הכשרת פסיכולוגים חינוכיים בצפון בפרוטוקול "מדברים ביחד"

רקע: עמותת "מדברים ביחד - הורים ילדים", אשר הוקמה לאחר ה7/10, פיתחה פרוטוקול טיפול ממוקד ויעיל המאפשר מתן מענה טיפולי נרחב (scalable) לילדים צעירים והוריהם (מגיל לידה עד 8) שנפגעו מחשיפה לאירועי טראומה קולקטיבית. הפרוטוקול הטיפולי, אשר פותח בשיתוף פרופ' אליסיה ליברמן, מהווה אפליקציה של המודל המבוסס CPP (Child Parent Psychotherapy, Lieberman et al. 2005) לטראומה קולקטיבית. ההתערבות הועברה למעל 2500 ילדים ולוותה במחקר בהובלת ד"ר טלי פרנקל מאוניברסיטת רייכמן וד"ר יובל סער היימן מאוניברסיטת בן גוריון, אשר הראה יעילות גבוהה בהפחתת תגובות סימפטומטיות של ילדים, ביכולת של ההורים לעזור לילדים ובתחושת המסוגלות של ההורים (ראה נספח א' לפירוט תוצאות המחקר).

פרויקטים: במהלך השנה הראשונה למלחמה, העמותה פעלה לסייע לילדים צעירים והוריהם שנחשפו לאירועים טראומטיים בעוטף עזה, שדרות ואופקים. החל מפברואר 2025, העמותה מפעילה פרויקט טיפולי רחב היקף לילדים ברשויות שונות בגליל מערבי, גליל מזרחי ובגולן. כמו כן נערכו התערבויות במרכז הארץ ובקהילת בדואיות בעקבות מתקפת הטילים מאיראן. בנוסף, העמותה עוסקת בהכשרת מטפלים לטיפול בפרוטוקול: כ350 מטפלים במרכזי החוסן ובמרכזי שפ"ח הוכשרו לטפל בפרוטוקול.

על ההתערבות: ההתערבות מיועדת לעזור להורים לתת מענה רגשי מלא לילדיהם. היא מתמקדת בהבנה משותפת של קשיי הילד על רקע האירוע הספציפי שהוא חווה, ובעיבוד משותף של האירועים ושל הקשיים באמצעות שיח ומשחק הורה-ילד, תוך קבלת תמיכה אקטיבית וישירה של המטפלת. בנוסף, ההתערבות כוללת הדרכת הורים שמתמקדת בהבנת הצרכים של הילדים מתוך ראייה התפתחותית, וברכישת מיומנויות הוריות להתמודדות עם הקשיים התפקודיים של הילדים.

מבנה ההתערבות: ההתערבות בנויה מפגישות הדרכת הורים ופגישות הורה-ילד. היא כוללת פרוטוקול טיפולי קצר ביותר המיועד לטיפול ראשוני. פרוטוקול זה נותן מענה למשפחות רבות ושיפור מובהק בתסמינים שנשמר גם לאחר חודש (עפ"י מחקר מבוקר). בנוסף, פרוטוקול קצר זה מאפשר מיפוי של משפחות הזקוקות למענה מורחב יותר בשל פגיעות מוקדמת, עוצמת חשיפה גבוהה או משתנים נוספים. הפרוטוקול המורחב כולל סדרה של כ- 12 פגישות. התוכנית הטיפולית מובנית ומגדירה מטרות ודרכי פעולה לגבי כל שלב ומרכיב בטיפול.

תוכנית הכשרה וליווי מקצועי:

התוכנית כוללת מרכיב של הכשרה ומרכיב של הדרכה:

הכשרה פרונטלית (40 שעות) הכוללת למידה תיאורטית, רכישת מיומנויות ותרגול שלהן.

תכנים עיקריים שיועברו בהכשרה:

- השפעת טראומה על ההתפתחות וההתקשרות בקרב ילדים צעירים.
- מאפיינים יחודיים של טראומה קולקטיבית
- עקרונות של עבודה טיפולית ממוקדת טראומה עם ילדים צעירים והוריהם.
- עקרונות ומיומנויות לעבודה עם הורים.
- עקרונות לעבודה חווייתית עם רגשות קשים בילדים צעירים
- עקרונות לעבודה דיאדית במסגרת התקשרותית: שבר ותיקון, הכרת הדיאלוג האפקטיבי-רפלקטיבי (Dan Hughes)
- רקע התפתחותי, השפעת שלבים שונים של ההתפתחות בגיל הרך על תגובה לאירועים מחוללי עקה.
- עקרונות בטיפול במשחק סביב טראומה ומשבר.
- מיומנויות הוריות להתמודדות עם קשיים התנהגות ותסמינים אופייניים (קשיי שינה, הרטבה, נסיגה התפתחותית, אנקופרזיס, סרבנות, התקפי זעם וקשיים רגשיים נוספים).
- התמודדות עם קשיים בשיתוף פעולה בטיפול בקרב הורים וילדים
- התמודדות עם אבל ואבדן בילדים צעירים בטיפול משותף להורה ולילד
- הצגת תיאורי מקרה, דיונים ותרגולים

ליווי מקצועי של המטפלים במהלך התנסות ביישום הפרוטוקול הטיפולי:

מפגשי התייעצות מקצועית קבוצתית (כל מפגש באורך 90 דקות) בקבוצות קטנות (כ-10 מטפלות) הכוללים הנחייה ודיון סביב מקרים שהמטפלים מביאים. הקבוצות מונחות על ידי מדריכים מיומנים של עמותת "מדברים ביחד" המשלבים ידע מעמיק בתחום טיפול בילדים והורים בטראומה וניסיון עבודה והדרכה עשיר בטראומה קולקטיבית.

Brief Summary of Preliminary Findings: Feasibility Study Evaluating the ‘Talking-Together’ Focused Response Protocol

Note. Study conducted in Ma'alot–Tarshiha, North Israel, January–July 2025. Findings represent preliminary analyses from partial sample; complete dataset analysis pending.

Principal Investigator: Dr. Tahl I. Frenkel, Baruch Ivcher School of Psychology, Reichman University.

Method

Participants and Procedure. Between January and July 2025, 109 families participated in the 2-session Focused Response intervention conducted in Ma'alot–Tarshiha (*M*child age = 4.6 years, 30% age 3 years and below). Data were collected across four time points: baseline (T1), pre-intervention (T2), 10 days post-intervention (T3), and one-month follow-up (T4). Complete data were available for 65 families across three time points and 44 families across all four time points.

War Exposure Characteristics. Participants demonstrated substantial exposure to war-related stressors: 97% reported frequent exposure to missile alert sirens, 81% experienced missile strikes within their municipality, and 63% reported direct or proximate missile impacts to their residences. Additionally, 57% evacuated their homes, 35% lacked access to fortified safe rooms, 29% had a parent deployed for military reserve duty, and 31% experienced significant economic hardship.

Measures. Child psychological distress was assessed at all four time points using the Pediatric Emotional Distress Scale (PEDS; Saylor et al., 1999). Maternal posttraumatic stress symptomatology was measured at pre-intervention (T2) and post-intervention (T3) via the PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013). Treatment acceptability was evaluated through subjective impact scales assessing perceived intervention efficacy across multiple domains.

Results

Child Symptomatology. At baseline, 92% of children exceeded the clinical threshold for anxiety and 69% for behavioral problems. Paired-samples t tests revealed statistically significant and clinically meaningful reductions in anxiety symptoms, $t(70) = 4.11$, $p < .001$, and behavioral difficulties, $t(71) = 6.11$, $p < .001$, from pre- to post-intervention, with a medium-to-large effect size (Cohen's $d = 0.65$). The proportion of children exhibiting clinically elevated symptomatology decreased from 92% to 68% for anxiety and from 69% to 53% for behavioral problems.

Repeated-measures ANOVA demonstrated a significant main effect of time, $F(3, 129)$ = significant, $p < .001$, indicating progressive symptom reduction from pre-intervention ($M = 48.98$, $SE = 1.41$) to immediate post-intervention ($M = 41.68$, $SE = 1.75$), with therapeutic gains maintained at one-month follow-up ($M = 42.59$, $SE = 1.92$). Pairwise comparisons confirmed that the principal symptom reduction occurred during the intervention phase (T2–T3: Mdiff = 7.30, $p < .001$) and remained stable thereafter (T3–T4: Mdiff = –0.91, $p = .413$). See Figure 1.

Maternal Posttraumatic Stress. Parental PTSD symptomatology exhibited significant amelioration from pre- to post-intervention, $t(44) = 3.64$, $p < .001$. The proportion of parents exceeding the clinical cutoff (PCL-5 $\geq$ 33) decreased from 26% at pre-intervention to 19% at post-intervention assessment.

Treatment Acceptability. Among the 87 parents who completed subjective impact assessments approximately two weeks post-intervention, greater than 85% reported enhanced comprehension of their child's behavioral patterns, modified parental responses to child affect and behavior, strengthened emotional communication, and improvements in the parent–child dyadic relationship. Notably, 69% of respondents perceived direct amelioration in their child's emotional functioning.

Discussion

These preliminary findings provide empirical support for the feasibility and acceptability of the 2-session Focused Response intervention protocol for families experiencing war-related psychological trauma, with promising preliminary evidence of therapeutic benefit. The intervention demonstrated significant and sustained reductions in both child anxiety and externalizing symptomatology, with medium-to-large effect sizes. Concurrently, parental posttraumatic stress symptoms evidenced meaningful clinical improvement. The high treatment satisfaction rates and substantial proportions of parents reporting enhanced parenting competencies suggest robust intervention acceptability and perceived utility. Critically, therapeutic gains were maintained at one-month follow-up, indicating potential durability of treatment effects. These findings warrant continued investigation through comprehensive randomized controlled trials to establish intervention efficacy and identify potential moderators of treatment response.

Figure 1. Change in Child Emotional Distress Over Time

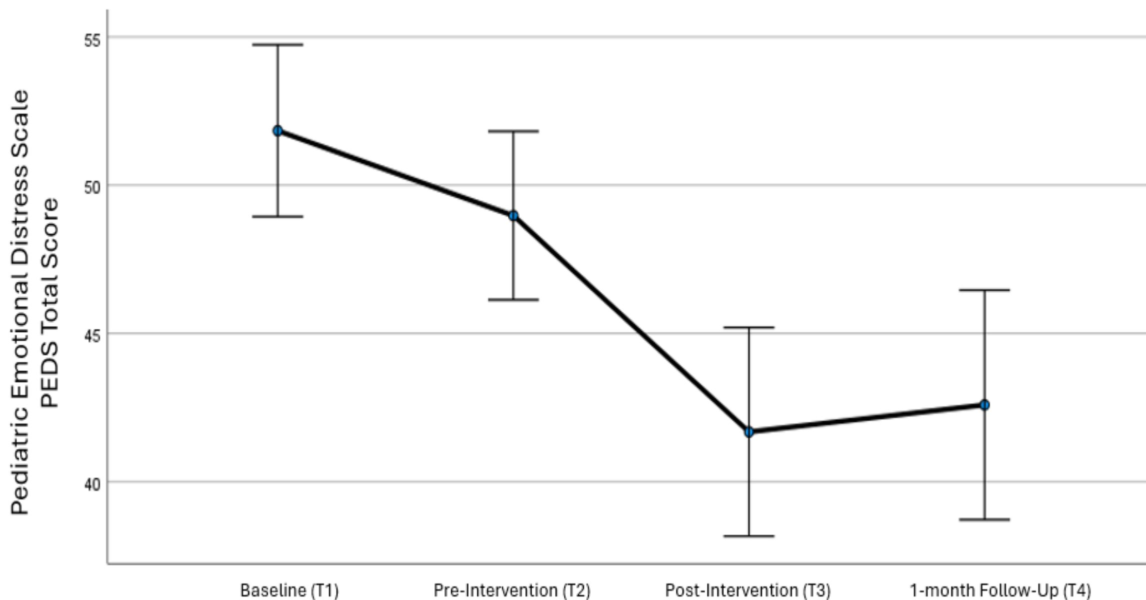

***Figure Note**. Repeated-measures ANOVA revealed a significant main effect of time on Pediatric Emotional Distress Scale (PEDS) scores across four assessment points: baseline (T1), pre-intervention (T2), 10–14 days post-intervention (T3), and one-month follow-up (T4). PEDS scores exhibited significant reduction from intervention onset ($M = 48.98$, $SE = 1.41$) to immediate post-intervention ($M = 41.68$, $SE = 1.75$), $p < .001$, with therapeutic gains largely maintained at one-month follow-up ($M = 42.59$, $SE = 1.92$). Pairwise comparisons demonstrated modest yet statistically significant symptom reduction from baseline to pre-intervention (T1–T2: $M_{diff} = 2.86$, $SE = 1.28$, $p = .030$), followed by substantial symptom amelioration during the intervention phase (T2–T3: $M_{diff} = 7.30$, $SE = 1.39$, $p < .001$). Critically, no significant change was observed between immediate post-intervention and one-month follow-up (T3–T4: $M_{diff} = –0.91$, $SE = 1.10$, $p = .413$), confirming maintenance of treatment effects.*

מדברים ביחד
הורים וילדים

Brief Summary of Findings: Feasibility Study Evaluating the 'Talking Together' Extended Response Protocol

Note. Study conducted in the Western Negev, January–June 2024. Complete methodology and results are available in the original study documentation.

Principal Investigator: Dr. Tahl I.Frenkel, Baruch Ivcher School of Psychology, Reichman University

Method

Participants and Procedure. Between January and June 2024, 233 families (*M*age = 5.63 years, *SD* = 1.74, 20% under the age of 3 years; 49% female) from the western Negev region of Israel participated in the 12-session Extended Response intervention. All families experienced extreme trauma exposure during the October 7, 2023, attack. Data were collected at two time points (pre- and post-intervention). Complete data on primary outcomes were available for 129 participants (69.7%). Little's Missing Completely at Random (MCAR) test confirmed that data were missing completely at random, $\chi^2(703) = 715.94$, $p = .36$.

War Exposure Characteristics. All families experienced extreme trauma exposure. Specifically, 78% spent prolonged time in a secure shelter, 74% reported armed terrorists entering their community, 60% witnessed or heard combat, 49% were cut off from electricity, food, or communication, 12% had a parent outside the shelter exposed to immediate danger, and 8% witnessed injured or murdered individuals.

Measures. Child psychological distress was assessed via the Pediatric Emotional Distress Scale (PEDS; Saylor et al., 1999). Maternal posttraumatic stress was measured using the PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2014). Maternal parenting self-efficacy was assessed with the Me as a Parent Scale-Short Form (MAAPS; Matthews et al., 2022). Treatment acceptability was evaluated through subjective impact scales assessing perceived intervention efficacy across multiple domains. Additional measures assessed hypothesized mechanisms of change, specifically maternal trauma-related parenting strategies and beliefs, including: (1) maternal endorsement of child avoidance strategies (i.e., the extent to which mothers encourage their child to avoid trauma-related thoughts, feelings, or reminders), (2) maternal beliefs that children's experience of negative emotions is dangerous or harmful, (3) maternal beliefs that trauma-related conversations may be dangerous or harmful to the child, and (4) maternal emotional reactivity (worry, anxiety) when contemplating trauma-related conversations with the child.

Analytic Objectives. Primary analyses examined pre- to post-intervention changes in children's emotional distress. Importantly, repeated-measures ANCOVA analyses were conducted to examine whether therapeutic benefit varied as a function of trauma exposure level, maternal PTSD symptoms, and socioeconomic status. Secondary analyses evaluated pre- to post-intervention changes in parenting self-efficacy and hypothesized mechanisms of change (i.e., trauma-related parenting strategies and beliefs), as well as associations between changes in parenting variables and changes in child symptoms.

Results

Feasibility Indicators. Recruitment yielded 233 of 250 families approached (93.2% enrollment rate). Retention was robust, with 209 families (89.7%) completing the intervention (defined as attending at least half of the parent–child sessions). Among completers, adherence was 88.5% for parent–child sessions, 76.3% for maternal sessions, and 41.3% for paternal sessions. Attrition (10.3%) was associated with lower trauma exposure levels, $t(189) = -2.47$, $p < .05$, suggesting non-completers perceived reduced intervention necessity.

Child Symptomatology. At baseline, all children exceeded the clinical threshold for total emotional distress. Paired-samples *t* tests revealed statistically significant reductions across all PEDS dimensions: total score (Mpre = 56.38, Mpost = 46.63), $t(129) = 10.15$, $p < .001$, Cohen's $d = 0.89$. McNemar's tests confirmed statistically significant reductions in the proportion of children exceeding clinical thresholds across all domains: anxious/withdrawn, $\chi^2(1) = 20.34$, $p < .001$; fearful, $\chi^2(1) = 27.03$, $p < .001$; and acting-out, $\chi^2(1) = 36.88$, $p < .001$. Post-intervention, 67.1% of children remained above the clinical cutoff for total emotional distress.

Examining Potential Moderators of Symptom Change. Repeated-measures ANCOVA analyses revealed no significant moderating effects of trauma exposure dose, maternal PTSD symptoms, or family income on therapeutic benefit (all ps > .18), indicating consistent symptom reduction across diverse clinical presentations and socioeconomic contexts.

Parenting Variables. Significant improvements were observed across all trauma-related parenting variables (all ps < .001), including increased parenting self-efficacy and decreased maternal endorsement of child avoidance, trauma-talk reactivity, and maladaptive beliefs regarding child negative emotions and trauma-talk danger. Effect sizes ranged from small to medium (d = 0.28–0.65). Residual change score correlations revealed significant associations between improvements in maternal variables and reductions in child distress.

Treatment Acceptability. Parents reported high perceived intervention benefit on both general impression scales and domain-specific measures. More than 70% reported enhanced parenting insight and psychoeducation, parent-child conflict repair, and enhanced child emotional understanding and expression (complete descriptive statistics reported in original study).

Discussion

These findings provide robust evidence for the feasibility and acceptability of the 12-session Extended Response intervention protocol for families experiencing acute war-related trauma, with promising preliminary evidence of therapeutic benefit. The intervention demonstrated excellent recruitment and retention rates, with high treatment adherence and parent-reported satisfaction. Statistically significant and clinically meaningful reductions emerged across child anxiety and externalizing symptomatology, with large effect sizes. Importantly, symptom reduction remained consistent across varying levels of trauma exposure, maternal psychopathology, and socioeconomic status. Maternal parenting self-efficacy and trauma-related parenting strategies and beliefs also evidenced significant improvement. These preliminary findings support the intervention's promise as an accessible treatment modality for trauma-affected families and warrant rigorous evaluation through fully powered randomized controlled trials.

Brief Summary of Qualitative Exploratory research on the 'Talking-Together' Focused Response Protocol

Note. Study conducted in the Western Negev, October-December, 2023.

Principal Investigator: Dr. Yuval saar-heiman, Ben Gurion University of the Negev.

Short, structured open interviews were conducted with 410 parents who participated in the intervention and 27 in-depth interviews with therapists who took part in this phase. Content analysis of the parents' responses to the short interview regarding their feelings following the intervention indicates high satisfaction with the intervention and a sense of improvement in the overall emotional state of the family following the intervention. Among parents who answered all of the questions: approximately 81% reported an improvement in their sense of competence as a parent, about 71% reported an improvement in their child's emotional state, about 74% reported an improvement in their own emotional state, and about 64% reported that they felt an improvement in their relationship with their children following the intervention. In addition, about 82% reported that they continued engaging in an emotional dialogue with their children in a manner similar to the one demonstrated in the intervention. The words of Ronit, a mother who participated in the acute intervention, illustrate the components of the intervention that were meaningful and significant for many families:

"It was very meaningful for me to hear the children and understand that they understood much more than we thought. It was a shocking experience. It turns out that they have heard, listened, understood. Our jaws dropped from what they said. I tried to defend them from what had happened, and only in the meeting did I realize how much they knew and how frightened they were. The therapist helped me see what was going on inside their world, and that they needed me and my support in all of this. And that's at a time when I can barely hold myself. Having another adult hold this with me helps me hold [the story for the children] and to explain and to be able to hear what the children are saying. It helps me to know how to answer them... This is very, very important. It also gives me support and helps me be with them. And what surprised me most was how my little girl came at the end of the meeting and curled up in my arms."

A comprehensive qualitative analysis of the parent interviews is currently underway. The analysis of the interviews with the clinicians echoes the satisfaction reported by the parents. The findings suggest that clinicians experienced the intervention as both feasible and effective, even within the extreme constraints of a post-mass-trauma context. Across diverse

settings, clinicians reported that the intervention helped re-establish emotional connection between caregivers and children, enabled shared processing of the traumatic experience, and offered a focused and structured model that could be implemented without intensive training or long-term engagement. Despite the brevity of the intervention, practitioners consistently described a deep and meaningful process that unfolded within a highly time-limited format.

Another significant finding from the therapists' interviews is the very high level of fidelity in their implementation of the intervention model as designed by its developers. In particular, the following components stood out in the therapists' narratives: (a) the perception of the parent as a central partner in the process, demonstrated in the creation of a strong therapeutic alliance with the parents based on acceptance and appreciation of their functioning, psycho-educational work regarding the meaning of trauma and intervention, and providing space for the parents' emotional experience before meeting with the children; (b) processing the events of the 7/10 with a focus on the variety of emotional experiences of all family members from that day; (c) interventions that focus on the relationship between parents and children, and allow children to receive validation from their parents of their emotional experiences.

In the following quote, Ditza, a therapist who worked in the acute phase of the intervention, describes how the application of these principles is expressed in working with a family:

"The younger brother also found the courage to talk about the things that scare him, and then the others remembered more details from the incident. It was a deeply moving moment, the mother's eyes filled with tears, and she said to him, "Wow!, I didn't know you could feel all this, and I'm so proud of you that you can now tell me all this, and now that I know, I'll help you too." It was an organic reaction that came from her spontaneously. She was very excited about this sharing. And then he ran to her for a hug, and then the second child also came, and then the father asked if it was possible to have a family hug."

Grounded in the findings of the study, a five-domain framework for understanding and assessing fidelity in ‘Talking Together’ protocol. These domains—relational, emotional, trauma framework, parental engagement and procedural fidelity—capture the essential therapeutic mechanisms clinicians described as necessary for delivering the intervention with integrity. Each domain is framed by a core clinical question and a set of practice-based indicators, offering a practical and conceptually coherent lens through which to examine fidelity.