. The research study examined the **reflective ability** of the staff and the families of the children at the day care center, and the extent to which this changed, by measuring "before" and "after" the emotional intervention. The De Lowe Center has four kindergarten classes, with a total of 44 children. Of these, approximately half move on to new settings each year and new children join.

The early childhood emotional intervention model was developed and established on the basis of our work at the Center. After the early childhood program had been running for four years, a systematic working model for emotional intervention in early childhood was formulated, featuring three groups: **the child, the family and the staff**. The components of the model will be set out in the coming chapters.

This Guide will describe the components and features of the working model, the methods that may be used to implement it and the functions required for it to work. Following this, the findings from the evaluation and research program that accompanied the program will be set out, as they relate to the model's components, and the key insights from the study will be presented. These data are a part of the comprehensive research that accompanied the early childhood program. Finally, we will suggest ways to implement and assimilate the model within frameworks for young children with disabilities, and we will present recommendations going forward.

Part A – Theoretical Introduction

Early Intervention

Comprehensive responsiveness to the needs of toddlers in early childhood has significant value and long-term impact on their entire life course. Early intervention during a period of development and growth is more effective than intervention at later life stages. This investment affects coping ability, social competence, and even his integration in society later in life (Guralnick, 2011).

"Early intervention" is a concept that refers to the provision of support that is adapted to the needs the preschool child, to help him advance in his first years, in all areas of development. This intervention approach emphasizes the child's domestic and educational environments, which enable him to develop as well as possible, despite the objective difficulties with which he arrived in the world.

Based on this approach, the Braman Institute developed an **integrative biopsychosocial intervention model** for rehabilitative day care centers for children with developmental disabilities. At the center of this model is an approach that calls for early and comprehensive intervention in the young child's life and their environment. This intervention includes an expanded component, in addition to the standard "basket" of tools that already exists at rehabilitative day care centers, and is a response to the emotional needs of the child, and his relationships with his parents and care team.

Early Intervention for Young Children with Disabilities

In the case of young children with developmental disabilities, early intervention is all the more critical. Their functioning in the various developmental areas is substantially determined by their genetic and neurological profile with which they were born, or by impairments incurred around the beginning of life (traumatic birth, premature birth, etc.). However, the child's environment also has a considerable impact on his development. Hence, an adapted environment that is attentive to the child's developmental needs, combined with an early intervention approach, can significantly affect his development.

One of the central goals of early intervention is to increase awareness among the parents and significant caregivers (such as educational and therapeutic staff) of the challenges involved in early intervention and of its positive effects. Guralnick and Bruder (2019) believe that one of the main goals of early intervention is to teach the child's parents and caregivers the positive impact of contingent and appropriate interactions, and to provide them with tools to create such interactions.

The tools required for these interactions include knowledge of early childhood developmental stages and of various developmental difficulties, and, most importantly, the caregivers' knowledge of the functioning components of each child under their care. This knowledge enables the caregivers to find ways to adapt the environment for the child's optimal development. It will help the child's close environment create contingent and appropriate interactions with him that will support his development. According to this approach, the role of the multi-disciplinary staff, in addition to adapting the environment to the child's various functioning components, is to provide emotional support to the family members. This support should give the family a sense of confidence and competence to cope with the child's special needs in the domestic environment (Guralnick & Bruder, 2019).

Emotional Development among Young Children with Disabilities

In 2021, Dr. Tali Hindi conducted a comprehensive review, which was published in her article (in Hebrew) "Mental Wellbeing of People with Disabilities – a Review of Research, Therapeutic Solutions and Policies in Israel and Around the World" (Hindi, 2022). This review sought out studies that examined emotional aspects of young children in infancy and early childhood. The search included studies conducted in the preceding five years that looked at infants and toddlers with normal development, and those with disabilities. There are a few key insights that can be gleaned from these studies:

- There are four main approaches on which early childhood interventions are based: relationship-based interventions, community-based interventions, family-based interventions and culture-based interventions.
- The majority of interventions in the emotional arena are based on the relationship approach, and focus on the parent-child interaction, which is in contrast with more traditional approaches that treat the behavior of the child and the parent separately.
- Assessment of parent-child relationships is a relatively young field of research, but there is evidence that this approach is promising.
- There are very few studies that examine the field of interventions for the caregiver (professional staff).
- The majority of studies are not focused on children with disabilities and their families, but on the general population (Hindi, 2022).

Schore (2001) proposed a multi-disciplinary approach that is focused on attachment patterns and their impact on various structures and regulatory functions as an explanation for normal development. He cites parts of Attachment Theory (Bowlby, 1969), which claims that the developmental process can be optimally understood as a product of the interaction between the unique genetic endowment that the child has received and the unique environment in which the child lives. It can be assumed that a child born with a neurodevelopmental delay may have poor interactive abilities due to his disability (sensory, motor,

communication impairments, etc.). In addition, sometimes the parent also has difficulty adjusting the skills required on his part in the face of these developmental challenges. Hence, the child may be more likely to develop vulnerability from relational trauma, compared to a child without developmental delay. The literature supports this hypothesis.

In studies conducted in the United States and the Netherlands, it was found that among children with disabilities less than 50% developed a secure attachment pattern, compared with 65% among children without disabilities (Alexander et al., 2018). This finding has a variety of explanations: One view brings findings that show that parents of children with disabilities describe themselves as being under stress, and report tensions in their relationships with their partners. Furthermore, these are often populations that are suffering from poverty. The studies that talk about the parents' emotional state show that parents who have come to terms with their child's diagnosis manage to develop a secure attachment pattern with the child (Koren-Karie et al., 2002; Oppenheim et al., 2012). Another explanation is based on the hypothesis that children with disabilities may have fewer possibilities for emotional expression and responsivity, and this affects the attachment process (John et al., 2012; Gul et al., 2016). Other studies show that children with disabilities have poorer communication abilities and have difficulty expressing their needs, and hence the great challenge for the parents is to be attentive to their needs (Howe, 2006; van IJzendoorn et al., 2007).

Another study shows that 35% of the fourth attachment group (Group D, insecure or disorganized attachment) were children with disabilities. This attachment pattern is often related to conditions of parental neglect. The researchers claim that these findings cannot be explained solely by parental neglect, even if this attachment pattern is found at a higher rate among children with disabilities. They say that it is also due to a parent's unresolved trauma and loss, or a result of the child's prolonged or multiple separations from his parents (Granqvist et al., 2017).

Many experts, including national authorities such as the Australian Children's Education and Care Quality Authority, recommend focusing on early childhood interventions (ECI), which promote and strengthen the parents' reflective functioning, as well as promoting and strengthening the parent-child bond.

The following is a review of five studies in the field of mental health that focus on parents of children with disabilities, and were conducted in the years 2016-2021 (Hindi, 2022):

a. A study conducted by Sealy and Glovinsky (2016), among parents of children with neurodevelopmental disabilities, aged two to six years, examined the effect of dyadic parent-child intervention on the parent's reflective functioning. The intervention included parent-child play followed by a conversation with the parents about their feelings and the child's motivations (mentalization). The study's findings showed that the group of parents that underwent the dyadic intervention received a higher score in reflective functioning relative to the control group. The study also found that treatment in a short timeframe was more effective in improving the parent's reflective functioning.

b. An evaluation study conducted by Burton et al. (2018) of the "Nurturing Program," examined the effectiveness of the intervention program for parents of children with special needs and health challenges (CSNHC). The families in the treatment group received twelve sessions of specialized content and were assigned a case manager. The families completed a questionnaire about their attitudes towards child rearing and family empowerment before and after the intervention. It was found that empathy towards their children increased among families who participated in the program. The study showed that the two types of intervention (case manager and the general intervention) provide the parents with coping tools and empower them.

c. The third study is a randomized controlled trial of early intervention for toddlers at high risk for CP. The intervention had two components: a personal physiotherapy coach for the family, and a neurodevelopmental component with a hands-off approach, which challenges the child to find his or her own adaptive motor strategy. The study examined the changes in family functioning and the child's level of participation and activity. The intervention lasted one year, during which one group received the intervention and a second group of children received ordinary physiotherapy. On the family empowerment scale (FES) and the children's functioning measures there were no differences between families that received the intervention and those that only received physiotherapy. However, the family quality of life significantly improved among those that received the intervention versus

the control group, mainly in measures of perception of the child's general health and the parents' emotional wellbeing (Hielkema et al., 2019).

d. An evaluation study (Kasparian et al., 2019) of emotional interventions aimed at treating parents of infants aged 0-12 months who suffer from congenital heart disease (CHD), and who needed surgery and hospitalization in intensive care units, conducted a comparison of different interventions, and found that all were carried out in person (as opposed to online therapy, for example), but each one used a different therapeutic approach (parent-child interaction, early pediatric palliative care, a psycho-educational approach, parenting skills training, and family-centered nursing). Four out of the five interventions succeeded in reducing anxiety, although the quality of data that was collected was low. In addition, positive results were also found for maternal coping, mother-infant attachment, parenting confidence and satisfaction with clinical care. There were no findings of improvement of quality of life for the parent or family.

In conclusion: It is striking that research on issues related to the emotional development of young children with disabilities is scarce. The studies that focused on the interaction between parents and children with disabilities showed that less secure attachment processes are observed among this population than among young children with normal development. Also, it seems that early intervention of various kinds improve the quality of life of families of toddlers with disabilities.

The concept that took shape at the day care center is an integrative approach, which seeks to address all the needs of the child and his family. According to this concept, the educational, rehabilitation and emotional fields are intertwined and complement each other. Hence, the emotional support at the day care center includes working with the child himself, his parents and the care team, as they play a central role in the child's overall care. The emotional therapy comes in addition to the educational and rehabilitation services. In this way, more comprehensive and complete care is provided that will promote the young child's physical and mental development.

The theoretical model of emotional intervention at the day care center is based on extensive literature in the field of Attachment and Theory of Mind, which

refers to the ability to attribute ideas, feelings and intentions to another person (Premack & Woodruff, 1978; Baron-Cohen et al., 1985). Hence, the work of the emotional therapist, whether with the families or with the care team, relies on theories that relate to mentalization and reflective functioning.

Developing the reflective functioning skills of parents of young children is especially significant, as children at this age begin to demonstrate an understanding of other people's emotional states (Sealy & Glovinsky, 2016). Theoretical models have assumed that these abilities develop when the child acquires language, and they derive from inborn mechanisms. However, researchers Target and Fonagy (2002) claim that this approach does not reflect the bi-directional connection that derives from the attachment relationship between the parent and the child, and that this lays the foundations of the child's future abilities to understand the emotional states of others, as an adult.

Fonagy, et al. (1991) claim that reflective functioning demonstrates the extent to which a parent can ascribe meaning to his own internal experience and to that of his child. It is also claimed that a parent with reasonably good reflective abilities can hold his child's thoughts, feelings, beliefs and intentions in his mind, and wonder about how these emotional states affect the child's behavior. At the same time, a parent with good reflective abilities is able to recognize and examine his own emotional state, and to understand the impact that it has on his relationship with his child. Later in their article, Target and Fonagy (2002) claim that the mentalization process enables a person to interpret the reasons for his own behavior or that of others, by examining and analyzing emotions, beliefs, intentions and desires, whether conscious or unconscious, and to act accordingly. The "mentalization process" concept comes from the theory of mind, which refers to the ability to ascribe ideas, emotions and intentions to another person (Premack & Woodruff, 1978; Baron-Cohen et al., 1985). The mentalization process also includes understanding the impacts of this process on the other person's behavior, and on his ability to regulate his emotions and behavior.

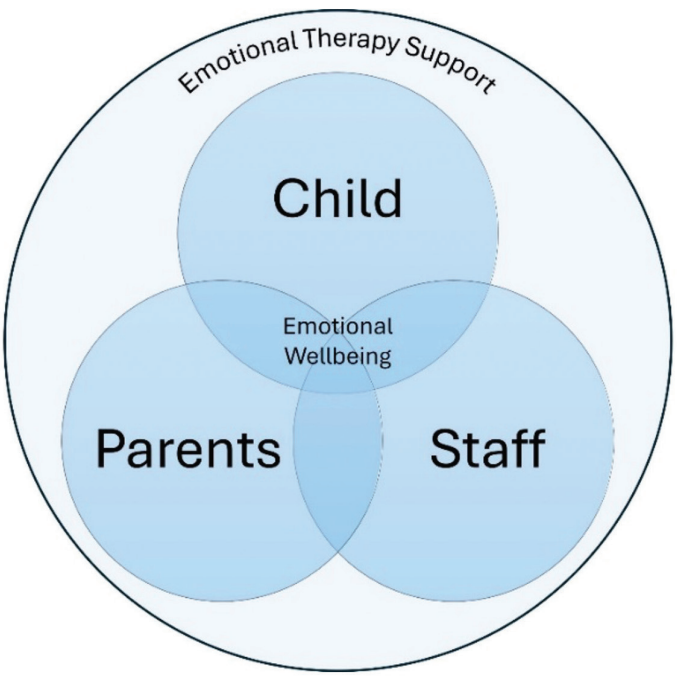
It is important to state that the theoretical model of emotional intervention at a day care center is based on additional theoretical conceptualizations, and has emerged from the knowledge and understanding that have accumulated over years of providing emotional therapy to people of all ages with disabilities.

This knowledge relates to emotional processes that include coping with anxiety, loss-related grief, becoming a special needs parent, the connection between challenging parenting and parental relationships, and an understanding of family dynamics, including the influence of siblings. The emotional therapists employ all of this knowledge to empower the parents' reflectivity while coming to terms with their child's disability, and being parents to a child with a disability. In this way, the contribution of the emotional therapists, via the interaction and exchange of information with the care team, helps the multidisciplinary team to provide emotional support that is more containing, beneficial and effective.

Part B – The Model and How to Implement It

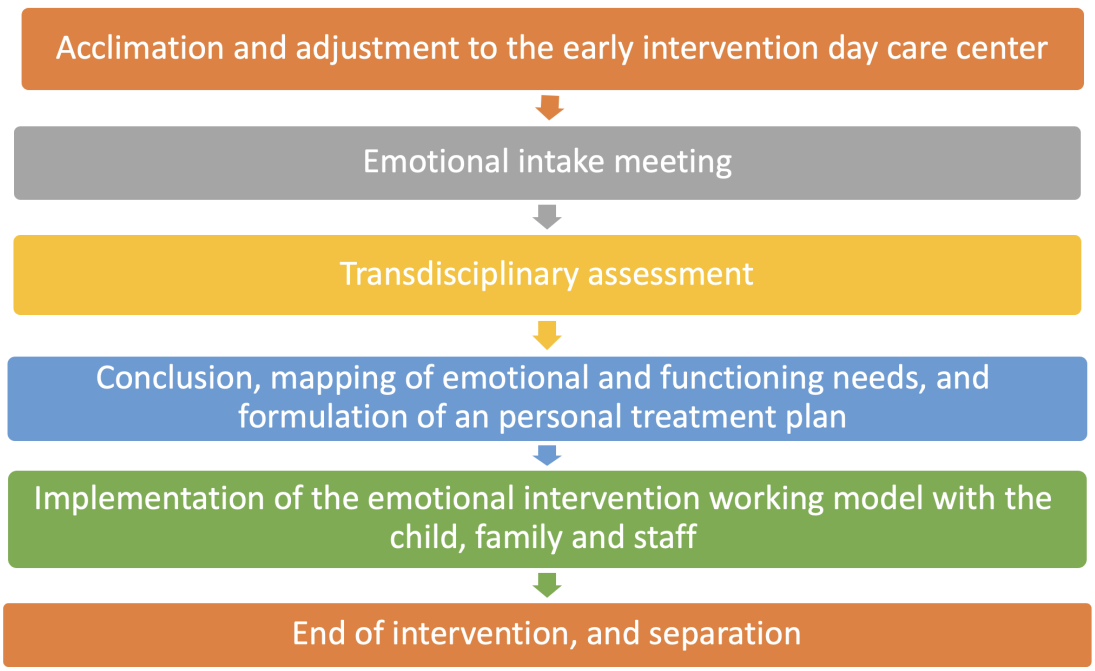
The systematic working model formulated in the Beit Issie Shapiro Early Childhood Program includes the young child, his parents, the day care center staff, and the support provided by the emotional therapists.

Figure 2: Systematic working model for early emotional intervention in early childhood



The emotional intervention process at the day care center is spread out over a school year, and includes the process of acclimation to the day care center, identifying needs, and execution of the emotional intervention.

The following flow chart describes the different stages of the process:



Absorption and acclimation to the rehabilitative day care center

Attending an early intervention day care center for the first time is a complex and meaningful experience for the young child and for his family. The acclimation process also has emotional dimensions that significantly affect the child's adjustment to his new educational framework, and usually this is his first ever experience in an educational institution. In the first few weeks of acclimation, the emotional therapist's perspective can shed extra light on a number of factors, including the child's inner world, his level of communication, and his ability to separate from his parents. At this stage the emotional therapist joins the daycare team and begins to meet with the parents in the intake sessions described in the next episode.

Emotional intake meeting

In the first few weeks of the year, an extensive emotional intake meeting takes place, which includes an in-depth interview with the parents, in which they provide details about their child. This meeting is conducted with the emotional therapist of the day care center class. The purpose of the intake meeting is to obtain information about the child, as well as to form an overall impression of the family. This meeting also enables the parents to get to know the emotional therapist as someone who provides individual and broad support throughout the year.

In the past, prior to the introduction of emotional therapists at the day care center, the center's social worker would conduct the intake meeting for each child. Since the start of the program and the emotional therapist joining the center, she has been a part of the kindergarten staff and responsible for conducting this meeting. This new arrangement enables us to convey to the parents and staff that the emotional dimensions of both the child and his parents need to be considered. The clear message is that we ascribe importance not only to the young child's motor and communication development, but also to the emotional sphere. In order to improve our understanding of the emotional elements, a special "intake form" was produced that focuses more on the following dimensions [Appendix 1 – Intake Form]:

- **The experience of starting to attend and acclimate to the day care center** – The initial period at the early intervention day care center is usually a meaningful and dramatic period for the child and his parents. The therapist meets the parents for the intake meeting in the first few weeks after he has joined the kindergarten, and we have found that it is generally appropriate to start the intake meeting with a question about the child's experience starting at the kindergarten, and how he is acclimating. Sometimes, separation and acclimation are key issues in the child's life at this age. Often, starting to attend the day care reflects, increases and exacerbates the issue of separation in the child's life. For most children, starting at the day care center is their first time separating from their parents since birth. For children with disabilities and their parents, this experience is extremely significant, and can present the parents

with dilemmas about issues such as their ability to trust others to care for their child, and their ability to trust their child to manage without them.

- **Birth, beginning of life and receiving the diagnosis** – This is a key part of the family dialogue and a central subject in individual and group therapies. Some parents describe the beginning of their child's life in terms of trauma. Oftentimes, the beginning of life for these children is dramatic and unusual (e.g., early birth, prematurity, traumatic birth, neonatal intensive care unit (NICU)). In some cases, the parents are informed close to the birth that their child has a congenital syndrome or disease, while in other cases the disability becomes apparent in the first few months of life. In most cases, these events take place in the first few months of the child's life, and are a traumatic experience that has barely been processed by the time the child starts attending the center. It therefore comes up at the intake meeting as primary and highly complex "raw material." The parents' description of their experience of discovering or receiving the diagnosis opens a window to what they have gone through, and are still going through, and will continue to resonate in all the therapeutic processes that they will undergo at the day care center.
- **Developmental lines** – The assumption is that the parents have provided the child's developmental history to the day care staff. This information is included on the intake form so as to provide a complete picture and make it clear that this topic may come up as part of the therapeutic discussion. The emotional therapist will decide during the meeting if, and to what extent, it is necessary to delve into the details.
- **The child's name and how it was chosen** – The child's name and how the parents chose it are additional pieces of the puzzle, and they help us to build an emotional picture of the family. Sometimes, this subject is emotionally charged, and discussing it helps form a deeper understanding of various topics, such as the bonding processes with the child, the parents' fantasies during the pregnancy, their thoughts ahead of the birth and the parents' perceptions of their child.
- **Parental history** – The intake meeting addresses the parents' history. Part of this history includes significant life events, traumas, losses and crises

throughout their lives. The message that we want to convey is that the parents' backgrounds and the resources with which they have come to special parenthood constitute an important part of the therapeutic work at the day care center. It is also important to obtain information about the various support networks available to the parents – extended family, friends, community, etc. It is crucial to understand the family structure, which is an additional component in the parents' ability to cope with the task of raising their child.

- **The parents' relationship** – The form includes reference to the issue of the parents' relationship and parental partnership. This information will contribute to a deeper understanding of the parents' resilience and weaknesses.] Siblings – It is important to consider the siblings of children with disabilities. One should understand, via the parents, the experience of the siblings and the questions that occupy the parents with respect to them. For example: Should we tell the older sibling about his brother's diagnosis? How can we give all family members the attention that they need? How should the family reorganize itself after receiving the news?

The intake meeting is a therapeutic act in itself and not simply an information-gathering session. It enables the emotional therapist to form more of an impression from non-verbal and non-content bearing information, such as body language, speech tone and behavior in the meeting. The emotional therapist also listens to the topics that the parents choose to focus on. She observes what happens in the room when one of the parents is agitated or annoyed. She sees how the parents look at each other during the meeting, if there is a good atmosphere and whether the emotions that come up are appropriate for the content that the parents bring up. She is also attentive to matters that are not discussed in this meeting. There are parents who have difficulty and even refuse to answer certain questions. In such cases, the emotional therapist will respect the request, but will infer from this that perhaps this is a sensitive issue, and it would be worthwhile going back and examining it later in the therapeutic process. It is important to remember that during the meeting there are "countertransference" processes taking place, in which the therapist is attentive to the feelings and emotions that come up for herself throughout the meeting. In the supervision processes that take place on an ongoing basis,

the therapist will try to track the unconscious reactions that arise for her from matters that come up in the meeting. This information contributes to a better understanding of the emotional world of the parents and their child.

The intake meeting lasts approximately one and a half hours, and includes an in-depth interview with the parents, using the outline on the intake form that was developed as part of the program, which gives a clear structure and an orderly framework. There is also room for discussion of substantial topics that may have clinical significance from a therapeutic perspective. The emotional therapist allows the parents to tell the story of the family and the child freely, as far as possible. Experience shows that adhering strictly to the intake form is difficult when conducting intake meetings, because of the desire to create an informal connection with the parents and to have a free-flowing conversation. Each therapist is very familiar with the intake form and chooses when and how to get to each section, so as not to spoil the flow of the conversation with the parents. For some parents, the intake meeting is a meaningful event, as the emotional therapist is the first member of the professional staff with whom they are sharing deep emotional concerns.

At the end of the intake meeting, it is important to discuss with the parents the format of emotional support provision at the day care center, and to explain to them how the process will continue. It is essential that the parents know that broad support is being offered to them, and that the kindergarten teacher and the emotional therapist are the people that they should turn to regarding emotional issues or crises, via one-on-one conversations, participation in parent groups or informal meetings at the day care center.

As part of the process of getting to know the child, other actions can be taken to help complete the emotional puzzle:

- Observation of the child in the day care center classroom.
- Joint viewing by the emotional therapist and the parents of videos of each parent playing with the child.

At the end of the process of getting to know the child and his family, the emotional therapist will note down the main themes and insights that arose during the emotional intake process.

Transdisciplinary meeting

During the acclimation process at the rehabilitative day care center, a meeting will take place that will include the child and his parents, and the entire staff of the kindergarten (kindergarten teacher, kindergarten assistants, allied health professionals, the center's social worker and the emotional therapist). This meeting is intended to help the staff get to know the child and his parents and to form an impression of the child's functioning and his relationship with his parents, as well as to formulate therapeutic goals for the coming year. The therapeutic goals are determined by the multidisciplinary staff at the center, together with the parents. The Transdisciplinary Assessment Form is used in this meeting [Appendix 2 – Transdisciplinary Assessment Form].

While for some families this meeting is perceived as a threatening or overwhelming situation, in most cases the transdisciplinary assessment meeting is a meaningful experience for the child's parents. The parents experience multidisciplinary cooperation and a spotlight on their child and his developmental needs. In addition, this is the first time that the parents meet the entire staff in one place, and it is an opportunity for them to hear each staff member's professional perspective. Furthermore, this is a chance for parents, as important and active partners in the discussion, to express their expectations from the rehabilitative day care center and from the members of staff. The important message that is conveyed in the meeting is that it is the joint mission of the staff and the parents to provide the child with the best possible support for his developmental needs.

As part of the assessment process, the emotional therapist observes the interaction of the child with his parents, as well as that between the child and staff members. The parents are also asked to bring video footage of interactions between them and their child in his home environment. The role of the emotional therapist is to look at the relationship patterns of the parent-parent-child triad and try to understand the emotional dimensions of the child's world and that of his parents. By this stage, many of the parents have already met the emotional therapist for the intake meeting, and therefore her presence as a familiar face can help the parents feel more confident at this special meeting. Sometimes, complex matters come up at these meetings that bring up intense emotions for both the parents and the staff. The emotional therapist can help to process these complex meetings.

Mapping of emotional needs and devising an emotional therapy program

In October every year, a summary is written for the Ministry of Welfare by the day care center's social worker, allied health professionals and emotional therapist. Following this, the kindergarten teacher and staff produce a Personal Rehabilitation Plan (PRP). The PRP is intended to promote each child's unique goals and objectives in the emotional arena. The goals will be formulated by the emotional therapist together with the child's parents and the professional staff. The formulation of goals will enable focused work and help mobilize the staff and parents to achieve the goals. When working in a multi-professional team with a transdisciplinary approach, it is important that each team member has all the goals set for the child in the PRP laid out before him. It is advisable to focus on measurable goals that can be added to the PRP if necessary:

1. Working with the parents on accepting their child's diagnosis.
2. Assistance with acclimation, e.g. anxiety, difficulty with transitions and changes.
3. Processing the child's disability.

However, there are situations in which we fail to identify a specific emotional goal when preparing the PRP. Our experience shows that the emotional therapist's perspective is often required to achieve the therapeutic goals set out in the PRP. The emotional therapist provides added value by looking at the child's emotional processes and inner world as they relate to the implementation of the PRP, and the achievement of the rehabilitation goals. Take, for example, a rehabilitation requirement that is consistent with the child's abilities but is met with refusal and resistance. Sometimes the emotional therapist will raise awareness of the emotional cost of one therapeutic goal or another.

As part of this process, there are several parallel thinking spaces. The guiding principle is to open up several thinking spaces that take into account the perspectives of the child and his family, as well as the perspective of the system. Sometimes, dilemmas arise due to the gap between the need identified by the emotional therapist, and the family's ability to comply with the treatment; or

an attempt is made to strike a balance between the need for treatment and the lack of resources, or inability to fulfill all of the needs. Taking all of these perspectives into account leads to the most accurate mapping of needs.

The first thinking space entails a meeting between the emotional therapist and the kindergarten staff, in which the emotional therapist describes the insights that arose from the emotional intake meeting, and her initial thoughts about the emotional needs of the child and his family. The second space is a meeting of the emotional therapy team in which stories of the child and his family are brought up for discussion, consideration and consultation. The third space involves meetings with the day care center director, the center's social worker, the emotional therapist coordinator and each emotional therapist individually. The purpose of the meetings is to make system-wide decisions regarding the mapping of the needs of all the children in the day care center.

Sometimes, we will identify a family that requires intervention but has difficulty accepting an invitation to therapy for various reasons. In other cases, parents report or feel that therapy could be more of a burden than a help. There are parents who are anxious, under stress or even traumatized, and have difficulty acknowledging the need for therapy, because their mentalization abilities have been affected. In these cases, the job of the therapist will be to help the parents understand the necessity of therapeutic intervention. The emotional therapist will continue to be in contact with parents who are not open to therapy, and will suggest that they come to therapy at a later date.

In the process of identifying needs, defining the urgency of therapy and determining the appropriate setting, we will take the following criteria into account:

Parent-related criteria

1. Intensity of the emotional distress.
2. Signs of stress such as low mood, lack of functioning, inability to care for the child.
3. Low mentalization abilities of the parents.
4. Parents' difficulty seeing the child's needs.
5. Families without familial, social or community support.

6. Difficulty communicating with the day care center staff.
7. The desire or openness on the part of the parents to receive emotional support, and to commit to it.
8. Difficulties in the parental relationship: relationship problems, divorce, problems with parental involvement, such as an uninvolved parent.
9. Cases of "cumulative trauma," such as background trauma in the family or traumatic incidents or events to which the child's birth was added.
10. The psychosocial picture, such as poverty, unemployment or physical illness.
11. Comorbidity of the parents' difficulties.

Child-related criteria

1. Evidence of a particular somatic symptom that indicates tension, or that may affect development, such as eating or sleeping problems.
2. An obvious emotional problem, such as difficulty separating, continuous crying or hair pulling.
3. Difficulties adjusting to the day care center environment.
4. Emotional regulation difficulties.
5. Temper tantrums.
6. Poor physical condition.

Criteria related to the parent-toddler relationship

1. Incompatibility between the parent's and the child's states.
2. Parent-child interaction that indicates a need to receive help.

Implementation of the working model for emotional intervention

The concept that took shape at the day care center is an integrative approach that seeks to consider all the needs of the child and his family. Under this approach, the educational, rehabilitative and emotional arenas are intertwined and complement each other. Hence, the emotional support at the day care center includes support for the child himself, for his parents and for the professional staff, who are a central part of the child's overall support system. This support is added to the educational and rehabilitative care provided by the center. Thus, a more complete and comprehensive support system is provided, which will enable the child to develop both physically and emotionally in the best way possible. The therapeutic inputs in the emotional arena include a broad range of therapies: individual therapy for the child, which is accompanied by parenting guidance; emotional therapy for the parents; parent groups and parent-child therapy (dyadic or triadic). The staff members also receive support and supervision.

The collection of services is offered to all children and their parents and is adapted to the needs identified in the diagnostic procedures mentioned in earlier chapters. During the years that we have been operating the model, we have found that it is possible to work in two types of therapeutic settings:

One option is to meet the families for therapy once a week for around 15 sessions (about four months). At these sessions, the therapist meets the triad (two parents and the child) in various combinations: two parents and child, mother and child, father and child, two parents without the child, and so on. The advantages of this format are that a close connection is formed with the families, and the therapeutic space becomes a part of the families' day-to-day lives. However, under this approach there is an extended period in which the families will not receive direct therapeutic support. It is important to note that in this period it is still possible to receive extensive support and to take part in parent groups, or to consult with the emotional therapist if something specific comes up.

Another option is to meet with the families throughout the year every two or three weeks. These sessions can be longer, and they include a child-parent

session and a session with the parents on their own. The advantage of this approach is that there is regular contact with the families throughout the year, which enables continuous support, and is therefore appropriate for some of the families. Another advantage is the synchronization with the multi-professional staff who are required by law to meet with the family throughout the year. However, large or irregular intervals between sessions may be challenging for the success of the therapy.

In addition to the emotional intervention for the families, there is also support for the emotional needs of the staff of the rehabilitative day care center. The staff members are an integral part of the young child's immediate support environment. The emotional therapist helps the staff to integrate the emotional aspects of the child and his family into their professional thinking, and thus to enhance their functional and educational work. The types of therapies provided to families and staff members will be described below.

Parent-child therapy (dyadic therapy)

Parent-child emotional therapy consists of joint sessions with a parent or parents and their son/daughter, together with the emotional therapist, and it focuses on the relationship between the parent and their child as a basis for the child's growth and proper development.

In the first years of life, the parent-child relationship is critical for the infant's development, both in the emotional and other arenas. The infant is dependent on the parent to understand his physical and emotional needs and to help him regulate his powerful emotions. The infant depends on the parent admiring him and taking care of his needs so that he can develop trust and confidence in the world and in himself. These elements of parent-child communication are a basic condition of proper emotional development (Spitz, 1965; Keren et al., 2013).

When a baby is born with a developmental disability, the initial parent-infant connection is severely challenged. The parent experiences high levels of anxiety, hopelessness and lack of control over the infant's medical condition, and over the interventions of the medical and developmental staff in his treatment. The parent's emotional distress is so powerful that the birth of a baby with a disability is considered to be a traumatic event. This may affect the parent's

ability to admire the baby, and to understand and meet his needs. The baby is born with a physical or cognitive disability that may affect his ability to express himself and to indicate his needs or distress to his parents. In most cases, the experiences that the baby goes through are also traumatic, such as a difficult birth or invasive medical interventions in his early years of life. Hence, parent-child therapy is an important tool, especially at younger ages for children with disabilities (Lieberman & Van Horn, 2008).

At the dyadic sessions, everyone present in the room will be listened to and will receive therapeutic attention, and attention will also be paid to the relations and interactions between them (Baradon, 2016; Salomonsson, 2018).

Parent-child therapy at the rehabilitative day care center tries to address the child's more difficult experiences as well as those of his parents, so as to make space for these experiences and legitimize them, and to facilitate the processing and digestion of the experiences, which will help them to recover and grow. This is done while supporting the positive forces of attachment and connection between the child and his parents. The dyadic therapy enables the parents to get to know their toddler and find ways to cope with raising him. The therapy can help parents regain their sense of their own good parenting abilities. Following this, the parents will work to improve the environmental conditions that enable the young child to grow and thrive in accordance with his ability (Lieberman & Van Horn, 2008).

Parental therapy

The birth of an infant with developmental difficulties can be a traumatic event, which requires the parents to deal with a complex reality. It is a serious existential experience, which brings up a variety of emotions for mother and father, such as grief, shame, denial and guilt (Levy-Schiff & Shulman, 1998). Sometimes, these are accompanied by a decrease in self-image, and feelings of helplessness and depression. This event has an impact and implications on the individual and the family as a whole, throughout their lives. It can be reflected in other areas: the parents may be forced to lose many work days, to change their life plans, to give up on their dreams related to their career or to having more children, and sometimes it may even be necessary to move to

a new location. (Krispin, 2009). Sometimes, the diagnosis can cause families to withdraw into themselves and avoid social gatherings due to shame or depression, while other families choose to share their situation with those around them and seek help from the wider family and community.

We believe that early intervention and emotional work with the parents is necessary from the very beginning of life. Therapy with a parent is intended to help him cope with the situation, to strengthen his sense that he is a good parent, to help him find his own strength and abilities, and sometimes even to deal with tensions that arise within the parental relationship. As part of the program, we offer emotional therapy to the parent or to the parents as a couple, who are trying to cope with raising a child with a developmental disability. The parental therapy includes sessions in a fixed setting once every one or two weeks. At these sessions, the emotional therapist meets with the parents in order to help them process their parental experience. It is recommended that both parents take part in the therapeutic process, so that the parental guidance is delivered in the best way possible. However, even if only one parent participates in the therapy, it can still be meaningful and create a change in the parental behavior. It is an attempt to help the parents process the feelings and acquire skills to deal with the child's difficulties and the day-to-day challenges that come with special parenting.

During the intervention, a variety of elements emerge that reflect the parents' feelings, such as: difficult feelings about the diagnostic process, which is often likened to a "rollercoaster ride"; emotional ups and downs and oscillating between great hope and deep despair; a profound understanding that the diagnosis will accompany the child and the family throughout his whole life; feelings of deep family crisis that engulf all family members, and an attempt to find a new equilibrium within the family; relief on receiving the diagnosis due to a sense of belonging that gives hope that solutions will be found; and attempts to find strengths in the new situation.

At the start of the guidance process, the parents will describe the difficulties and challenges that they are dealing with, and, together with the therapist, they will determine the goals that they would like to achieve in the therapeutic process. Based on these goals, an intervention plan will be developed. The intervention plan will include tools that will be adapted to the child's difficulties

and needs, or to the difficulties that arise for the parent when dealing with the child. As part of the therapeutic process, the parents learn to understand their child's world on a deeper level. Alongside this deeper understanding, there is a focus on the quality of communication between the parents and their child, and sometimes even between the parents themselves. In some cases, the parents each have a different way of coping with the diagnosis and caring for their child. Since the parents are the authoritative figures in the family, who guide the lives of the family and children, the parental therapy will focus on their parenting skills, from a place of empowering and strengthening their confidence in their parenting abilities.

The reality of raising a child with a disability leads many parents to change their life plans. Receiving the diagnosis is just the start of a journey in which the parents will experience both happy and sad moments. They'll feel both weak and strong, accepted and rejected, supported and supportive, and ultimately most will create a routine for themselves in which to conduct their lives. The parental therapy helps improve parenting, reduce feelings of stress and enhance the family's quality of life. We meet many families for whom this life mission becomes meaningful. They view the raising of their special child as a natural and integral part of their lives, rather than as an event that has interrupted the course of their lives.

Individual therapy for the young child, and parental guidance

Emotional therapy for children is designed to address the child's difficulty or his mental coping, in accordance with the psychological and developmental issues that are specific to children. The pioneers of emotional therapy for children were Anna Freud, Melanie Klein and Donald Winnicott. Klein assumed that child analysis is similar to adult analysis – while an adult patient will bring up free associations, a child will express them in play. Ferro (2012) also claims that there is no difference between treating adults and children. In his view, there is one psychoanalysis, with different clinical situations.

The psychodynamic perspective forms the basis of the emotional therapists' professional approach at the rehabilitative day care center. Psychodynamic therapy refers to a variety of therapeutic approaches that emerged from Freudian psychoanalysis. In therapy using the psychodynamic perspective, we

attach importance to the past, the patient's history, the unconscious layers and the meaning of the actions that take place in the therapy room, with the understanding that these events are closely related to what the patient experiences in his internal or external reality. Dynamic therapy for children has developed as a separate field, and in most cases is based on making contact with the child's inner world through play.

Hence, while in adult therapy the main tool is speech, in child therapy the main tool at work is play, which is a familiar and safe place for the child to express his experiences and feelings. The ability to play is fundamental, and, according to Winnicott, play is essential for everyone: "Psychotherapy takes place at the overlap of two areas of playing: that of the patient and that of the therapist. 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" (Winnicott, 1995, p. 66). According to Winnicott, play is essentially a creative experience, and he links it to health, growth and relationships with others. In his view, play in itself is therapeutic, and if a therapist and patient manage to play together, an element of healing takes place.

Therapy for children in early childhood – This focuses on early detection and diagnosis of difficulties in the communication, language, cognitive and emotional fields. The developmental and environmental context become central, alongside the child's inner world. The first years of life are characterized by accelerated development in all areas. Understanding the child's emotional world must include knowledge and understanding of the stage he is at in the other developmental areas. The common reasons for turning to emotional therapy in early childhood include developmental delays or deficiencies in various areas, such as: difficulties adjusting to kindergarten; difficulties giving up a transitional object or pacifier; bedwetting issues; separation difficulties; separation anxiety; various anxieties and fears; selective mutism; difficulties establishing social contact; outbursts of anger and behavioral problems; and extreme shyness.

When working with children in early childhood who are in a rehabilitative day care center, the tools must be adapted. It is important to remember that these are children who may have a motor, cognitive, communication or sensory disability that affects their ability to function in many areas of life, including play. Within the working model at the rehabilitative day care center, the type of therapy chosen is dependent on identifying the core of the difficulty. If we notice problems with the attachment processes of the parents with their child, we will focus on dyadic therapy and/or parental guidance. If we notice problems that are related to the child and his inner world and difficulties that he has in dealing with reality (such as anxieties, regulation problems, and the like), we opt for individual emotional therapy that includes parental guidance.

Individual therapy for children within the framework of the rehabilitative kindergarten – This will be provided for children who have difficulty functioning and adapting to life with a disability, and who need a safe, permanent and protected space where they can express their difficulties and their "true self" with the therapist as an accepting, stable, attentive, non-judgmental and non-critical figure. The therapist will listen to the child's emotional expressions, while bearing in mind the child's developmental history and the traumatic experiences he may have experienced at birth and at the start of his life. The therapist will observe the attachment types between the child and his parents; she will take into account his cognitive abilities and his comprehension skills and will listen to the sources of his anxiety. Based on her understanding of the child, the therapist will clarify, resonate and intervene in the most appropriate way for the child in her care. The individual therapy setting includes regular sessions with the child at least once a week, at a fixed place and time. In addition, sessions are held with the parents at a frequency of once every two weeks to once a month, based on a view that individual therapy for the child is always accompanied by parental guidance. It is a consultative, educational and therapeutic process in which parents gain knowledge, insight and skills with respect to their relationship with their child, and share with the therapist what is happening in the home space.

Parent groups

A parent group is a therapeutic tool to help parents cope with the special parenting they are experiencing, through meeting with parents dealing with a similar reality. This enables them to discuss issues that concern them, as well as expectations, worries and fears, in a supportive and encouraging atmosphere. The group is run by two facilitators from the therapeutic team, who have a background in and understanding of group processes and the field of developmental disabilities.

At the beginning of each school year, we examine the needs of the parents of the day care center children that year, and, based on this information, we make a decision regarding the number of parent groups to open, and the make-up of the groups. When there is a large number of new parents, a group will usually be opened especially for them. In this situation, in the second half of the year (around March), another parent group will be opened, called the "Separation and Transitions Group," intended for parents whose children are due to leave the center and move on to their next educational setting. In other cases, a group will be opened for all the parents. The parent groups meet once a week for an hour and a quarter, throughout the school year or part of it, as described above. The parent group provides a stable and continuous framework of support. This framework allows group participants to process issues related to the complex parenting experience. The parents are invited to use the group space to share and explore feelings, thoughts, fantasies and dreams related to this special parenting, in order to promote growth and development. In addition, meeting with other parents is significant in and of itself, as the parents form relationships with each other even outside of the group meeting. Sometimes, the bonds forged in these groups continue for many years after the children leave the rehabilitative day care center for other settings.

The parent groups work according to a psychodynamic approach, which views the group as the central therapeutic resource that contains the healing power for personal growth of the individual. The diverse topics discussed at the meeting are brought up by the group participants, and relate to everyday life in the present and the future. Topics include relationships with the family and social circle following the birth of the child; other children in the family (i.e. the siblings of the child in day care) and how they are coping; anxieties due to managing complex medical conditions; concern for the child's immediate

and long-term future; and processing the trauma surrounding the child's birth or the discovery of his developmental condition.

The parent group provides a stable and continuous framework of information and support, as well as the opportunity to process various facets of the complex parenting experience, to share and explore life experiences, feelings, thoughts, fantasies and dreams connected to parenting, growth and development. In the group work, the participants look within themselves for additional ways to look at their lives as parents of a child with disabilities. This group work sometimes leads participants to connect to and understand the meaning of elements of their lives that were previously denied (Mashiach et al., 2023).

The "transitions group" is more structured in terms of the topics raised, and focuses chiefly on the experience of separation and transition from the day care center to other educational settings. This experience echoes these issues in the lives of the toddlers and their parents. Some of the sessions are held in a more structured format, such as meeting with parents whose children left the day care center the previous year, or providing practical information regarding the transition to the next setting (e.g. information regarding placement committees and eligibility). Other group sessions are conducted using a more dynamic approach, as described above.

In the professional literature (Teller, 2001), support groups in the initial stages of special parenting are described as an effective intervention method. The earlier the intervention, the more beneficial its effect on the functioning of family members throughout the life cycle. The support networks help the family by providing emotional and material support, by alleviating stress, and by creating a social fabric that surrounds the family and the child with a disability, as well as preserving this support in the future.

Supervision groups for health professionals and kindergarten teachers

Working with young children with disabilities at a rehabilitative day care center is an important and rewarding mission, but it is also physically and emotionally demanding, and sometimes presents the educational and therapeutic staff with complex professional and mental challenges that expose the staff to

risk of burnout. This work involves contact with a complex population, which is compounded by the complexity of dealing with parents, family members and the day care staff. Oftentimes, staff members are so immersed in their day-to-day work that they do not stop to think about these complexities and what they mean. There are various forums that provide support to the staff as part of the day-to-day work of the teams themselves, such as team meetings, ventilation meetings, and conversations in the kindergarten assistants' room. Usually these meetings focus on finding solutions to specific issues that arise in real time. The supervision group provides the various staff members with a space that is available to them throughout the year, to discuss issues and challenges that arise in their work with young children with disabilities and their families. This group is led by two facilitators from the team of emotional therapists at the day care center (Mashiach and Leibowitz, 2018).

Group supervision for staff is a widely accepted practice in many therapeutic settings, sometimes as a process of ongoing support, and sometimes as a one-time intervention in times of crisis. A supervision group can be used to support, teach, counsel and even to provide therapy for staff members. In addition, the literature discusses interventions related to deepening the staff's understanding of the relationships and mutual influences between staff members, patients, the professional role and the organization, as well as interventions related to identifying projective processes and their impact on day-to-day work. Peleg (2015) suggests viewing the supervision as a space in which to "dream" the therapy, just as the goal of therapy is to help the patient play with as wide a range as possible of thoughts, feelings and emotions, which he experiences as his own in a projective manner, and which have been formed in the context of his presence alongside other people in the past, and his relationships with them. Berman and Berger (2007) suggest inviting the supervision group to a process called "reverie," a term that refers to the therapist's need to stay in an open state to absorb the patient's emotional experience, especially around wordless and unconscious mental areas.

The staff supervision group operates throughout the year and invites the educational team (kindergarten teachers) and the health professionals (speech therapists, occupational therapists and physiotherapists) to meet once every two weeks in the afternoon, at the end of the work day, for a one-and-a-half

hour meeting. The group space allows the staff members to share, consider and process together issues arising from their work "in the field." For example, a parent becomes angry with the physiotherapist because she suggests that the parents purchase a walker for the home; a speech therapist who takes care of a child with severe cerebral palsy and feels great frustration, because every time something positive happens in the therapy and the child laughs, his muscle tone increases and he seems to be in pain; a kindergarten teacher who is struggling with one of the girls in her class who does not stop crying, and opposes every activity suggested to her.

Using the tools of free-floating association, within a protected and secure group space, the group facilitates the formulation and understanding of the experiences and processes that are brought up by the group members. The empathy and validation from the other participants alleviate the supervisee's feelings of loneliness. Inviting the supervision group to freely discuss and share the issues raised enables the staff to develop the required shared language, and thus to jointly examine all aspects of our experiences in our work.

Supervision for the kindergarten assistants

Working using an integrative biopsychosocial intervention model includes intervention in the child's own life, alongside intervention and investment in his environment, namely, his parents and the therapeutic staff. For young children with a developmental difficulty, such as the toddlers in a rehabilitation day care center, such intervention and investment take on great significance precisely because of the difficulty of the environment in dealing with the disability. Addressing the mental state of the child's primary caregivers (parents, kindergarten teachers, healthcare professionals and assistants), and helping them deal emotionally with the child's condition, will improve their ability to foster the best possible mental wellbeing for the child, and enable him to thrive and develop to the best of his ability.

Out of all the day care center staff members, the kindergarten assistant who is assigned to the child is the caregiver that is closest to them. She knows him extremely well, sometimes better than any other staff member. She is responsible for the achievement of the goals in the PRP that was created for

him, for ensuring all his primary needs are met (food, hygiene, sleep), and often both the child and his parents regard her as the main staff member responsible for his wellbeing.

Given that some of the work of the emotional therapist is with the kindergarten staff, it was clear to us that emotional support should also be provided to the kindergarten assistants. Every emotional therapist meets with the assistants in her kindergarten class (three or four assistants in each class) for group or individual sessions, to help them process their experiences working with the day care center children, and to improve their reflective functioning abilities. Two working models were developed through the work with the assistants:

In one model, the emotional therapist met with the assistants as a group, once a week, for the whole year. The group included assistant-child dyads, similar to the parent-child therapy given to families. Each assistant has two children under her care, so in the first half of the year the assistant came to the sessions with one of the children, and in the second half she came with the other child.

In the other model, individual sessions were conducted between the emotional therapist and the assistant for one-on-one supervision regarding the emotional issues that arise during her work with the children in her care. Similar to the work with the parents, the intervention model for the assistants is based on theories relating to reflective functioning and mentalization. This approach is motivated by the perception that the mentalization process creates changes in the individual's (the parent's or staff member's) reflective functioning ability, and hence contributes to the child's emotional and physical development.

In the group sessions, as with parent-child therapies, the children and assistants engaged in "free play" in the treatment room. While jointly observing what was happening in the room, both with the children and with the assistants, it was possible to focus on and enhance the participants' ability to think about the inner world of the children in their care. The important working tool in these meetings is what was going on in the "here and now" between the children and the assistants, and between the children themselves. At the end of each session, after the children were returned to the classroom, an effort was made to stay for a while longer (assistants without the children) in the treatment room, to talk about and process the experience. Similar to parent-child therapy,

so too in these sessions, the caregivers and assistants are aware that insights and thoughts spoken in the therapeutic space should be formulated while imagining them also being said to the child himself.

Clinical supervision for the emotional therapists

Throughout the year, the support provided to the emotional therapists includes individual supervisions, a supervision group on the subject of parent-child therapies, and staff meetings that include clinical thinking about the families and other issues related to work in the day care center. The various supervision circles are provided by the program coordinators and an external supervisor (a clinical psychologist specializing in parent-toddler therapy, a child psychiatrist or the program coordinator).

Supervision for emotional therapy is a first-rate tool for optimal functioning and the development of emotional therapists. For the emotional therapist, supervision constitutes an emotional and cognitive support tool that helps her grasp, digest and process the elements of the therapy and formulate the therapeutic interventions.

In group supervision, the group itself constitutes a support for the therapist, and enables the expansion of therapeutic thinking, by allowing for a variety of voices and opinions of the different therapists who each hold different aspects regarding the patient in their response to the therapeutic material.

The supervision group for parent-child therapy was set up to create a space for the emotional therapists in the different kindergartens of the day care center to share the complexities and issues that arise in parent-child therapy, and to consult with both the group and the supervisor. Parent-child emotional therapy (dyadic therapy) is more complex than individual therapy or parental guidance, due to the need to support both the parent and the child, who are in a mutual but asymmetrical relationship with each other. In the rehabilitative day care center, there is the added complexity associated with being in the treatment room with a parent and his/her child with a developmental disability. This challenges the mutual emotional understanding and the self-image of each of the participants. The positioning of the therapist in such therapy is difficult and challenging. However, given appropriate guidance, it has the potential

to create a fundamental and profound change. In the supervision group, we discuss the dyadic therapies of the different therapists in turn. Space is given to the therapist's feelings and thoughts about the therapy, as well as those of the rest of the group. In addition, the participants consider the therapeutic material, which helps the therapist to better understand the needs of the family, and to implement tailored and more effective therapeutic interventions.

The end of the intervention and separation processes

Ending a process and separation are important and meaningful processes in emotional therapy. The emotional work at the rehabilitative day center is done in the context of a school year in an educational-rehabilitation framework. We have learned that matters related to the end of therapy and separation are interwoven with matters related to leaving the day care or moving between kindergarten classes at the end of the year. As in any emotional therapy, the role of the emotional therapist is to highlight the topic of separation in the final meetings. We see that separating from the rehabilitative day center evokes strong emotions – sometimes anxiety, sometimes grief over the separation and sometimes anger at the staff or the framework when the parents feel that the child has not made sufficient progress. There are cases where the experience of leaving the educational setting is so dramatic that it masks the experience of separating from the emotional therapy. In the emotional therapy, we try to contain and process the emotions related to the double separation from the educational framework and the therapy.

The timing of the end of the therapy is "imposed" by the culmination of the school year. The end of the school year marks a transition to another kindergarten class, or a farewell to Beit Issie Shapiro altogether. These tend to eclipse the process of separation from the therapy itself and from the therapist. The separation (from the kindergarten class or from the day care center itself) is also processed at the day care center, mostly by the kindergarten teacher. The role of the emotional therapist is to help process the thoughts and feelings that arise around these transitions.

Part C – Challenges and Dilemmas

During the emotional therapists' work, dilemmas and issues often arise that need to be addressed and that require intervention protocols to be devised. Certain issues are experienced by both the emotional therapists and the other day care professionals, while others are unique to emotional therapy. We have chosen to present key dilemmas that have arisen while operating the model.

Parents who have difficulty attending emotional therapy

As a center that views the family as the child's primary and most significant environment, we believe that the best emotional therapy for a young child requires parents to be open to, and to commit to, attending the sessions as set out in the individual plan devised for their child. The question is: What should be done in cases where we see that parents have difficulty coming to therapy, or when parents frequently cancel sessions or fail to respond to the emotional therapist's invitations to the required therapy sessions? This is particularly problematic when it is clear to the emotional therapist that the parents' active involvement in the therapeutic process is crucial. This kind of behavior necessitates a thorough examination with the family in order to understand the difficulty. This raises the question: **How can we convince these parents to attend emotional therapy** or parental guidance sessions?

Sometimes, **the parents are troubled by the sense of exposure** that is required from them in the therapeutic process. This issue has also been raised by the professional staff, who have wondered whether it is legitimate to ask parents who have enrolled their child in a rehabilitative day care center to undergo an intense emotional process, which delves into their own private lives, history, traumas and previous relationships. Unlike clients who have chosen to receive treatment, the day care parents are asked to undergo a therapeutic process without having requested it. For example, parents who are in a deep marital crisis will find it difficult to attend therapy at the day care center, out of concern that this will be revealed to the staff members who take care of their child.

The perception is that if it is established from the outset that emotional support is an integral part of the rehabilitative day care center's work plan, this will encourage the parents' participation in the emotional intervention program. In addition, we believe that once a therapeutic alliance is formed between the parents and the therapist, the parents will understand that the resources with which they have come to this special parenting have an impact on the nature of their relationship with their child.

Emotional work within a multi-professional team

Therapeutic confidentiality is one of the cornerstones of the therapeutic relationship. Confidentiality and trust are crucial to enable the client to be open with the therapist. Information may only be disclosed to a third party with the client's approval, and he must sign a "confidentiality waiver form". In extreme cases, where the therapist has reasonable grounds to believe that there is an immediate risk of a client harming himself or someone else, the therapist is obligated to deviate from this procedure and report to the authorities.

When working within a transdisciplinary model, the question arises as to whether matters that come up in emotional therapy should remain inside the therapy room, or if they can be brought up in the multi-professional team meetings. If the conclusion is that bringing them up in the team meetings is permitted, there is a further question as to which matters that come up in therapy should be disclosed to the day care center staff.

Unlike the work of the other staff members, including the healthcare professionals, the work of the emotional therapist is closely interwoven with work with the parents. In the parents' sessions with the emotional therapist, matters related to the parents' relationship or events from the parent's personal history often come up, and often include difficult topics such as trauma and domestic violence. Sometimes the kindergarten staff discuss problems or barriers in working with the child, and the emotional therapist believes that these issues are related to psychodynamic processes and issues to which she has been exposed in the sessions with the parents. In such situations, sharing this

information may enlighten the staff and deepen their understanding of the difficulties and issues experienced by the toddler, and can help them work with him. However, there is a concern that sharing information, even if this is done with the parents' consent, may damage the parents' trust in the therapist and adversely affect the treatment. A situation may arise where the parent would prefer not to share important and essential information with the therapist about things that are going on at home, or will refuse to come to sessions for fear that their information will be "leaked" or disclosed.

In these situations, the emotional therapist will share her thoughts with the parents about how the issues that have come up in the sessions with them are connected to the difficulties experienced by the child. It is recommended to then discuss with the parents the possibility of sharing these insights with the staff, so as to help the staff find ways to handle these difficulties.

Who does this information belong to? Recording and storing information

The rehabilitative day care center, which works in a multi-professional team model, maintains full documentation of every treatment given by the healthcare professionals, and this file is available to all the day care center staff. Every rehabilitative day center has a file on each child, which contains information about the therapies provided by the healthcare professionals. This file is kept in the kindergarten classroom. The information collected during the therapies is maintained in accordance with the Ministry of Welfare guidelines. The file also includes medical information, minutes of PRP meetings and any other information related to the child.

According to the Patient's Rights Law (1996), anyone who provides mental health care or counseling undertakes to keep records of and to monitor the process. The medical records of psychologists and psychotherapists include sensitive content alongside the treatment records. The records kept when providing psychological treatment consist of two parts: a medical record (formal content of the therapeutic session) and personal notes (regarding the therapist's

feelings and associations, informal thoughts, content for supervision sessions). These notes are considered to be private. Hence, the emotional therapy at the rehabilitative day care center is also documented by the emotional therapist, as required by law.

The question is: **Should record-keeping for treatments by healthcare professionals be the same as for emotional therapy**? As mentioned above, emotional therapy in early childhood also involves parents. Sometimes issues come up in the therapy that are directly related to the rehabilitative, emotional and educational processes of their child, and therefore it is beneficial to share the information with all staff members. However, personal information about the parents' relationship or their personal history, which is not related to the child's care, also comes up in the therapy. If this information is visible to all the staff, then they will have access to all kinds of information, including some that is not directly connected to the child's care. We therefore ask ourselves whether these medical records should be treated like any other medical records.

On the one hand, emotional therapists are required to maintain confidentiality; on the other hand, the idea of integrating insights about the child's emotional world requires that work be shared between the members of a multi-professional team. There is also a view that there should be no distinction between "body" and "mind," and this distinction in the records serves to reinforce the existing stigma surrounding emotional therapy versus physical therapy. A proposed solution to this issue is to only include in the client's (i.e. the child's) file information that the family agrees to, and is aware that it will be recorded there. At the same time, the emotional therapist's personal notes will be brought for peer consultation and to the supervision spaces, and will then be kept separately from the child's therapeutic file, as is standard procedure.

How do you integrate emotional language into a multi-professional team?

Work in a multi-professional team is based on a transdisciplinary approach (the word "trans" means "across" in Latin). A transdisciplinary team is an integrative team spanning different professional fields. The team members exchange knowledge and develop skills beyond each individual person's professional field. A transdisciplinary team is defined as a team where duties are shared beyond the boundaries of the professional field, so that communication, interactions and collaborations between team members are maximized.

Integrating emotional therapists into the day care staff is an extension of this concept. Thus, the role of the emotional therapist, similar to that of all healthcare and pedagogy professionals, consists of two aspects: providing direct therapies to children in the day care center, and **integrating her professional language and emotional intervention principles** into the multiprofessional team.

We view the emotional therapist's role as including expanding the staff members' understanding of the young child's emotional aspects in the day care classroom. Her job is to shine a spotlight on these aspects and, together with the staff members, to see how the emotional arena can help in other rehabilitation areas, or alternatively, how it might hinder them.

In this integration process, we have several tools at our disposal:

Support and supervision – As mentioned above, the emotional therapists support the kindergarten staff in several settings: group or individual supervision for kindergarten assistants; conversations with the kindergarten teacher; and a supervision group or a one-on-one session with the healthcare professionals. These spaces enable the staff members to learn and internalize the view of the emotional dimensions of the child's life in the kindergarten space and the therapy room.

Training – In addition to giving support and supervision, one can also provide focused and structured training on theoretical topics related to the emotional development of children with disabilities, including finding connections with the day-to-day work at the day care center. For example, we hold meetings

between the emotional therapists and the kindergarten assistants once every two months, with each meeting dedicated to studying a theoretical concept in the field of emotional development (such as attachment, family and disability).

The emotional therapist works to integrate emotional language in the different spaces in the kindergarten:

- **At team meetings** – Once a week there is a kindergarten team meeting with all staff members. At this meeting, we usually discuss the children in the day care. The emotional therapist is present at these meetings and presents the emotional dimensions of the child's rehabilitation process.

- **As part of the kindergarten staff** – As part of her role, the emotional therapist is present in the kindergarten throughout the school day. She takes part in the daily routine: at breakfast, in circle time, in free play, in the playground etc. Her role during these periods is dynamic and includes observation, intervention, real-time supervision of the assistant and even active participation.

- **One-on-one meetings** – Sometimes the therapist meets with one of the staff members individually in order to reflect on an incident or a specific case, and to shed light on the emotional aspects.

In our experience, effective integration is dependent on the constant presence of the therapist in the different spaces in the kindergarten. This integration is reflected in the expansion of each kindergarten staff member's repertoire, in their thinking, understanding and use of language that takes the emotional arena into account. The transdisciplinary concept stretches the limits of each staff member's viewpoint and professional knowledge, and deepens his professional outlook. It also allows the entire team to speak in the multidisciplinary language of therapeutic solutions, thus seeing both the child's needs and the solutions provided by the staff as a "whole" that is greater than the sum of its parts.

Part D – Infrastructure: Personnel and Physical Infrastructure

Personnel

In order to provide the best emotional therapy, the therapeutic staff need to be skilled in working with children in early childhood and their parents, and they must be familiar with the world of disabilities. The job requirements have been formulated on the basis of insights from our experience in running the program[1]. Given the importance of the emotional therapist's role as the person who directs and manages the emotional processes at the day care center, her job requirements and responsibilities will be detailed below.

Emotional therapist

The emotional therapist joined every kindergarten class at the rehabilitative day care center as a member of staff, with the aim of highlighting the emotional dimension and bringing it into the conversation and thought processes at the center. The emotional therapist's role is pivotal when it comes to the emotional aspects of the kindergarten, and her role has been molded and honed throughout the years that the early childhood program has been operating. Her role is to guide the emotional arena, to present it to staff members and parents, and to instill a perspective that centers the emotional aspects of the child. Alongside the incorporation of emotional thinking at the day care center, the therapist has a therapeutic role and is responsible for providing emotional care to the children and parents of her kindergarten class.

1 The chapter is written using female language for convenience purposes, but, of course, applies to both men and women.

Job description

- Introduction of the emotional way of thinking to staff and parents
- Active participation in the kindergarten with the aim of interweaving emotional work into the rehabilitative day care center's daily routine
- Participation in the acclimation process of the child and his parents into the day care center
- Providing emotional care to the child and his family
- Providing support and individual, dyadic or group therapy for the child's parents
- Providing assistance, support, supervision and advice to the day care staff
- Active participation in staff meetings
- Writing and documentation of therapeutic processes

Job requirements

- Formal education in the field of social work, psychology, or expressive therapy
- Experience in working with children and toddlers with disabilities
- Experience in the clinical field
- Experience in group facilitation
- Ability to work in a team
- Experience working with a multi-professional team

Detailed job description

1. Participation in the acclimation process of the child and his parents – The emotional therapist is responsible for the emotional domain in the kindergarten to which she is assigned. She conducts the emotional intake meeting with the child and his parents. She summarizes the insights and issues that arise from the meeting and gives recommendations for emotional support for the families.

2. Providing emotional support to the child and his family – The emotional therapist provides emotional therapy to the child and his parents in accordance with the treatment plan set out for him, and documents the therapeutic processes.

3. Providing assistance, support, supervision, and advice to the daycare staff – The emotional therapist is involved in all the emotional aspects of the kindergarten classroom. This includes helping the kindergarten teacher and staff deal with day-to-day tasks and with the difficulties that arise for the children and their families; participating in kindergarten staff meetings, where the emotional therapist highlights the emotional issue as an area that is interlinked with the rehabilitative-educational work; advising the kindergarten staff on emotional issues that arise in their day-to-day work; identifying when a staff member needs advice, guidance, or support, and creating the space for the relevant support to be provided. All of these are made possible by the fact that the emotional therapist operates in different spaces: in staff meetings, in the time she spends in the kindergarten, and in observations.

The emotional therapist's work interactions with the day care staff

In our view, the emotional therapist is part of the day care staff, and, as a result, she has many work interactions with the staff and the kindergarten teacher:

- One interaction is at the kindergarten staff meetings, where the emotional therapist will raise the emotional issue in a structured way, from the very beginning of the year. This helps to raise awareness and to integrate emotional thinking among the day care staff from the outset.
- Another interaction is the ongoing dialogue with the day care staff, and providing assistance in identifying emotional needs among the parents, which may come up in meetings between the staff and the families.
- The interaction with the kindergarten teacher is extremely important, and it is recommended that the two hold regular meetings to discuss issues concerning staff management and the relationship with the families at the day care center.

If the emotional therapist starts her position as part of the kindergarten staff in the middle of a school year, it is important to be mindful of her need to acclimate and settle in as a new member of a seasoned, cohesive team that has established ways of working.

Emotional therapy coordinator

In places that employ several emotional therapists, a coordinator should be appointed to head the team of therapists. The coordinator's role will be to direct and manage all the work in the emotional sphere, as detailed below:

- Lead the implementation of the early childhood program at the rehabilitative day care center.
- Coordinate the work in the emotional sphere with the director of the day care center and the social worker.
- Guide and support the emotional therapists, as the person responsible for their day-to-day work.
- Lead a professional forum with the emotional therapists, the goals of which are clarifying, expanding, and defining the role of the emotional therapist and her working methods at the day care center. The purpose of the forum is to conduct joint clinical reasoning and to refine the process of needs mapping, assessment and determining the personal treatment plan.
- The coordinator maintains professional and ongoing contact with the emotional therapist throughout the year, both on a one-on-one level and as a team. One-on-one meetings allow for professional dilemmas to be discussed, and for guidance and assistance in professional matters to be provided.

The emotional therapy coordinator should be a senior or experienced emotional therapist. In the event of limited resources, we see no problem appointing one of the emotional therapists in the kindergarten as the emotional therapy coordinator.

Social worker at rehabilitative day care centers

Entering the rehabilitative day care center often signifies the end of the parents' dream of having a healthy child. The role of the social worker is to help the family members deal with the recognition of the fact that their child has a disability, and with the implications of this diagnosis. This is based on the understanding that requiring a rehabilitative day center for one's child can evoke different feelings among parents and other family members, such as grandparents.

The role of social worker is a system-wide role that requires a broad view of all the children at the day care center, in accordance with the Rehabilitative Day Care Centers Regulations (Licensing, Basket of Services for Toddlers with Disabilities and Their Treatment Terms), 2008.

The social worker's role includes:

- **Maintaining contact with the family** – Starting from the intake and acclimation processes when they enter the day care, and at various points during and at the end of the year, when they say goodbye to the child and his family as they move on to their next setting.
- **Needs mapping** – As a family-focused day care center, we view the family as the primary and most significant environment for the young child. After getting to know the children, the social worker carries out a psychosocial assessment, which includes assessing needs and identifying coping resources and strengths, as well as highlighting factors that might inhibit therapy for the children and their families.
- **Responsibility for psychosocial aspects** – These are crystallized into an intervention plan after a comprehensive mapping process of the child's needs. The social worker's focus is preventing frequent crisis situations and assisting in dealing with these situations.

The psychosocial plan may include the following dimensions:

- Providing support, assistance and advice to the family according to the child's needs, while taking into account the rehabilitation challenges that arise in the various developmental stages and at significant points during the year.

- Strengthening the family system and maintaining the family's quality of life and individual and family well-being.
- Therapeutic interventions focused on the child's emotional world, or referral to the emotional therapist.
- Parental guidance regarding the needs of both the child and the family system.
- Facilitating support groups for parents, grandparents and siblings.
- Assistance in claiming the financial and legal rights to which the child and his family are entitled.
- Liaising between the families and relevant professional persons and entities in the community, and maintaining contact with these parties.
- Participation in day care team meetings.
- Counseling and training for the day care staff on the psychosocial aspects of the overall care of the child.

In the working model of an emotional therapist for each kindergarten, some of the therapeutic functions of the day care center's social worker will be transferred to the emotional therapist in the kindergarten classroom. The social worker may also serve as an emotional therapist for one of the kindergarten classes, separately from her role as the day care's social worker. It is important to maintain a separation between the psychosocial parts and the emotional parts, especially in therapies that highlight a divergence between the family's functioning and its emotional needs. In these situations, the therapeutic space created with the emotional therapist should be safe and secure, and the social worker will be able to bring the functional and practical aspects into the dialogue with the parents.

Pediatric Psychiatrist / Pediatric Neurologist / Rehabilitation Doctor

Infants and toddlers in rehabilitative day care centers often have physical and psychological co-morbidities that are interlinked. The physical disability affects their behavior, which affects how they cope with the disability. Also, a significant portion of these young children receive medications to treat neurological conditions (such as epilepsy), some of which have behavioral and emotional side effects. The day care staff does not have the medical training required to make the differential diagnosis as to whether a particular abnormal behavior is due to the physical disability and/or medication, or to environmental and family-related psychological processes.

A doctor employed by the day care center who knows the children well and sees them in their day-to-day lives, understands the nature of multi-professional work, and can provide a broad perspective. This perspective helps him understand how a child's specific disability might affect his behavior, how medications given to the child might affect him, and how to distinguish between behaviors resulting from the organic defect itself, and those resulting from medications or from psychological processes in their families or their environments. The doctor can help the staff and parents understand the complex interactions between these areas, and thus expand their perspective regarding all areas of functioning.

In our working model, the pediatric psychiatrist who works with the project comes regularly to observe the different kindergarten classes. In each of these meetings she observes one child. She then meets with the kindergarten teacher, the emotional therapist and sometimes the healthcare professionals, to talk about the child that she observed. The psychiatrist also participates in some of the transdisciplinary assessment meetings at the beginning of the year. She is usually invited to the assessment sessions with the children whose disabilities also include neurological or emotional components. She also leads a clinical supervision group for the emotional therapists throughout the year, together with the program coordinator.

Physical infrastructure

Along with the importance of recruiting skilled personnel to run the program, the therapeutic spaces in which the professional intervention is carried out should also be given serious consideration. The therapeutic work with the children and their parents takes place in treatment rooms adapted to parent-child therapy, individual therapy and parental guidance. While operating the working model presented here, we identified a number of features that should be included in the treatment room and the equipment kept in the room.

The treatment room

- A seating area for working with parents, and a spacious area for dyadic and one-on-one work. The space will include a soft, washable and foldable activity mat for dyadic work with toddlers.
- The room should not be too big, so as not to spoil the intimate atmosphere of the space. However, it is important that the space is big enough for the toddler to be free to move around in it.
- In order to avoid sensory overload, the room should be suitable and inviting, both visually and auditorily. The room should be painted in light colors; bright colors should be avoided. There should be soft lighting that can be adjusted when required. It is preferable for the room to have windows, with curtains or blinds for the benefit of children with visual impairments.
- Ideally, the furniture in the room should not be dominant, and preferably it should be in neutral colors.
- The safety features in the room must be maintained in order to allow a safe space. For example: a high lock on the door, sharp or dangerous objects stored in a closed place.
- It is a good idea to have low cabinets in the room so that children can see and access items in them.
- There should be a larger room with similar features for group work with parents, staff and children.

Equipment and games

- Basic sensorimotor toys, such as stuffed animals and rubber toys, activity toys for infants, balls of different textures, play scarves, soap bubbles, rattles, teethers, musical instruments and more
- Toys for basic symbolic play – dollhouse and dollhouse furniture, kitchen and kitchen utensils, animals, cars, dolls and figurines, doctor's kit, toy phone, toolkit
- Basic construction toys
- Arts and crafts materials such as markers, paper, stickers, playdough
- Children's books
- Lego, wooden blocks of different sizes, soft building blocks
- Play tent
- One of the walls can be used as an erasable drawing board.

Experience shows that having the appropriate physical infrastructure and a properly equipped therapy space for emotional therapy with patients in early childhood are key to being able to provide optimal treatment.

Part E – Insights from the Formative Assessment and Quantitative Study

The Early Childhood Emotional Intervention Program – an integrative biopsychosocial intervention model for rehabilitative day care centers for children with developmental disabilities – was accompanied by **a formative assessment and a quantitative study that examined the model's effectiveness** (Gur et al, 2023). This chapter presents the main findings.

Quantitative study – parents

In the first stage, a **quantitative study** was carried out with the aim of examining the intervention model's contribution to the **parents of the children in kindergarten**. The study was conducted in the 2020-2021 school year at the De Lowe Rehabilitative Day Care Center, and the data was collected at the start and end of the school year. The quantitative study is part of an evaluation study, which examines the intervention program's contribution to parents with respect to reflective ability and coping mechanisms. The study examined the extent to which the intervention improves parents' levels of reflective functioning and strengthens their coping mechanisms. This is based on the Braman Institute's view that a parent with high reflective ability is sufficiently emotionally oriented towards his child, and that this process has a positive effect on the child's emotional development. A parent's reflective functioning may cultivate feelings of effectiveness in dealing with distressing situations, and is therefore a variable that mediates the feeling of distress and the interpretation that the parent gives to the situation. In contrast, parents with low reflective functioning may believe and feel that their interactions with their child are spiraling and are out of control, which leads to higher levels of stress in parenting and feelings of parental incompetence. Therefore, our

assumption was that a parent who develops better coping skills will also have a positive effect on the child's emotional world. The study also examined the level of therapeutic intensity that is required to create an effective emotional support framework that contributes to the parents' reflective functioning.

Seventy parents of children with disabilities participated in the study (out of a total of 87 parents of children in the day care), with the mother and father being tested separately. All participants were Jewish, and most identified as secular and/or traditional with respect to religious observance.

Research tools:

The parents were asked to complete questionnaires at the beginning and end of the year.

Before the intervention, the parents completed three questionnaires:

1. The PRFQ (Parental Reflective Functioning Questionnaire) for the parent. (Luyten, Mayes, Nijssens and Fonagy, 2017).
2. COPE (Coping Orientation to Problems Experienced), a coping strategies questionnaire for the parent (Carver, Scheier and Weintraub, 1989).
3. Life events questionnaire for the parent: questions concerning events and changes that have occurred in the family or with any of the family members (McCubbin et al., 1985).

In addition, the emotional therapist objectively assessed how she perceives the parent's reflective behavior by completing a reflective functioning questionnaire (PRFQ).

At the end of the intervention (at the end of the school year), the parents completed questionnaires 1 and 2 again, and the emotional therapist completed the reflective functioning questionnaire.

The PRFQ (Parental Reflective Functioning Questionnaire) is a multidimensional questionnaire that is designed for self-report, and assesses the parent's reflective ability or the mentalization process done by the parent. This process reflects the parent's ability to relate to their child as a psychological being. It is more convenient than other tools for measuring reflective ability, since

it is a self-report tool that is suitable for parents from diverse socioeconomic backgrounds and educational levels.

The PRFQ includes three dimensions for assessment: pre-mentalizing modes; a dimension that assesses the parent's level of certainty about the mental states of the child; and a dimension that estimates the degree of the parent's interest and curiosity in the mental states of the child. In total, the questionnaire includes 39 items in the Hebrew language.

Parents' coping mechanisms were examined using the COPE (Coping Orientation to Problems Experienced) questionnaire produced by Carver et al. (Carver, Scheier and Weintraub, 1989). This questionnaire was translated into Hebrew by researchers Ben-Zur and Zeidner (Ben-Zur and Zeidner, 1995), and has been used in many studies of parents of children with disabilities (Lori, 1999; Gal-Etrog, 2002; Lamis, 2007; Yanai-Yitzhaki, 2009).

The questionnaire includes thirty items, each one describing a specific coping response in a sentence. There are fifteen coping strategies, which can be divided into two groups: problem-focused coping strategies and emotion-focused coping strategies:

1. Active coping; 2. Positive reinterpretation and growth; 3. Planning; 4. Emotional support; 5. Instrumental support; 6. Suppression of competing activities; 7. Acceptance; 8. Behavioral disengagement; 9. Venting of emotions; 10. Mental disengagement; 11. Denial; 12. Restraint; 13. Appeal to religion; 14. Alcohol and drug use; 15. Use of humor.

The study's findings showed that the intervention inputs contributed to an increase in the parent's reflective functioning following the intervention. Also, the higher the reflective functioning following the intervention, the more evident was the increase in proactive coping and the coping style of support and emotional ventilation. Therefore we can conclude that the intervention benefits the parents. It was important to note that when the intensity of the intervention was not taken into account, no significant difference was found in the parent's reflective functioning before and after the intervention. However, when this was taken into account, a significant difference was found in the parent's reflective functioning among parents who received thirteen or more hours of therapy, such that their reflective functioning was higher after the

intervention. It should be noted that there was a diverse mix of therapies, which included direct therapies (dyadic or parental therapy) and participation in a parent group.

It was also found that the higher the initial reflective functioning was, the more therapeutic inputs the parent received. It was noted that it could be assumed that parents with higher reflective functioning are more aware of the benefits of participating in the intervention program, and therefore cooperate more with the staff. Another finding that should be taken into account is a distinct difference between the measurements before and after the intervention in the number of coping strategies.

In the report's conclusion, it was stated that the research sample is sufficient for the pilot, but it was found that the change in reflective functioning and coping styles over time should be monitored. In addition, it was found that the research model should be tested on a broader population. It should be noted that the study design did not include a control group.

Quantitative research – kindergarten assistants

In the second phase, a **quantitative study** was carried out, to test the effectiveness of the intervention model focusing on the **kindergarten assistants** as the test subjects.

The study was conducted in the 2021-2022 school year at the De Lowe Rehabilitative Day Care Center (first measurement at the beginning of school year and second measurement at the end of the school year). Throughout the year, the assistants received various therapeutic inputs. Ten assistants working at the day care center participated in the study. The age of the assistants ranged from 21 to 72 years, and their tenure at Beit Issie Shapiro ranged from one to twenty years. Each assistant completed questionnaires for the two children in her care. Similar to the structure of the parent research, the assistants completed two questionnaires at the beginning of the year:

1. PRFQ – a reflective functioning questionnaire: several adjustments were made to this questionnaire (after a pilot).

2. Coping strategies questionnaire (COPE), as completed by the parents.

These questionnaires were also completed by the assistants at the end of the school year.

Unlike the study with the parents, the emotional therapist did not complete questionnaires for the assistants.

During the year, the assistants were given inputs that included:

1. **Training of assistants** – A number of group sessions where various topics in the emotional sphere were taught by the team of emotional therapists.
2. **Assistant-child therapy** – Each assistant came to the treatment room with a child she looks after. Through joint play, an opportunity for dyadic therapy was created. Each assistant has two children in her care, therefore half of the therapy sessions took place with one child and half with the other child.
3. **Child-focused supervision for assistants** – Supervision related to taking care of a child, which was given to the assistant without the child being present.

The research findings show that no differences were found in the level of reflective ability of assistants towards child A and child B. It was found that the assistants' level of reflective functioning in the first measurement at the beginning of the year was very high, and approached the maximum rating in the index. Also, no differences were found in the reflective ability of assistants before and after the intervention. It was noted that it is possible that the initial high level of the assistants' reflective functioning (who were most likely chosen for their position based on their excellent abilities in this area) explains why no change was found in their reflective ability after the intervention.

In the coping strategies questionnaire, a difference in the "avoidant" coping style was found following the intervention: the assistants reported that they were less avoidant than in the past. It was noted in the report that this may be due to increased awareness or the multiple resources around them in the kindergarten, which enable them to seek advice frequently. We believe that this finding can be attributed to the supervision process that the assistants received, in that the assistants learned to use the joint reflection work as a tool to deal with the emotional care of children. It should be noted that it was not possible to run a statistical mediation model as the sample consisted of

only ten subjects. Therefore, only the relationships between the variables were examined.

Formative assessment

In addition to the quantitative research, a **formative assessment** was conducted during the 2021-2022 school year, which constitutes the **qualitative** part of the research-evaluation framework that accompanied the program. The assessment was based on in-depth interviews with Braman Institute management and members of the therapeutic staff, so as to gain an in-depth understanding of the model's goals and components, and to examine whether these goals and components were aligned once the program started to be implemented.

According to the formative assessment, the goals of the model were divided into goals related to the impact on the individual (the child and his family) and goals related to the impact on the day care center as a system.

The basic premise of the project is that emotional work is an integral part of the rehabilitation work at the day care center. The expectation is that the system-wide change will lead to a view of parenthood, the kindergarten experience and the child himself that will take into account emotional aspects, in addition to the rehabilitative and pedagogical aspects.

The impact on the parent-child relationship, emotional resilience and well-being

The impact of the intervention model on the individual is related to three super-variables: emotional resilience of the parents, the parent-child relationship and well-being.

a) Emotional resilience of parents of children with disabilities

The conclusions of the formative assessment are that the goal is to equip the family with all the tools necessary for them to have emotional resilience, which will also be with them in the future. Emotional resilience can depend on support networks, which include the parent's overall ability to reflect, share with others and create a supportive and active parenting community.

b) Improving the parent-child relationship

Processing the parents' trauma and improving their reflective ability improves the attachment process between the parent and the child. There is a high probability that a parent whose prolonged trauma has been processed during his child's time at the day care center will be a better parent to the child with the disability, as well as to his other children. Furthermore, they will have greater awareness and emotional capabilities and learn to see reality from different perspectives.

c) Well-being

The biopsychosocial model aims to improve the child's well-being. Well-being for a child with a disability has several aspects: the child will develop a sense of belonging – he will feel that he is part of humanity, and that his difference has a place in society; he will be aware of his objective difficulties, but will also feel that he has value, is loved and is wanted.

We believe that when a parent develops his reflective abilities and dares to consider the child's thoughts, this will inevitably affect the child's emotional well-being.

The formative assessment examined the initiative's long-term goals. The main goal is sustainability, i.e. the ability to provide the biopsychosocial model, with all its components, over time. One of the key aspects of the introduction of the emotional component is the inclusion of emotional therapists as partners in the multi-professional team at the day care center. This aspect is very significant for the Ministry of Welfare, which considers social workers to be the people responsible for providing emotional support at rehabilitative day care centers. We want to increase the emotional support currently provided, via the implementation of the program as detailed above, by assigning a staff member who specializes in the emotional sphere to each kindergarten class. Sustainability will exist when the inclusion of the emotional component at rehabilitative day care centers receives recognition from the establishment, and is enshrined in legislation as part of the collection of services provided at every rehabilitative day care center that is jointly managed by the Ministry of Welfare and the Ministry of Health.

The impact on the kindergarten as a whole

a) First outcome: Emotional work will be a part of the kindergarten work.

b) Second outcome: To change the system so that the perception of parenthood, the kindergarten experience and the child will change, and be more oriented to creating an atmosphere in the kindergarten that also takes emotional aspects into account, with all staff members looking at things with the same spirit. When a kindergarten assistant talks to the child, she will speak a similar language to the therapist. It is not therapy, but the atmosphere is one of looking at things **through an emotional lens**.

c) Result: A kindergarten atmosphere that takes the emotional dimension into account.

In answer to the researchers' question as to how the "kindergarten atmosphere" can be measured, Yitzhak Hirshberg (former director of the Center for Emotional Therapy for Children and Families at Beit Issie Shapiro) replied:

> *"When I was young I worked in set design. There was a very famous set designer in the United States who made sets for movies. His neighbor went to watch one of his movies to see his work. At the end of the movie, she came out and said to him, 'The movie was excellent but I didn't see what you did.' He replied, 'I guess I did a good job. The set created the right atmosphere and was seamlessly embedded.' Good therapy is seamless. It is something organic, that neither grates nor shouts."*

Conclusion and Recommendations

The Braman Institute has developed an **integrative biopsychosocial intervention** model for rehabilitative day care centers for children with developmental disabilities. At the heart of the model is an outlook that calls for early and comprehensive intervention with the young child and his environment. This model talks about the inclusion of an expanded component, in addition to the standard "basket" of support that is provided at rehabilitative day care

centers. This expanded component addresses the child's mental needs, as well as his relationships with his parents and the staff members. This expansion is based on the view that body and mind should not be separated, and on an integrative work outlook that seeks to address all the needs of the young child and his family. Thus, the educational, rehabilitative and emotional fields are intertwined and complement each other. In addition, this model also addresses the caregiving staff, as they are a central part of the child's overall support framework.

This guide was written with the aim of describing the characteristics and components of the working model of emotional therapy at the rehabilitative day care center, as well as how to operate it and the functions required to do so. In addition, the purpose of the model is to propose ways to implement and incorporate it at all rehabilitative day care centers in the State of Israel.

The theoretical model of emotional intervention at the day care center is based on extensive literature from the field of attachment and theory of mind, which centers on the ability to attribute ideas, feelings and intentions to another person. Consequently, the work of the emotional therapist, both with the families and with the staff, is based on theories relating to **mentalization and reflective functioning**. The model is also derived from the knowledge and insights accumulated over years of emotional therapy provided to people with disabilities of all ages.

The concept that took shape at the day care center is an integrative approach that seeks to address all the needs of the child and his family. According to this approach, the educational, rehabilitative and emotional arenas are intertwined and complement each other. Hence, the emotional support at the day care center includes support for the child himself, for his parents and for the professional staff, who are a central part of the child's overall support framework, and this comes in addition to the educational and rehabilitative care provided by the day care center. Thus, a more complete and comprehensive support framework is provided, which will enable the child to develop both physically and emotionally in the best way possible. Adding an emotional therapy professional to the multi-professional day care team introduces the emotional outlook and consideration of the child's emotional world into the day-to-day discourse. The therapeutic inputs in the emotional sphere include a broad

range of therapies: one-on-one therapy for the child, which is accompanied by parental guidance; emotional therapy for the parents; parent groups and parent-child therapy (dyadic or triadic). The staff members also receive support and supervision.

This work was accompanied by a study that examined the effectiveness of the model. The research findings showed that the intervention inputs contributed to an **increase** in the parent's reflective functioning following the intervention. It was also found that the higher the reflective function after the intervention, the more evident was the increase in proactive coping and the coping styles of support and emotional ventilation. Therefore, we can conclude that the intervention benefits the parents. It was also found that the higher the initial reflective functioning was, the more therapeutic inputs the parent received.

In light of the research findings, and in view of the experience accumulated over the years of the project's operation, we believe that the implementation of the model at rehabilitative day care centers will help to maximize the child's development by attending to his emotional world, by working on his relationship with his parents, and by expanding the abilities of the caregiving staff to include addressing the emotional aspects of the child's life.

This model can be replicated at any rehabilitative day care center. Based on our understanding of the importance of the emotional arena, we call on the Ministry of Welfare, which is responsible for operating rehabilitative day care centers in Israel, to introduce the emotional component into the therapeutic support provided to young children.

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Appendices

Appendix 1: Emotional Intake Form

Meeting with the Parents (Parent Intake)

Date .....

First name ..... **Last name** .....

ID no. ..... **Date of birth** ___ / ___ / ___

Sex M / F **Child's country of birth** .....

Address

City ..... **Street** ..... **No.** ..... **Zip code** .....

Diagnosis .....

Previous/additional educational settings .....

Does the child receive a disabled child allowance? Yes / No / In process

Does the child receive a mobility allowance? Yes / No / In process

Name of social worker at the Welfare Department ..... **Tel.** .....

Part Two – Family

Child history

Pregnancy and birth (pregnancy, Caesarian section, traumatic birth for the father/mother, fetal distress, medical complications, abortions, source of the pregnancy, previous miscarriages, birth order, course of the pregnancy, spontaneous delivery, week of pregnancy, birth weight)

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Development

Meaning of the infant's name for the parents .....

Traumatic events in the infant's environment .....

Previous hospitalizations (age, duration, reason) .....

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The infant's temperament .....

Duration of nursing .....

Weaning difficulties .....

Daily routine at home .....

Developmental milestones .....

Sitting .....

Crawling .....

Walking .....

Stranger anxiety .....

Social engagement (eye contact, responsiveness to interaction, communication initiation) .....

Transitional object .....

Eating .....

Sleeping .....

Separation anxiety .....

Language (babbling, gestures, language comprehension, first words, word combinations) .....

<u>Family Structure</u>

Parents

Parent's name (1) ..... **ID no.** .....

Country of birth .....

Parental status .....

First marriage? Yes / No **Are there children from previous marriages?** Yes / No

Who do they live with? .....

Health status .....

Religious identity Observant / traditional / secular / other

Parent's education ..... **Parent's place of work** .....

Parent's occupation .....

Language spoken at home .....

Housing situation .....

Parent history

(Memory of relationship with mother/father, traumatic events, sexual abuse, place of birth, number of siblings, family illnesses, chronic illness, disability, losses, crises, past or present emotional therapy)

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Relationships with the extended family / significant figures (grandparents, aunts, uncles)

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Parent's name (2) ..... **ID no.** .....

Country of birth .....

Parental status .....

First marriage? Yes / No **Are there children from previous marriages?** Yes / No

Who do they live with? .....

Health status .....

Religious identity Observant / traditional / secular / other

Parent's education ..... **Parent's place of work** .....

Parent's occupation .....

Language spoken at home .....

Housing situation .....

Parent history

(Memory of relationship with mother/father, traumatic events, sexual abuse, place of birth, number of siblings, family illnesses, chronic illness, disability, losses, crises, past or present emotional therapy)

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Relationships with the extended family / significant figures (grandparents, aunts, uncles)

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Siblings

Sibling's name	Sex	Date of birth	Educational framework	Does the sibling have special needs / health problems?	Notes

Emergency contact person ..... Relationship .....Tel. .....

Is the family in contact with other groups or organizations, such as: parent groups, charitable organizations, assistance organizations?

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Appendix 2: Transdisciplinary Assessment Form

Transdisciplinary Assessment Form

***Come to the meeting with the parents and child with a summary of their file.**

Date .....

Child's nam ..... **Date of birth** ..... **Age** .....

Diagnosis .....

Observers .....

Points for observation

Interaction with the parents (Does he recognize the parents? Does he initiate contact with them? Trust/distrust? Who does he turn to? Why does he turn to someone? Is he confident? Does he move away? Who does he look to for comfort?)

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Functional mobility (from place to place, independent sitting, crawling)

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Play (what motivates the child, what he enjoys, which toys, other stimuli, people, reaching for a toy that he likes, how he uses an object, stage of play, type of play: interactive/sensory, how the game is played: free/structured, curiosity, initiative, degree of participation, duration of play)

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Level of comprehension (linguistic, situations, level of planning, learning ability, problem solving)

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Sensation Which sense/senses are more active/reactive?

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Means of communication (how and with whom, eye gaze, gestures, vocalization, speech, turn taking, sharing communicative intentions, requesting, protesting, sharing, asking, joint attention, communication board)

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Social-emotional (adaptability, responses to people, objects, unfamiliar situations, response to strangers, who he responds to in his environment, use of people present in the room)

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Behavioral-Emotional (active, passive, initiating, mood, level of anxiety and confidence, how he reacts when in distress, how he reacts when frustrated, curiosity, interest)

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Video observation

Self-care (eating. drinking, what he likes, independence when eating [holding a bottle, spoon])

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At the end of the meeting, together with the parents, set three main goals that they would like to work on during the first few months (ask the parents about their expectations for the first third of the year)

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2. .....

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3. .....

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Notes

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Name of person completing the questionnaire .....

Position .....

Beit Issie Shapiro is a groundbreaking organization dedicated to changing the lives of people with disabilities by outlining a model for action in the field at the national and international level.

The organization works to guarantee people with disabilities full participation in community life and a better quality of life, through the provision of innovative therapeutic and educational services and their development, a broad activity to create a social change in attitudes and operating a center for excellence, research and professional training in the field of disabilities.

Beit Issie Shapiro has a professional relationship with about 30 countries in the world. Its experience and professional reputation allow it to contribute knowledge in the field of disabilities, keep up to date with innovations and take an active part in the national and international professional discourse.

The Braman Institute for Emotional Wellbeing and Mental Health was established at Beit Issie Shapiro in 2019 as an inclusive service, bringing together the range of emotional intervention services developed by the organization. Simultaneously, the institute focuses on developing new emotional intervention models for people with disabilities and establishing these models through evaluation and research.

The Early Childhood Emotional Center, in memory of Michal Aharonoff Ben Rei, was established with the aim of developing an emotional treatment model for young children with disabilities and their families. The center focuses on integrating emotional aspects into early intervention to ensure optimal development and enhance the emotional resilience of both the child and their family.

www.beitissie.org.il | 09-7701632 | rigshi@beitissie.org.il | shafim@beitissie.org.il