

Talking Together

Parents and Children: Preventive Intervention for Young
Children and their Parents Exposed to Collective
Trauma

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“Talking Together for Parents and Children” (Medabrim Yahad; TTPC) is an attachment-based parent–child intervention developed for infants and young children, from birth to age eight, and their parents' following exposure to collective trauma. The intervention was initially developed as a brief, scalable adaptation of Child-Parent Psychotherapy (CPP), specifically designed for the immediate aftermath of collective trauma, and was rapidly implemented following the October 7, 2023, attacks in Israeli communities in the Western Negev. TTPC is grounded in the premise that young children depend on their caregivers as their primary source of emotional regulation and security, and that collective trauma may disrupt this regulatory function precisely when it is most needed. Accordingly, the intervention is conducted jointly with parents and children and aims to restore the parent–child relationship as a context for emotional regulation, safety, and meaning-making, while helping parents and children directly engage with frightening experiences and the painful emotions they evoke. The intervention is structured in two phases:

- **Brief acute preventive intervention (2–4 sessions):** Typically includes a preparatory parent session followed by a joint parent–child session, with additional sessions when clinically indicated. Designed for rapid implementation in the acute aftermath of collective trauma, this phase provides immediate dyadic support and also serves a triage function, helping identify children and families

whose needs exceed its scope and require more extended treatment.

- **Extended intervention (12–14 sessions):**
Offered to families requiring more intensive support, the extended phase consists of approximately equal numbers of parent-only and joint parent–child sessions. Building on the same attachment-based and emotion-focused principles, it allows for more sustained therapeutic work with persistent distress, disruptions in the parent–child relationship, and difficulties in processing traumatic experiences.

Both stages are based on the same theoretical principles, focusing on fostering an emotional dialogue between parents and children about the difficult events and the emotions they evoked. Through this shared emotional dialogue, the intervention seeks to strengthen parents' capacity to recognize, validate, and co-regulate their children's emotional experiences and to restore the attachment relationship as a secure context in which previously unspoken traumatic experiences can be approached and processed.

From October to December 2023, approximately 730 families, including about 1,750 children, received the brief acute intervention; during 2024, approximately 400 children received the extended intervention. Families who experienced the death or abduction of a first-degree relative were not included in the brief protocol and were referred directly to more intensive treatment. The present chapter provides a brief theoretical account of the intervention's conceptual framework, along with a general description of preliminary findings from its initial implementation and evaluation. These findings generally indicate high feasibility and parent-perceived benefits in children's and parents' well-being and parental

functioning, including a significant decrease in distress symptoms among children and an improvement in parental self-efficacy, particularly in parents' willingness to face the emotions triggered by the traumatic event in their children. Since its initial implementation, TTPC has been disseminated more broadly across Israel. Detailed empirical reports on the brief acute and extended phases have been analyzed and are presented elsewhere [see Kroyzer et al. (under review), Saar-Heiman et al. (in preparation) for the brief phase; see Frenkel et al (in preparation) for the extended phase].

Case Description

October 7, 2023, 6:29 a.m., at the home of the Davidian family (all names have been changed to maintain anonymity) in a village near the Southern border of Israel. An emergency alarm sounds, and the parents, Maya and Dor, rush to the safe room¹, where their two daughters, four-year-old Adi and one-year-old Chen, are asleep. Minutes go by, and the parents realize—through messages in the village WhatsApp group and the sounds of bombs and gunfire outside—that what is happening is unlike anything they have ever experienced before. The village is flooded with terrorists who are breaking into houses, setting them on fire, killing or kidnapping adults and children. Soon, the family hears them approaching their home. Maya nurses Baby Chen, to keep her quiet so she won't reveal where they are. Four-year-old Adi is crying in terror, and Maya repeatedly silences her. When the sounds of gunfire and the voices of terrorists approach the door of the room, Maya puts Adi into a large laundry basket that stands in the room and covers her with pillows. Now silent, Adi spends the next four hours in the laundry basket, with her parents shushing her every time

¹ In this area all houses have safe rooms to protect them from recurring rocket attacks.

she moves, shielding the laundry basket with their bodies. Finally, Adi drifts into a dissociated sleep and wakes only when her parents lift her out of the laundry basket, flushed and dehydrated.

Twelve hours later, the family is safely rescued from their home by the army and evacuated with all the village members to a hotel. Upon leaving their home, they are confronted with a horrific sight: bodies everywhere, and houses and trees burned to the ground. In the days that follow, Adi remains very quiet, speaking only in a whisper. She rarely moves or plays, clings to her parents at all hours of the day and wakes up in fear during the night. Occasionally, she lashes out at small things such as being asked to take a shower, behavior that was previously uncharacteristic of her.

Background

Adi and the thousands of other children from the South of Israel who experienced the events of October 7th have been confronted with horror and fear that most children never have to face. Talking Together – Parents and Children is a rapid therapeutic intervention that uses brief trauma-informed therapeutic strategies to enable children and their parents to feel and process their intense emotions, give meaning to their traumatic responses, correct pathogenic misperceptions of the traumatic events and of their parents' behaviors and reactions in the traumatic situation, and restore trust in the child-parent relationship.

There are two central components at the heart of the trauma of October 7th threatening Adi and the other children's mental health in the aftermath. The first is the difficulty in processing and coping with the intensity of the emotions she is experiencing. The second is the emotional rift that was created between Adi and her devoted parents who, to protect her life, behaved toward her in a way that

they had never behaved before. From her young point of view, unable to understand the broader context of the events and their behavior, she experienced them as aggressive, hurtful and even frightening.

When children are exposed to a traumatic event that threatens their basic well-being, they experience difficult and overwhelming emotions which they cannot control, such as terror, rage, and helplessness. These intense and flooding emotions are experienced by them as a threat to their mental integrity. Even when the immediate danger passes, children are left with its emotional imprint, which they cannot process alone. Since young children still lack the mental structures required to process and regulate the emotions triggered by trauma, they need their parents' help in this process. The younger the child, the more she needs the help of her parents (Lieberman & Van Horn, 2008; Chu & Lieberman 2010; Beebe & Lachmann, 2002; Schore, 1994; Stern, 1985). A lack of, or delay in emotional processing creates difficulty in connecting the event to the sequence of memories and meanings that the child holds, a resource she normally draws upon to help her integrate her experiences and thus threatens her mental integrity. These unprocessed emotions are the point from which post-traumatic stress disorder can crystallize and then interfere with the child's normal mental and physical development, harm her health, her self-perceptions and her perceptions of the world around her (Van der Kolk, 2014; Levine, 1997; Ogden, et al., 2006).

The second challenge that a traumatic event poses to children is the threat it places on their confidence in their parents and their ability to protect them and help them in situations that arouse fear and overwhelm. When a child experiences overwhelming emotions and the parents—who are focused on physical survival—are not available to help her cope with those emotions (Cohen & Shulman, 2019),

and sometimes even insult or frighten her with their own behavior, there may be a breakdown in her ability to trust them as a source of protection and security. Since young children tend to attribute omnipotence to their parents, they fail to understand the situation and may experience the parents as *choosing* not to help them. Or alternatively, they experience themselves as unworthy of help. Without correcting these perceptions, the trauma may severely damage the child's willingness to trust the parents, express vulnerability to the parents, and turn to them for help. These fundamental changes in the quality of attachment and the level of trust in the child may impair the child's ability to use the parent as a crucial resource to process the overwhelming emotions mentioned above and thus have implications for the child's continued development (Lieberman & Van Horn, 2008).

Parents are often unaware of how a traumatic event affects infants, toddlers, and young children and do not necessarily connect the difficulties and behaviors the child exhibits to the traumatic event she has experienced. Even when parents do recognize that their children are experiencing distress related to the event, they do not always have the tools to help their child process their intense emotions and cope with the attachment crisis, or they believe that simply returning to routine and maintaining an attentive relationship is sufficient for recovery. Moreover, many parents tend to avoid or distance themselves from their child's expression of negative emotions, especially intense feelings of fear, anger and sadness. Instead, they often try to distract the child or moderate her emotional expression. This natural response usually stems from the parents' attempts to protect the child and/or themselves from difficult emotions, which are sometimes perceived as dangerous in and of themselves. In this way, consciously or unconsciously, they encourage the child to avoid contact with traumatic emotions and, as a

result, do not allow the trauma to be processed effectively. The Talking Together intervention was designed to provide a broad and rapid response to both issues, through short therapeutic interventions with parents and their young children.

The Intervention

The intervention is based on Child Parent Psychotherapy (CPP), which is organized around the therapeutic importance of “*Speaking the Unspeakable*” —articulating what happened during the traumatic event, link the event to the traumatic emotions experienced by the child and the parents, correct pathogenic misperceptions about the cause and consequences of the trauma, and repair trust in the parents’ capacity to protect (Lieberman & Van Horn, 2008; Lieberman, Ghosh Ippen and Van Horn, 2015).

Modifications of the original model for application to situations of collective trauma were made in consultation with the CPP principal developer, Prof. Alicia Lieberman. Components of experience-focused approaches (Fosha, 2000) and Affective-Reflective Dialogue (Dan Hughes, 2007) were incorporated to model for parents how to speak directly to their child’s emotional experience because war and collective trauma require streamlining clinical strategies to accelerate the therapeutic process and reach massive numbers of children and families that need rapid intervention.

The goals of the intervention:

- To help parents support their children in regulating difficult emotions that arose following the collective traumatic event by creating contact, expression, validation, and containment of those emotions.
- To help parents regain a sense of competence and effectiveness in their ability to support their children during conditions of communal external danger that are outside of their control.

- To help the child gain a developmentally appropriate understanding of the traumatic event and to correct pathogenic misperceptions of the event that blame the parent or create guilt and self-blame in the child.
- To help restore trust and closeness in the parent-child relationship, which may have been compromised as the result of the collective trauma.

Key Intervention Guidelines:

- 1. The unit of intervention is the parent-child relationship.** Young children rely on their parents to process overwhelming emotions; therefore, the entire intervention takes within the parent-child relationship. With the help of the therapist, the parents create and maintain a dialogue that gives the child renewed confidence and trust that the parents will help understand and process the traumatic event and the emotions it evoked. The therapeutic intervention focuses on fostering beneficial interaction between parents and the child, emphasizing both increasing the sense of security and capability of the parents and the child and reminding them of the great strength of the bond between them.
- 2. Focused work with the parents, built on a relationship of trust and partnership between the therapist and the parents:** The therapist's role is to make sure that the parents feel that they and the therapist are a "team" and that the therapist can lead them safely. The therapist actively searches for the parents' benevolent intentions and their ability to help their children. She expresses – explicitly, warmly, and authentically – her appreciation for them and for their efforts to understand the child's experience. Working with parents focuses on helping parents

help their children regulate the emotions at the heart of trauma in several ways:

- a. Providing knowledge about the impact of trauma and the importance of direct contact with traumatic emotions for recovery.
- b. Preparing parents for the dialogue that will take place in the joint meeting – a dialogue that encourages children to share their feelings, with an emphasis on negative and conflictual feelings that arose from the traumatic experience.
- c. Providing direct assistance to parents in conducting this dialogue with their children during the meeting itself by actively leading the dialogue. In this way, parents can learn this skill through lived experience and directly feel its impact and the closeness it fosters.

3. Speaking directly about trauma: Young children do not have the ability or internal permission to bring up these difficult events and emotions on their own, without an explicit invitation and guidance from their parents. Therefore, the therapist and the parents are responsible for leading and focusing the session on the traumatic events and feelings.

4. Focusing on processing the emotions that the child experienced during and after the traumatic event: The overwhelming emotions the child experiences as a result of the events are at the heart of the trauma response. As such, the intervention focuses on processing and regulating these emotions. The therapist and the parents invite the child to vividly recall the emotional experience of the event, using techniques that foster emotional connection to the experience (such as playful and lively talk, explicit and warm curiosity about the child's experience,

unconditional acceptance toward any experience, focusing on the body and significant details). In contrast to what happened during the traumatic event, children are allowed to fully experience their emotions in a supportive and safe environment while receiving approval, understanding and inclusion from the parent. Such an environment enables processing, regulation, and the creation of a shared and integrative narrative.

5. **Emphasis on the attachment rupture and on restoring the child's trust which was damaged during the traumatic event:** This component of the intervention is presented by the therapist in the preparatory meeting with the parents and remains a significant part of the joint meetings from the start of the process. The therapist provides parents with knowledge about children's typical emotional reactions to their parents in the context of trauma, which includes conflictual emotions (such as anger, disappointment, and insult), and sensitively explores with the parents the possibility of these feelings in their child. With the therapist's help and guidance, the parents raise this possibility with the child in a direct, warm, and accepting manner. The parents later take responsibility and express regret that they were unable to protect the child from the event and/or from the difficult emotions he experienced, and in the effort to survive may have even unintentionally hurt or frightened the child during the traumatic events.
6. **The intervention is simultaneously targeted to acute trauma and preventive of long-term negative sequelae and therefore takes place as close in time as possible to the traumatic event:** Proximity in time to the traumatic events is a critical window for processing the experience.

While a traumatic event that undergoes optimal, timely processing can contribute to the child's sense of resilience and the strength of the parent-child relationship, an event that undergoes only partial processing may catalyze vulnerability and create secondary difficulties. These difficulties -- such as behavioral problems, tension in the relationship with the parent and damage to self-image -- can stand in the way of the child's normal development. In addition, the time proximity to the traumatic event makes it more accessible for processing because defenses such as repression and forgetfulness, which pose a challenge in interventions down the road, have not yet occurred. The staggering number of children who were directly affected by the events of October 7th, and the understanding that it was essential to reach as many of them as possible in a short period of time, necessitated the construction of a focused and short-term intervention. That said, while we aim to facilitate emotional processing before the onset of post-traumatic stress, it is crucial to note that this emotional processing occurs only once the parent and child are in a safe environment and the immediate threat is behind them. Only in this state of relative stability can they sit together, reflect, and process their shared experience.

7. **The therapist operates from a leadership stance that is active and deliberate:** this approach stems from the need to expedite the process, as well as from the desire to maintain a constant focus on the goals of the intervention. This stance is expressed both in meetings with parents and in joint parent-child meetings. The therapist proposes the topics, shares her knowledge with the parents, and leads the discussion in the room. Of course, this approach is combined with deep and

benevolent listening to the parent and the child. The main therapeutic tool is verbal, lively, and playful dialogue that the therapist conducts in interventions with very young children. The use of verbal dialogue helps focus and accelerate the intervention by processing the traumatic event and the emotions it evokes. Therefore, greater emphasis is placed on this special kind of dialogue rather than on trauma-focused play, as might be used in different circumstances.

8. **The therapeutic work is based on the CPP Clinical Formulation Triangle, i.e., a three-pointed conceptualization of the trauma and its effects:** The triangle conceptualization connects what happened to the child (point one), how his psyche reacted to deal with his emotions (point two), and how the therapy will help him (point three). This formulation directs the joint understanding of the therapist and the parent regarding the goals and methods of therapy (Lieberman & Van Horn, 2008; Lieberman et al., 2015). This conceptualization assumes that the symptoms are the most adaptive form of coping that the psyche has found for the overwhelming experiences resulting from the trauma (Fosha, 2000). Based on this understanding, an attitude of acceptance and curiosity develops toward the child's symptoms, helping both the child and parents to understand the deeper logic—and even wisdom—behind the symptom, allowing them to approach it with empathic acceptance. Only after establishing this understanding and acceptance can behavioral interventions be used to help cope with the symptom while finding more adaptive responses to the distress expressed through it.

Structure of the intervention:

The intervention was structured in a gradual process that includes two stages: in the first stage ("the acute stage"), expansive yet brief interventions were conducted that included one or two sessions. Each meeting included a meeting with the parents and a joint meeting for parents and children. This short and acute preventive intervention was implemented with about 730 families from the communities near the Southern border of Israel, Sderot and Ofakim, in the first two months after 7/10. In the acute state, the intervention involved an initial preventive response and served as triage for identifying children in need of more intervention. In follow-up interviews conducted with parents after the intervention, a more prolonged intervention (hereinafter referred to as the "extended stage") was offered to children from birth to age 8 who suffered from symptoms of distress. This 12-session intervention was held in collaboration with the Resilience Centers and the Israeli Trauma Coalition and also included children referred by the Resilience Centers. The intervention took place in a dyadic (parent-child) format and consisted of 6 parent meetings and 6 dyadic sessions that took place alternately. Over 400 children participated in this intervention during 2024. It is important to note that families who experienced the death or kidnapping of a first-degree relative on October 7th were referred to receive an extended intervention, as their trauma was too severe to be adequately addressed by the initial or extended 12-session interventions.

We now return to the story of Adi and her family, to demonstrate how the principles of the intervention are applied in practice:

In the preliminary meeting with both parents, Maya, Adi's mother shared that she experienced intense fear

throughout her stay in the safe room and "froze with fear" many times. She described that most of the time she was busy with keeping the girls quiet, especially the baby Chen, and she felt that she was not available enough for what they felt during the event. Adi's father Dor said that he tried to "hold the situation" and to function. He focused on guarding the door of the safe room and holding a knife at all times, and as a result, he often spoke harshly or matter-of-factly whenever the girls or Maya approached him. When discussing four-year-old Adi, both parents expressed deep pain as they described what she had gone through that day. They shared that since the event, Adi had not been herself. She rarely played, showed great anxiety about separation and was not willing to stay away from her parents, even with her grandparents. She had trouble falling asleep and often woke up at night. In addition, since the event, she had been resistant, angry, and lashing out over small things, insisting on "nonsense" such as seating arrangements at the family meal or what clothes she would wear to kindergarten in the morning. The therapist suggested to the parents that maybe Adi was, in fact, angry, and explained that in many cases a child is angry with the parents after a traumatic event: children expect their parents to protect them from painful and difficult events and feelings, and when this is not possible – they can feel both scared and angry. The therapist asked whether the parents had a more specific reason for her anger. Both parents immediately suggested that Adi didn't understand why her parents had put her in the laundry basket, and they were pained by the fact that she'd had to be hidden there alone for so long. In addition, the mother added her lack of availability to Adi throughout their time in the safe room, because of her preoccupation with baby, Chen. The father also spoke of his own unavailability during those long hours. The parents expressed initial concern about speaking about it, but after understanding the importance of doing so, they responded positively to the therapist's

offer to talk about it with Adi in the meeting, and even to the idea of apologizing to her for the difficult experience she underwent.

Session Vignette:

Adi enters the meeting with her mother. (Father stayed to take care of the baby, and both the father and the baby participated in a dyadic session afterward.) She clings to her mother's leg and hides her face.

Therapist: Adi and mother Maya, I've been waiting for you! It's wonderful you came. And I see, Mom, that you were absolutely right! Adi is a very sweet girl.

Mom: Right? I told you!

Adi (smiling and hiding her face more behind Mom's leg)

Therapist: *And even if Adi is a little shy right now, it's okay, isn't it, Mom? Because she doesn't know me at all!*

Mom: *That's right... It's really okay that you feel a little shy* (sits down on the carpet with Adi in her lap. Adi looks at the games on the carpet and starts playing)

Therapist: *Adi, do you know that your mother told me what happened to you on that scary Saturday? You spent lots and lots of hours in your room, and there were a lot of bad and scary people on the kibbutz.*

Adi: *They also killed people*

Therapist: *They also killed people... That's how bad they are!*

Adi: *And frightening!* (exposes teeth and nails)

Therapist: *And very scary! Were you afraid?*

Adi: (Nodding)

Therapist: *What were you most afraid of?*

Adi: *There were big booms*

Therapist: *There were big booms... Did you hear them too, Mom?*

Mom: *Of course I heard. They were really strong*

Therapist: *And what did the booms do to your body, Adi?*

Adi: (She puts her hand on her heart)

Therapist: *Oh... Heart... Did it beat fast?*

Adi: (Nodding) *And in my ears too!*

Therapist: *Also in the ears because there were strong booms*

Adi: *And there were also small booms (banging with the Playmobil guy on the Playmobil house at a fast pace)*

Mom: *She means the sounds of shooting*

Therapist: *Oh, even small booms are really scary... So you were scared both in your heart and in your ears! Were there other places where you were afraid?*

Adi: *My whole body was scared.*

Therapist: *Wow... Your whole body was scared. Do you hear, Mom? Adi's whole body was scared? Did you know that?*

Mom: *Sure. Because my whole body was also scared.*

Therapist: *So both of you were scared!*

Adi (turns to mother): *But why did they kill? What did they want?*

Mom (looking at the therapist with a question)

Therapist: *Mom, Adi really wants to understand who they were? Why did they come and kill? Is it okay for her to ask Mom?*

Mom: *Of course it's okay, sweetheart, because it's really confusing. They're really, really bad people.*

Therapist: *So bad?? They even wanted to kill?*

Mom: *yes, really bad and scary*

Therapist: *So bad... No wonder you were really scared like that... I'm sure I'd be so scared if I was there... So Adi, your mother tells me that since they were in your house, these people who are so bad, it's hard for you to say goodbye to Mom and Dad, and you also wake up at night from really scary dreams, is that true? Because if so, there must be a very good reason for it*

Adi: (Nodding and looking curiously) *And I don't want to sleep in my bed, only theirs*

Therapist: *Oh... So you probably have a very smart heart! Right, Mom?*

Mom: (smiling and nodding) *That's right, Adi has a really smart heart*

Therapist: *Right, because you were so scared there and now you want to feel safe and just be with mom and dad?*

Adi: *Yes! Even at night*

Therapist: *Oh! Now I understand. So your whole body felt this terrible fear in your heart, and in your ears, and now your heart wants to make sure that Mom and Dad will always stay by your side and watch over you, right?*

Adi: (Nodding)

Therapist: *So Mom, you have a really smart girl! Because that's what happens to children when something so scary happens to them like what happened to you. And slowly Adi's body will calm down, and the fear will leave her heart and ears, and she will be able to go back to sleep in her bed, and stay with Grandma, and sleep without bad dreams!*

Adi: (Listens carefully and happily plays in the Playmobil house. She puts the girl in the room and locks her in the room)

Therapist: *Oh! She's alone! Adi, were you also alone when the bad guys came?*

Adi: *No! I was with Mom and Dad and Chen*

Therapist: *Oh... So you were all together... But do you know what else Mom said to me? That you were alone in a laundry basket...*

Adi: (Looks up at the therapist) *It was hot*

Therapist: *It was really hot in there... And you were alone... Now I have a question for brave children: Maybe*

*sometimes you have a sentence like this in your heart:
'Mom, why did you put me in a laundry basket? I was
there alone and I was scared, Mom, and it was very hot!'*

Adi: (Looking at her mother questioningly)

Therapist: *Mom, if Adi has a sentence like that in her
heart, is that okay? Will you be angry?*

Mom: *No, I won't get angry at all, the most important
thing in the world to me is what you feel*

Therapist: *That's wonderful Mom. So sometimes you
might think so, Adi?*

Adi: (Nodding) *Because I was hot there and I didn't
breathe well and I was scared and I didn't move*

Therapist: *Wow... Adi, you are such a brave girl that you
can tell your mother what you felt... That you were scared
and you were alone and you had no air. Mom, is it
important for you to hear how Adi felt in the laundry
basket?*

Mom: (tears) *It's really, really important to me,
sweetheart. I'm so sorry that you felt like that, alone and
scared, that's so sad for me*

Therapist: *Because you didn't want Adi to feel that way,
Mom?*

Mom: *Of course not! I never want her to feel that way!*

Adi: *But you put me there and put a pillow on me*

Therapist: *Maybe you're angry, Adi? That your mother
put a pillow on you?*

Adi: Yes! And she told me to be quiet all day

Mom: That's right... I really told her... Sorry my sweet Adi, I wish I didn't have to do that

Therapist: Because you love Adi? And is it really important to you?

Mom: Because I love her very much, and she's really important to me... Come to me, Adidi. I wanted to hide you from the bad people, so that they wouldn't take you, and you were there alone...

Adi cuddles in her mother's lap and they give a long hug.

In this example, we can see how the therapist actively leads the conversation, focusing on Adi's emotions while ensuring full coordination with and participation of the mother. Through playfulness, focus on the physical experience, as well as explicit encouragement and validation, Adi is able to unfold, share and understand together the feelings she felt during the traumatic event – including those directed towards her parents. When she shares her anger and fear with her mother, Maya – with the help of the therapist – responds positively and acceptingly, and this makes it possible to turn the difficult emotions from a source of crisis and distance into a source of strengthening the sense of closeness and security. In addition, the therapist helps the child and the mother to reframe the symptoms she has experienced since the traumatic event as an adaptive, smart, and healthy way of her mind to deal with the fear. Moreover, she even instills hope reassuring them that as the fear slowly leaves her body, the symptoms will decrease.

Research:

Both stages of the intervention were accompanied by a mixed-methods study (qualitative and quantitative). The purpose of the study in the acute phase of the intervention was to describe the model and examine how families and therapists experienced the implementation of the intervention. The purpose of the extended-phase study was to evaluate feasibility and preliminary outcomes, as well as to examine pre–post changes in hypothesized change processes to inform future investigation of mechanisms of change. The study included several components, while collecting data from multiple informants, at different points in time: a short structured open interview with parents and in-depth interviews with therapists after the intervention in the acute stage, questionnaires for parents and short interviews given at the beginning and end of the extended treatment phase.

The various components of the study indicate positive changes in the children and parents, aligning with the goals of the intervention. The following is a description of the study in the two stages of the intervention and a summary of the initial findings [Detailed empirical reports on the brief acute and extended phases have been analyzed and are presented elsewhere (see Kroyzer et al. (under review) for the brief phase; see Frenkel et al (in preparation) for the extended phase]:

A. Exploratory research on the acute phase:

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 85% reported an improvement in their sense of competence as a parent, about 70% reported an improvement in their child's emotional state, about 74% reported an improvement in their own emotional state, and about 69% 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."

The analysis of the interviews with the therapists echoes the satisfaction reported by the parents. The therapists described the intervention model as effective and well-adapted to the needs of many of the parents and children with whom they met. They observed that, in many cases, the intervention helped to regulate and reduce the children's symptoms, strengthen the sense of parental competence and create a beneficial shared experience for the family members.

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 (For a detailed account of the therapists' perspectives on the implementation of the acute phase, see Saar-Heiman et al., in preparation).

In the following quote, Ditzza, 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."

B. Research on the Extended Treatment Phase:

The extended-phase study was conducted with a sample of approximately 150 families, using questionnaires completed by parents at the beginning and end of treatment. The purpose was to evaluate treatment feasibility and preliminary outcomes, as well as to examine pre–post changes in hypothesized change processes to inform future investigation of mechanisms of change. The current chapter provides only a general overview of the study design, domains assessed, and direction of preliminary findings; detailed analyses of treatment outcomes and potential mechanisms of change will be reported separately (Frenkel et al, in preparation).

At the beginning of treatment, parents reported very high levels of emotional and behavioral distress among children, with a substantial proportion scoring above clinical thresholds. Preliminary analyses indicated high treatment feasibility, with a high completion rate of the treatment protocol. Comparisons from the beginning to the end of treatment indicated significant reductions in children's distress symptoms, including anxiety and behavioral problems, with a substantial proportion of children

who initially scored above clinical thresholds falling below them by the end of treatment.

In addition, parents reported high levels of satisfaction with the intervention and described receiving practical tools to help them understand and respond to their children's emotional needs. Significant improvements were also observed in parents' sense of self-efficacy in helping their children cope with traumatic experiences, parental burnout, and the quality of the parent–child relationship, including children's reliance on their parents for support in coping with trauma-related emotions.

Notably, the degree of improvement in children's symptoms was not associated with several factors that might be expected to constrain treatment response, including parents' own post-traumatic stress symptoms, socioeconomic status, severity of war-related exposure, and parental psychiatric history. Thus, preliminary findings suggest that improvement was observed across families with differing levels of parental distress, exposure, and background risk.

The study also examined pre–post changes in several processes hypothesized to contribute to therapeutic change. These processes concerned how parents experience their parenting role, respond to their children's expressions of negative emotions and distress, and help their children regulate difficult trauma-related emotions. Preliminary analyses indicated changes in several of these processes, including reduced parental distress when discussing traumatic experiences, greater willingness to engage with rather than

avoid trauma-related emotions, greater recognition of the importance of expressing painful emotions, and increased acceptance of children's negative or complex emotions, including anger and disappointment directed toward the parent. Changes in some of these parenting processes were also associated with improvements in children's symptoms.

The following quote allows us to see the hypothesized mechanisms of change found in the analysis of the questionnaires from the point of view of Rina, a mother who participated in the ongoing treatment phase:

"We were very afraid to talk about what happened that Saturday with our son ... But she (the therapist) was not afraid. She literally spoke to him in his own language, at his own pace, and we learned that he understood a lot of things from that day, things that we were sure he didn't understand and didn't realize had happened. And she really helped us know how to talk to him about this issue, about what he felt there, and how to answer his questions."

Discussion and Conclusions:

As we described above, in planning the intervention, we assumed that young children who were exposed to a traumatic event face two main challenges. One is the difficulty to regulate the emotions that arose during the event. The second is the risk for rupture in the security of attachment with the parents. Because of their young age and still-immature cognitive and emotional resources, young children need their parents support to cope with these two challenges in order to return to a normal developmental trajectory. For this reason, the intervention we built focused on working with the parents and

facilitating joint meetings of the parents and their children, with the main goal being to help parents help their children with these two tasks.

The findings from the various components of the study are consistent with the clinical impression that the intervention was beneficial in improving children's emotional well-being and reducing distress. Pre–post changes in processes hypothesized to contribute to therapeutic change were also observed, including changes in parents' attitudes toward children's emotions and increases in their willingness and ability to talk with children about their emotions and respond to them in supportive ways. Although these findings do not establish mechanisms of change, they provide preliminary support for processes that warrant further investigation. Taken together, the findings point to the potential of the intervention to support young children and their parents following traumatic events.

Implementing the intervention among evacuated and displaced families in real time and without prior infrastructure demonstrates the feasibility of delivering it to parents and young children as an initial intervention during emergencies and on a large scale. Notably, the degree of improvement in children's symptoms was not significantly associated with socioeconomic status, degree of exposure to the traumatic event, or parental psychiatric history, suggesting that improvement was observed across families with differing levels of exposure and background risk. Given the feasibility and preliminary outcomes observed, we propose that the two-stage “Talking Together” intervention warrants further evaluation as an initial psychological response for young children and their parents exposed to collective trauma, particularly when large-scale preventive intervention is required. At the public-health level, we suggest examining the possibility of

establishing a structured mechanism, based on this intervention, to provide an initial preventive response for young children and their parents during emergencies. Controlled studies are needed to establish intervention effectiveness and to test the hypothesized mechanisms of change.

Future Studies:

The initial intervention commonly used in early childhood trauma in many cases is parental guidance. We hypothesize that the main strength of the Talking Together intervention lies in its dyadic structure. An analysis of the parents' and therapists' reports shows that it was the direct, real-time, help that the parents received from the therapist that enabled them to actually talk to their child about his difficult feelings. The therapist's support was significant in terms of their ability to do so, as well as in dispelling their fears about opening up the trauma in such a direct way. The parents described that the positive reaction of the children to this, and the sense of closeness that was created as a result, motivated a significant change in family culture: from avoiding difficult emotions, to courageously approaching and showing open interest in these feelings. The therapeutic value of "Speaking the Unspeakable" by helping young children and their parents express use words and play to process traumatic events and repair quality of attachment has been documented in 5 randomized studies and several clinical studies of Child-Parent Psychotherapy (www.childparentpsychotherapy.org). The current study provides preliminary support for the feasibility and potential benefit of extending this approach to situations of war and collective trauma. In light of these findings, future controlled studies are needed to examine its effectiveness in other contexts and types of collective trauma in which many young children are exposed to traumatic events, such as abuse in kindergartens and daycare centers. It is also

potentially important to examine the application of this focused intervention in situations of non-collective trauma.

For more information – visit our website at www.medabrimyahad.org.il

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