



# Parental PTSD and Children's Well-Being During Wartime: The Role of Interpersonal Emotion Regulation

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## Abstract

On October 7, 2023, the Israel–Hamas war broke out, leading to heightened psychological distress across the civilian population in both Israel and Gaza. Research shows that children are especially vulnerable to war-related stress, with caregiver mental health strongly influencing their psychosocial outcomes. Yet, studies on the link between parental posttraumatic stress disorder (PTSD) symptoms and children's well-being during wartime remain scarce, particularly regarding protective factors that may buffer the impact of parental mental health on children's well-being. A promising protective factor is how parents help children regulate their emotions, i.e., interpersonal emotion regulation (IER). This study explored the moderating role of adaptive parental IER strategies on the relationship between parental PTSD symptoms and children's behavioral and emotional difficulties. The research was conducted shortly after the war began (November 10–25, 2023), during a period of potential exposure to severe violence and stress. Participants were 318 Israeli parents (76% mothers;  $M_{age}=40.2$ ,  $SD=6.9$ ), all of whom had children aged 5–18 ( $M=9.2$ ,  $SD=3.8$ ). A regression analysis revealed that higher parental PTSD symptoms correlated with greater behavioral and emotional difficulties in children, and that parental IER buffered this relationship. These findings emphasize the protective role of adaptive IER in mitigating family stress during wartime. Integrating that role into trauma-informed parenting programs can provide a critical resource for families facing chronic stress or trauma in conflict zones.

**Keywords** Posttraumatic stress disorder · Parents · Behavioral and emotional difficulties · Children · Interpersonal emotion regulation · Israel–Hamas war

## Introduction

The lives of Israeli and Gazan citizens changed dramatically on October 7, 2023, when the ongoing Israel–Hammas war erupted following the largest attack against civilians in Israel’s history, carried out by Hamas. In response, Israel launched an attack on Gaza, calling up hundreds of thousands of reservists, many of them parents. There was a marked increase in psychological distress in the Israeli population, with rates of posttraumatic stress disorder (PTSD) nearly doubling compared to levels documented just 2 months before the attack (Enav et al., 2024; Levi-Belz et al., 2024).

Children are particularly vulnerable to distress, as they are at heightened risk for maladaptive responses to war-related stress (Bendavid et al., 2021; Murphy et al., 2017; Slone & Mann, 2016). Children’s mental health risks may increase disproportionately during conflict, in part due to their limited cognitive and emotional resources for coping with extreme stress, as well as their dependence on (absent or distressed) adult caregivers for safety and regulation (Bendavid et al., 2021). Previous research indicates that exposure to war negatively impacts children’s well-being (Rousseau et al., 2015). Specifically, it may lead to PTSD symptoms, behavioral and emotional difficulties, sleep disturbances, disrupted play, and psychosomatic symptoms (for a review see Slone & Mann, 2016).

Recently, in a retrospective research study, Israeli parents reported that after the October 7 attack, their children had higher levels of aggression and social difficulties (Shechory-Bitton et al., 2024). These symptoms may negatively affect children’s social, emotional, academic, and physical development (Fairbank & Fairbank, 2009; Halevi et al., 2016). However, not all children experience the same levels of psychological difficulties in times of war. This observation has prompted researchers to explore both risk and attenuating factors moderating the effects of children’s exposure to intense stressors (Kadir et al., 2019).

A growing body of research suggests that caregiver mental health is vital in predicting the psychosocial outcomes for war-affected children and that parental behaviors can foster resilience in stressful situations (Betancourt & Khan, 2008; Meyer et al., 2017; Shechory-Bitton et al., 2024). Previous research suggests that parents’ subjective psychological response to the stressor has a meaningful impact on the child’s development (Simcock et al., 2017). For example, a systematic review found that maternal depression and posttraumatic stress in a war context were predictors of children’s mental health, behavioral difficulties, and somatic complaints (Slone & Mann, 2016). Additionally, prospective studies with war-affected families demonstrated that caregivers’ mental health was prospectively associated with the child’s mental health over a 1- to 4-year period (Betancourt et al., 2015; Panter-Brick et al., 2014). These findings suggest that parental posttraumatic symptoms might be a major risk factor for children’s adjustment to stress during wartime (Lambert et al., 2014).

Although the precise mechanisms by which a parent’s posttraumatic symptoms affect their child’s mental health remain largely unclear (Bowers & Yehuda, 2016), research provides some insight. Studies suggest that having a parent with

PTSD may increase a child's vulnerability to mental health difficulties, either due to genetic predisposition (i.e., the potential inheritance of similar genetic vulnerabilities that affect their stress responses) or through behavioral changes resulting from the parents' stress-related psychopathology (Yehuda & Bierer, 2007).

Focusing on the latter, studies have demonstrated that parental PTSD can influence parenting behaviors (e.g., Creech & Misca, 2017; DiLillo & Damashek, 2003; Leen-Feldner et al., 2011), which can lead to emotional and behavioral difficulties in their children. For example, mothers with more severe PTSD symptoms may exhibit more hostile and controlling behaviors (Davies et al., 2008; Van Ee et al., 2016). Furthermore, PTSD symptoms may compromise parents' ability to be emotionally available and attuned to their children's needs, which can negatively influence the child's emotion regulation and overall adjustment (Pat-Horenczyk et al., 2015; Samuelson et al., 2017). From a developmental and family-systems perspective, it can be assumed that parents experiencing trauma-related distress may struggle to provide the emotional support needed to help their children cope with stress (Lambert et al., 2014). Nonetheless, research exploring the role of the family environment in high-stress contexts, such as war zones, remains limited (Al-Yagon et al., 2023; Flanagan et al., 2020; Thabet et al., 2009).

According to resilience theory, children's ability to adapt under extreme adversity is shaped not only by risk factors but also by promotive and protective processes embedded within their close relationships and caregiving environments (Masten & Narayan, 2012). Identifying such protective factors at the family level is critical for understanding children's capacity for resilience in the face of war-related stress. One promising protective factor for children's mental health within the family environment is parental IER. Parental IER involves the parents' attempts to help their children recognize and manage their emotions while respecting their emotional expression (Eisenberg et al., 1998; Hajal & Paley, 2020). Adaptive parental IER has been identified as a buffer in the context of parental psychopathology, such as PTSD symptoms, anxiety, and depression (Cohodes et al., 2017; Greene et al., 2020; cf., Gadassi-Polack et al., 2024).

Though not yet extensively studied in the context of armed conflict, previous research has shown that awareness and acceptance of children's negative emotions act as protective factors, reducing internalizing and externalizing difficulties and enhancing the child's emotion regulation skills after exposure to trauma, such as domestic violence (Johnson & Lieberman, 2007; Katz & Windecker-Nelson, 2006). Furthermore, an intervention program aimed at supporting parents after military deployment and strengthening their emotional socialization skills led to a significantly greater reduction in their children's internalizing and externalizing symptoms over two years (Zhang et al., 2020). Supporting IER as a protective factor, a study conducted during the COVID-19 pandemic found that parental IER strategies such as acceptance and problem-solving helped mitigate the mental health impact of pandemic-related parental stress on youth (Cohodes et al., 2022).

## The Current Study

Taken together, the studies reviewed above suggest that parental IER plays a vital role in protecting children against the harmful psychological effects of traumatic events. However, the role of parental IER during an armed conflict has not been studied. To address this gap, the present study examined the role of parental IER in shaping children's behavioral and emotional adjustment at an early stage of the ongoing Israel– Hamas war (starting October 2023). We also studied the relationship between parental PTSD and their children's behavioral and emotional difficulties. We focused on parental PTSD symptoms, as this is one of the most prevalent and well-documented mental health outcomes following exposure to war-related trauma. Regarding children's behavioral and emotional difficulties, we assessed children's depression/anxiety, somatization, and aggression symptoms. We hypothesized that parental IER would buffer the negative association between parental PTSD symptoms and their children's difficulties.

## Methods

This study is part of a broader project on parenting during the Israel– Hamas war (Keleynikov et al., 2025).

## Participants

The sample included 318 parents (76% mothers;  $M_{age}=40.2$  years,  $SD=6.9$ ), all of whom had children aged 5–18 ( $M=9.2$ ,  $SD=3.8$ ). On average, the participants had 2.7 children ( $SD=1.2$ ). All participants identified as Jewish. Most were married (91%), reported average or above-average income (78%), and had an academic degree (92%). One-sixth (16%) of the participants stated that their spouse had been drafted into reserve service, and 5% reported displacement from their homes due to the war. The participants also reported significant exposure to war-related events, as detailed in Table 1. For instance, 6% indicated they were in immediate danger, 32% experienced a rocket landing in their residential area, and 28% suffered the loss of a close other.

**Table 1** Participants' exposure to the Israel– Hamas war

Direct exposure		Indirect exposure	
Experienced a life-threatening event	6%	A close other was injured	23%
Was injured	1%	A close other was kidnapped	13%
Serves in the army/police	5%	A close other was murdered	28%
Was displaced	5%	A close other survived the attack	35%
A rocket hit their residential area	32%	Spouse in reserve duty	16%

## Procedure

The study received ethical approval from the University of Haifa's Ethics Committee (IRB approval number: 383/23). Prior to data collection, we conducted an a priori power analysis using G\*Power to determine the minimum sample size needed to detect a medium effect size ( $f^2=0.25$ ) in a multiple regression analysis, with a power of 0.95 and  $\alpha=0.05$ . The analysis indicated that a sample of at least 50 participants would be sufficient. All hypotheses and analytic plans were preregistered (<https://osf.io/qnmec/>). Participants were offered approximately 10\$ (40 NIS) gift voucher upon completing the survey.

Parents were recruited nationwide through ads in parenting-related public Facebook and WhatsApp groups, inviting parents to take part in a study on parenting during wartime. Eligible participants had at least one child aged 5–18 years. The selected age range was based on the age appropriateness of the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1991), used to assess child emotional and behavioral difficulties in this study. Parents with more than one child in this age range were instructed to complete the survey regarding the child who, in their view, was having the most difficulty coping with the war. This instruction was intended to reduce participants' burden while capturing meaningful variability in child functioning.

The online survey was administered via the Qualtrics platform from November 10 to November 25, 2023, approximately 1 month after the war began. During this period, hundreds of thousands of Israeli citizens were called to reserve duty, and large parts of Israel were subjected to intensive rocket attacks (Institute for National Security Studies, n.d).

## Measures

### Demographic Variables

Participants reported on sociodemographic variables including age, gender, socioeconomic status, and relationship status. In addition, they reported variables related to their children, including the number of children they had, and as mentioned, chose one child for whom they reported age and gender, as well as the research variables.

### Exposure to War-Related Events

This questionnaire was adapted from the Political Life Event Scale (Slone, 1998) and modified for the purposes of this study. It included ten yes/no items. The questionnaire comprised two subscales: one assessing direct exposure to war-related events (e.g., "I was injured during the war"; "I was evacuated from my place of residence") and the other measuring indirect exposure (e.g., "A person close to me was killed during the war"; "My spouse was drafted into reserve duty").

## Parental Posttraumatic Stress Symptoms

The International Trauma Questionnaire (ITQ; Cloitre et al., 2018) is a self-report measure designed to assess PTSD symptoms according to the International Classification of Diseases, Eleventh Revision (ICD-11; World Health Organization, 2022). It focuses on six symptoms across three clusters—re-experiencing, avoidance, and a heightened sense of threat—each containing two symptoms. In addition to PTSD symptoms, the ITQ includes three items assessing functional impairment caused by these symptoms. Responses are recorded on a five-point Likert scale, ranging from 0 (not at all) to 4 (extremely), with total scores ranging from 0 to 24. A score of  $\geq 2$  (moderately) indicates endorsement of a symptom. A PTSD diagnosis requires exposure to a traumatic event, endorsement of at least one symptom from each of the three clusters, and at least one indicator of functional impairment. The reliability for this scale in the current study was high (Cronbach  $\alpha = 0.89$ ).

## Parental IER

The Parental Assistance with Child Emotion Regulation (PACER; Cohodes et al., 2021) questionnaire was used to measure parental tendency to use adaptive IER strategies. The complete questionnaire covers ten IER strategies, five adaptive and five maladaptive. To minimize participants' burden, only the adaptive strategies were assessed in this study. Participants were asked to reflect on their typical parenting behavior, not specifically in relation to the war period, using those five items (reappraisal, "I help my child think of a situation in a positive light"; acceptance, "I help my child accept his/her negative feelings"; problem-solving, "I help my child take steps to solving a problem"; venting, "I help my child talk openly with other people"; distraction, "I help my child find ways to distract themselves from their negative feelings"). For the parental IER composite score, we computed the mean across 25 items (5 items per strategy  $\times$  5 strategies). As each was rated on a 7-point Likert scale (1 = strongly disagree, 7 = strongly agree), the range of the composite score was 1 to 7, with higher scores indicating greater use of adaptive IER strategies.

To ensure the questionnaire's appropriate use, we obtained permission from the author for its employment and translation. A Hebrew-speaking researcher translated the items into Hebrew. Following this, an English native speaker back-translated the scale into English. An independent researcher compared the translated questionnaire to the original one to ensure sentence meanings were maintained, and one of the authors of the questionnaire examined the back-translation for inconsistencies. All five scales had high internal consistency reliability with Cronbach's  $\alpha$  values in the good to excellent range ( $> 0.85$ ). Based on the high correlation between the strategies (Pearson correlations ranging from 0.46 to 0.78), we used the composite score of all five strategies.

## Child's Behavioral and Emotional Difficulties

Three subscales of the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1991) were used: aggressive behavior, depression/anxiety, and somatic complaints.

The participants were instructed to report on their child's behavior specifically since the war had erupted. The original questionnaire comprised eight subscales; to reduce participant burden, an effort was made to shorten it by focusing on indicators of internalizing and externalizing behaviors, commonly affected in children exposed to war (Slone & Mann, 2016). Consequently, only three subscales were selected. The checklist was completed by parents to determine the presence or absence of emotional and behavioral difficulties in their child. Responses were coded as 0 (not true), 1 (somewhat or sometimes true), or 2 (very true or often true). The aggressive behavior subscale included 18 items (e.g., "*My child argues a lot*"); depression/anxiety consisted of 13 (e.g., "*My child cries a lot*"), and somatic complaints 12 (e.g., "*My child is overtired without good reason*"). The three scales were combined to yield the behavioral and emotional difficulties scores. These ranged from 0 to 86, with higher scores indicating more severe emotional and behavioral difficulties. Cronbach alpha was high for all three scales (aggressive behavior,  $\alpha=0.93$ ; depression/anxiety,  $\alpha=0.85$ ; somatic complaints,  $\alpha=0.84$ ), as well as for the total score,  $\alpha=0.94$ .

## Data Analysis

The data were analyzed using SPSS Version 27 (IBM Corp). Descriptive statistics, including means, standard deviations, and correlations, were calculated for all variables. To examine the moderating role of IER on the relationship between parental PTSD symptoms and children's behavioral and emotional difficulties, a linear regression model was fitted. We examined correlations between demographic variables and children's behavioral and emotional difficulties and found a significant positive association with war-related exposure. As a result, war exposure was included as a covariate in the regression analyses. To examine the conditional effects of the interaction, the PROCESS macro for SPSS (Model 1: Hayes, 2018) was used. Simple slopes were tested at low ( $-1\ SD$ ), medium ( $M$ ), and high ( $+1\ SD$ ) levels of parental IER.

## Results

### Descriptive Statistics

Table 2 presents the means, standard deviations, and Pearson correlation coefficients for all variables. Results indicate that 28% of parents scored above the clinical threshold for PTSD ( $M=14.17$ ). War exposure was positively correlated with parents' PTSD symptoms and children's behavioral and emotional difficulties. Parental PTSD symptoms were positively associated with children's behavioral and emotional difficulties. Parental IER was related to fewer behavioral and emotional difficulties among the children, but was unrelated to parental PTSD symptoms. Note that although normality tests indicated deviations from the normal distribution for some variables, Pearson's correlation is considered robust to such violations in large

**Table 2** Means, standard deviations, and correlations ( $N = 318$ )

	<i>M (SD)</i>	1	2	3
1. War exposure	1.67 (1.62)			
2. Parental PTSD	14.17 (8.23)	0.16**		
3. Parental IER	5.34 (1.06)	0.11	−0.02	
4. Child's behavioral and emotional difficulties	15.22 (12.98)	0.17*	0.38***	−0.25***

Note: \* $p < 0.05$ ; \*\* $p < 0.01$ ; \*\*\* $p < 0.001$

samples (Schmidt & Finan, 2018). Visual inspection suggested linear relationships and no extreme outliers, supporting the use of Pearson's  $r$  in the current analyses.

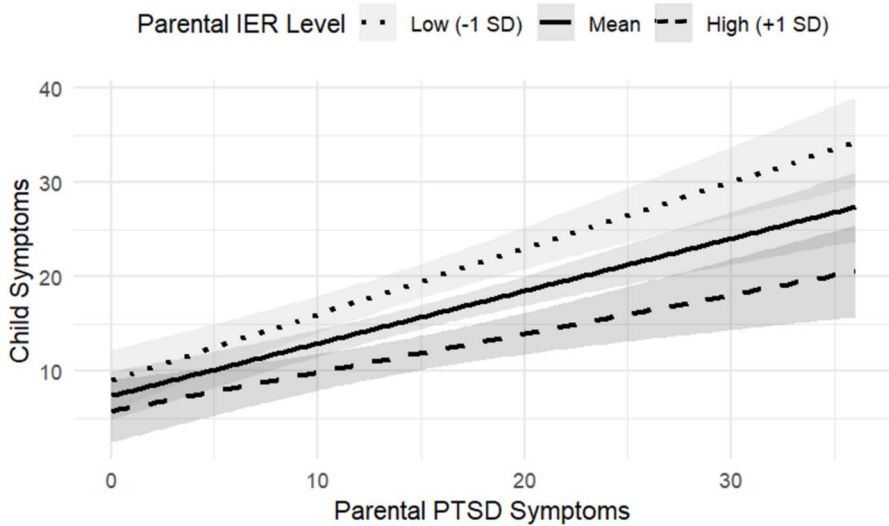
### IER Moderating the Link Between Parental PTSD and Child's Behavioral and Emotional Difficulties

We conducted a regression analysis to test whether the relationship between parental PTSD symptoms and children's behavioral and emotional difficulties is moderated by parental IER. War exposure was entered as a covariate. The model was statistically significant,  $F(4, 313) = 24.44$ , and accounted for 23.8% of the variance in the child's behavioral and emotional difficulties (see Table 3). War exposure and parental PTSD symptoms significantly predicted more children's behavioral and emotional difficulties. The main effect of the IER strategies was not significant, yet the interaction between IER and parental PTSD symptoms was. A simple slopes analysis revealed that the association between parental PTSD symptoms and child behavioral and emotional difficulties was significant at all levels of parental IER. Specifically, the relationship was strongest at low IER levels ( $-1$  SD;  $b = 0.70$ ,  $SE = 0.10$ ,  $t = 7.04$ ,  $p < 0.001$ , 95% CI [0.51, 0.90]); moderate at the mean level ( $b = 0.56$ ,  $SE = 0.08$ ,  $t = 7.06$ ,  $p < 0.001$ , 95% CI [0.40, 0.71]); and weakest—but still significant—at high levels of IER ( $+1$  SD;  $b = 0.41$ ,  $SE = 0.10$ ,  $t = 3.99$ ,  $p < 0.001$ , 95% CI [0.21, 0.62]). See Table 3 and Fig. 1. A sensitivity analysis restricted to female participants yielded a similar pattern of results, suggesting robustness despite potential non-independence among respondents.

**Table 3** Linear regression analysis to predict the child's behavioral and emotional difficulties

	<i>B</i>	<i>SD</i>	<i>t</i>	<i>p</i>	95% CI	
					Low	High
War exposure	1.24	0.40	3.07	<b>0.002</b>	0.48	2.04
Parental PTSD	1.29	0.33	3.92	<b>&lt; 0.001</b>	0.64	1.93
IER	−1.54	0.99	−1.56	0.120	−3.48	0.40
PTSD $\times$ IER	−0.14	0.06	−2.27	<b>0.024</b>	−0.26	−0.02

Note: Results in bold are significant



**Fig. 1** IER moderating the link between parental PTSD and child's behavioral and emotional difficulties

## Discussion

To the best of our knowledge, this is the first study to examine parental IER as a resilience factor for children during armed conflict. It provides preliminary evidence that IER may mitigate the impact of parental trauma-related symptoms on children's behavioral and emotional difficulties in wartime. Specifically, we explored the relationship between parental PTSD and children's behavioral and emotional difficulties, assessing whether IER could serve as a moderating factor.

The findings revealed that 28% of parents scored above the clinical threshold for PTSD symptoms. This prevalence is comparable to rates reported in other studies conducted during the first month of the Israel–Hamas war (30% in Levi-Belz et al., 2024; 36% in Palgi et al., 2024) and appears markedly higher than those found in Israel 5 years ago (e.g., 9%; Ben-Ezra et al., 2018). These elevated rates likely reflect the profound psychological toll of the October 7 attack and ensuing war, which involved unprecedented civilian casualties and persistent rocket attacks across the country.

Our findings are especially significant in the context of parenting, given the well-established link between parental PTSD and children's psychological adjustment (Lambert et al., 2014; Slone & Mann, 2016). Moreover, we found that parental adaptive IER moderates the association between PTSD symptoms and children's difficulties. Even at relatively low levels of adaptive IER, the association between PTSD and children's emotional and behavioral challenges was significantly attenuated. However, the weakest association was observed at high adaptive IER levels. This underscores adaptive IER's potential as a protective factor for children facing parental trauma. These findings indicate that parents may support their children's reaction and adaptation to stress and trauma

through adaptive IER. For instance, parents may encourage open sharing of feelings, provide distraction, help with problem-solving, or support children in accepting their emotions without judgment. Such strategies can help children perceive stressful situations as less threatening and more manageable.

These important insights align with broader perspectives on the value of IER, showing that parents play a pivotal role in promoting children's emotional stability (Murray et al., 2023), and extend this understanding to the underexplored context of exposure to armed conflict. These findings align with prior research on the related concept of emotion socialization, which highlights the role of parents in shaping children's emotional responses through three components: modeling, reactions, and coaching or guidance, the latter of which can be conceptualized as a form of IER (Katz et al., 2014; Morris et al., 2007). For instance, studies examining trauma-exposed families suggest that mother–child relationship acts to regulate the physiological responses of the child (Gewirtz et al., 2008). Additionally, research on war-exposed populations has shown that parental supportive emotion socialization behaviors serve as protective factors against psychological distress in children (Feldman et al., 2013; Zhang et al., 2018, 2020).

Earlier studies have demonstrated a link between PTSD symptoms and maladaptive IER (Chesney & Gordon, 2017; Glaser et al., 2006), as well as an association between PTSD symptoms and ineffective parenting behaviors (Greene et al., 2020; Van Ee et al., 2012, 2016). Based on these findings, it may be hypothesized that parents with higher levels of PTSD symptoms may be less likely to use adaptive IER strategies. However, we found no significant association between parental PTSD symptoms and adaptive IER use.

One possible explanation is that while PTSD is known to impair intrapersonal emotion regulation, such as reducing the likelihood of using strategies like cognitive reappraisal, it may not impair the capacity or motivation to engage in IER. Indeed, emerging evidence suggests that emotion regulation difficulties observed at the intrapersonal level do not always translate into impairments in interpersonal contexts. For example, individuals with elevated depressive symptoms have been shown to engage less frequently in reappraisal when regulating their own emotions (e.g., Joormann & Gotlib, 2010). However, Massarwe and Cohen (2025) found that they used reappraisal just as frequently as non-depressed individuals did when regulating others' emotions. This suggests that IER may involve different cognitive and motivational processes. Another explanation for this unexpected result is the timing of the study, conducted during a period of acute national crisis. It is likely that the significant increase in PTSD symptoms during this time had not yet persisted long enough to disrupt parent–child interactions (Ehring & Quack, 2010). Disruptions in such interactions may only emerge if symptoms remain chronic and fail to improve over time. Taken together, our findings suggest that even in the context of elevated PTSD symptoms, parents can engage in adaptive IER strategies during wartime interactions with their children, and that this tendency can contribute to better outcomes for their children.

## Limitations and Future Research

While this study provides important insights, several limitations should be noted. First, the use of self-report measures presents potential biases, especially when parents report both their own PTSD symptoms and their child's behavioral and emotional difficulties. Parental PTSD symptoms may influence perceptions, potentially inflating observed associations. Specifically, PTSD-related cognitive changes may influence how parents perceive their own IER abilities and their child's behavioral and emotional symptoms (Wamser-Nanney & Sager, 2021). Future research would benefit from incorporating multi-informant approaches, such as reports from teachers and caregivers, and direct assessments of the child, to gain a more objective understanding of the child's functioning.

Additionally, the cross-sectional design limits the ability to draw causal conclusions. Longitudinal studies are needed to establish the directionality of these associations and to explore how they may evolve over time, particularly as families continue to cope with trauma exposure. Further, participants received payment for their participation. The potential impact of this incentive on sample composition and response patterns is acknowledged, as it may have selectively attracted participants with financial motivations (Singer & Couper, 2008). That said, the socioeconomic status of our sample was relatively high, and to minimize the impact of compensation, we offered only approximately \$10.

The lack of diversity in our sample, composed exclusively of Jewish, mostly female, married, and highly educated participants, was likely influenced by the use of convenience sampling via online platforms, attracting individuals who are more socially engaged or have greater access to digital resources. Moreover, as the study was conducted in Hebrew, participation may have been further limited to individuals fluent in Hebrew, excluding those with less proficiency. This approach limits the generalizability of our findings, and future studies should include more socioeconomically and culturally diverse populations to enhance external validity.

Next, the decision to exclude maladaptive IER strategies was driven by the study's focus on understanding adaptive regulatory processes that may buffer the effects of parental PTSD on child outcomes. Additionally, given that this study is part of a larger investigation, we sought to minimize participant burden by focusing on concepts most relevant to our central research questions. However, this exclusion is recognized as a limitation, as including maladaptive strategies could have offered deeper insights into family dynamics during wartime. Future research should explore both adaptive and maladaptive strategies to provide a more comprehensive understanding of emotion regulation within families affected by trauma.

Another limitation is that we asked parents to report on only one child, which may have introduced bias. While this approach allowed us to capture clinically relevant variance, it may have biased our findings. Additionally, we did not assess whether multiple participants came from the same household (e.g., spouses or coparents), which may have introduced non-independence into the data that was not accounted for in our analyses. Although a sensitivity analysis using only female participants yielded consistent results, future research should explicitly address this potential source of bias.

Finally, the results indicate that even in our sample with parents from relatively high socioeconomic backgrounds, levels of PTSD symptoms were elevated to the point of negatively affecting children's mental health. It remains unclear, however, whether families facing greater adversity and lower socioeconomic status might experience even more pronounced difficulties, or whether adaptive IER would be equally effective under such circumstances. Future research should therefore include more socioeconomically diverse populations to clarify these possibilities and enhance the external validity of the findings.

## Conclusion

The findings of this study emphasize the critical protective role of adaptive IER in supporting children exposed to traumatic events, particularly in families where a parent experiences PTSD symptoms. Our results suggest that when parents engage in adaptive IER, this moderates the association between their PTSD symptoms and their child's behavioral and emotional difficulties. This underscores the importance of equipping parents with skills to provide emotional support, fostering a more resilient environment for children facing adversity. Supporting parents' use of adaptive IER strategies can be a powerful tool for mitigating the negative impacts of trauma on their children. While professional interventions are essential, parents' ability to model and support emotion regulation in everyday interactions provides accessible, ongoing support for children. Finally, integrating IER techniques into parenting programs for trauma-exposed parents may significantly enhance children's emotional well-being, particularly in high-stress contexts such as war.

**Author Contribution** Study design: MK, NC, DL, RGP, JB; data collection: MK; data analysis: MK; investigation: MK; and manuscript preparation: MK, NC, DL, RGP, JB. All authors reviewed the manuscript, tables, and figures.

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**Data Availability** The datasets and the questionnaires of the current study are available in OSF: <https://doi.org/10.17605/OSF.IO/QNMEC>.

## Declarations

**Ethics Approval** This study was approved by the IRB committee of the Faculty of Education, University of Haifa (IRB approval 383/23).

**Conflict of interest** The authors declare no competing interests.

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