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CHAPTER 29

Child–Parent Psychotherapy

A Trauma-Informed Treatment for Young Children and Their Caregivers

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Alicia F. Lieberman
Miriam Hernandez Dimmler
Chandra Michiko Ghosh Ippen

*C*hild–parent psychotherapy (CPP) is a relationship-based treatment for infants, toddlers, and preschoolers who are experiencing mental health problems or are at risk for such disturbances due to exposure to traumatic events, environmental adversities, parental mental illness, maladaptive parenting practices, and/or discordant parent–child temperamental styles. The overarching goal of treatment is to help parents create physical and emotional safety for the child and the family. This goal of physical and psychological safety is pursued through therapeutic strategies designed to promote an age-appropriate, goal-corrected partnership between parent and child (Bowlby, 1969), in which parents become the child's protectors and guides in striving toward three components of early mental health: developmentally expectable emotional regulation, safe and rewarding relationships, and joyful engagement in exploration and learning. In situations of danger to physical well-being as a result of domestic violence, maltreatment, or community violence, CPP endeavors to create a safe caregiving context by fostering the parents' and child's realistic appraisal of danger and promoting safe caregiving practices as vehicles to increase the child's trust in the parents' availability and competence as protectors. More concretely, CPP targets for change dangerous environmental and family circumstances; symptoms of mental health conditions that impair the parent–child relationship, such as depression, anxiety, and posttraumatic stress; and frightening or maladaptive parent and child behaviors, including externalizing problems (e.g., excessive controllingness, punitiveness, self-endangerment and aggression) and internalizing problems, such as emotional constriction and social withdrawal (Lieberman, Ghosh Ippen, & Van Horn, 2015).

Reality and Internalization in the Child–Parent Relationship

The cornerstone of CPP is Bowlby's premise that reality matters, and that the parents' availability and competence as protectors from danger are key ingredients in fostering young children's secure attachments (Bowlby, 1969). Attachment theory placed the function of children's attachment and parents' caregiving behaviors in the evolutionary context of protection from predators and emphasized the role of environmental threats not ameliorated by access to a safe caregiver as an etiological factor in children's mental health disturbances (Bowlby, 1988). Since the influential move of attachment research from the level of behavioral observation to the level of internal representation starting in the 1980s (Main, Kaplan, & Cassidy, 1985), there has been a growing interest

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in the intergenerational transmission of anxious and disorganized patterns of attachment and a concomitant decrease in attention to the child's exposure to real-life dangers as an etiological factor in attachment disturbances and mental health disorders in infancy and early childhood (Lieberman, 2004).

CPP is based on the premise that given the well-documented high level of young children's exposure to traumatic events such as accidental injury and interpersonal and community violence (Lieberman, Chu, Van Horn, & Harris, 2011), it is essential to incorporate the identification of exposure to frightening and dangerous events and its impact on the child's emotional life as an integral component of therapeutic interventions in infancy and early childhood (Lieberman et al., 2015). CPP helps parent and child discover and address sources of danger and fear, practice safe and enjoyable ways of acting and relating, and internalize perceptions of themselves and each other as worthy and capable of love and protection. These goals are pursued through *joint child–parent sessions,* in which the CPP therapist uses spontaneous behaviors, interactions, and free play as ports of entry to translate the meaning of the child's behavior for the parent and to facilitate the child's age-appropriate understanding of the parent's motives.

Assessing Real-Life Circumstances and Their Impact

The Assessment and Engagement Phase

It is widely known that young children are profoundly affected by their environmental circumstances and most specifically by what happened to them and to their parents. Exposure to trauma and adversity may affect children, parents, and their relationship through different transactional processes that have been comprehensively elucidated in the relational perspective on posttraumatic stress disorder (PTSD) proposed by Scheeringa, Zeanah, Myers, and Putnam (2003). Nevertheless, this understanding is not regularly translated into systematic screening and assessment of risk factors, trauma exposure, and protective factors when a young child is referred for mental health treatment, with far-reaching consequences for inaccurate diagnosis and inappropriate treatment when trauma is not uncovered as a possible etiological factor in the child's symptom picture (Crusto et al., 2010). Bowlby was emphatic about the pathogenic consequences of "knowing what you are not supposed to know and feeling what you are not supposed to feel" as children's defensive strategies against the dangers of knowing and showing how they feel about frightening family events take the form of dissociation, aggression, depression, and other maladaptive responses (Bowlby, 1988, p. 99). CPP emphasizes the importance of an open and supportive attitude toward knowing and exploring the impact of trauma as a core therapeutic strategy shared by most trauma-informed treatment approaches to help traumatized individuals put their trauma experience in context, normalize their experience, differentiate between remembering and reliving the traumatic event, and restore healthy engagement with developmental goals (Marmar, Foy, Kagan, & Pynoos, 1993).

CPP starts with a four- to six-session assessment and engagement period. This introductory stage constitutes the *foundational phase* of treatment and includes individual sessions with the parent, with the goal of co-creating a treatment plan based on a shared understanding of the child's needs. All effective treatment depends on the client's motivation to collaborate in treatment, and the goal of the CPP foundational phase is gathering and framing information to create a collaborative relationship with the parent on behalf of the child. Information gathering includes the presenting problem, background of the referral to treatment, demographic information, child's developmental timetable and individual differences, and risk and protective factors in the family constellation. The parent is asked about specific traumatic and stressful events in the child's life, and in the life of each of the child's primary caregivers.

Throughout the foundational phase, the therapist balances information gathering with respect for the caregivers' sense of timing in self-disclosure, but conveys a consistent message that the questions are geared toward creating a treatment plan by understanding how the real-life circumstances of the family may influence the child's emotional states and behavior, as well as the parents' self-perception, emotional well-being, and parenting practices. A recurrent concern raised by clinicians who are first learning about CPP is that speaking with the parent and the child about traumatic events early in treatment may be detrimental to the formation of a therapeutic alliance. This concern has been disconfirmed by many years of practice. CPP outcome research has found that therapeutic

engagement and progress are facilitated when treatment incorporates open acknowledgment of real-life conditions that affect children's and parents' emotional states. Parents and children consistently respond with relief to the clinician's message that the frightening events that happened to them are influencing how they feel and behave, and that treatment can help change the behaviors that are interfering with their sense of well-being and trust in relationships. Putting traumatic events in the larger context of the parents' and child's life-affirming goals and conveying a message of hope and possibility are the core goals of the foundational phase and guide every aspect of treatment. For these reasons, therapist comfort and skill in addressing traumatic events is a core CPP competency.

Clinical considerations are primary in guiding how the foundational phase is conducted. The therapist consciously cultivates an empathic stance and active expressions of emotional support in response to parental disclosures and engages the parent in thinking how the emerging understanding might inform the co-creation of a treatment plan. The therapist consistently weaves into the sessions the rationale for joint parent–child sessions and explores the role of parental individual and cultural childrearing values and practices, including attitudes regarding trauma disclosure. Although there are many individual variations, the basic structure of the foundational phase includes the suggested topics described below.

- *Session 1*: Obtaining informed consent; explaining confidentiality; describing the legal requirements to report maltreatment and how the agency handles these requirements; learning about the reasons for seeking treatment, including whenever relevant, an exploration of different perceptions and motivations in the parent(s) and other involved parties, such as the child welfare system; demographic information; child developmental history; child symptoms; and parental understanding of child symptoms and efforts to address the symptoms.
- *Session 2*: Observation of the parent and child during structured and/or free-play situations; observation of the child in interaction with the therapist or another assessor during structured and/or free-play situation; assessment of the child's developmental functioning using structured tools or clinical observation; assessment of the child's functioning in alternative settings or with other caregivers (e.g.,

child care), either through direct observation, interview, or structured questionnaire.
- *Session 3*: Assessment of child exposure to traumatic events, preferably using a structured instrument such as the Traumatic Events Screening Interview—Parent Report Revised (TESI-PRR; Ghosh Ippen et al., 2002).
- *Session 4*: Assessment of the parent(s) trauma history, preferably using a structured instrument; assessment of parent(s) depression and PTSD symptoms.
- *Session 5*: Feedback.

The foundational phase culminates in an individual session with the parent(s) to co-create a treatment formulation and treatment plan. The clinician elicits the parents' experience of the assessment, focusing on how they felt and what they learned about themselves and their child, and building on the parents' description to explain the clinician's own perceptions and recommendations. Although the therapist provided preliminary therapeutic interventions—including psychoeducation and trial insight-oriented interpretations—throughout the foundational phase, the feedback session offers the opportunity to present a coherent formulation of the clinician's understanding of the child's mental health needs in the context of the parents' own individual needs and family circumstances. The feedback culminates in the creation of "the formulation triangle," in which the therapist succinctly links the proposed core etiological factors to the child's symptoms and explains how treatment will address these key causal connections (see Figure 29.1). If the parents' own trauma history and mental health disturbances are an important etiological factor in the child's functioning, the therapist proposes a "parents' formulation triangle," in which the parents' pathogenic experiences are linked to their current individual functioning, perception of the child, and parenting practices. The parents' experience is then linked to the child's experience. When the parents agree with the proposed formulations, the next step involves a conversation with the parents about how the child will be introduced to treatment, taking into account the child's developmental stage, individual differences, and capabilities. When the parents do not agree with the proposed formulation, the therapist engages the parents in a conversation that leads to a consensus about next steps.

Core CPP Treatment

The feedback session marks the formal end of the foundational phase and the beginning of the core treatment, which is based on an agreed-upon explanation between parent(s) and therapist about how to understand the child's difficulties, what presenting problems to focus on, how to introduce treatment to the child, and how the parent(s) will participate in the joint sessions.

The First Treatment Session: Introducing the Child to CPP

The first session builds on the feedback session by introducing the formulation triangle to the child using words and actions that are geared to the child's developmental stage. The parent is asked to explain treatment to the child whenever possible, but many parents find themselves at a loss for words even after agreeing to do so during the feedback session. In those situations, the therapist takes the initiative in describing the triangle of explanations to the child, asking for the parent's participation as clinically indicated (see Figure 29.1).

Treatment Considerations

Child's Developmental Stage

The child's developmental stage is incorporated into the clinical case formulation, and ongoing observations are used during treatment to align therapeutic objectives to the child's changing developmental needs. The safety and emotional quality of the child–parent relationship is the unifying clinical theme across the birth–5 years age range encompassed by CPP. For this reason, the term "child–parent psychotherapy" represents an overarching construct that encompasses the age-specific labels of "infant–parent psychotherapy" (Fraiberg, 1980; Lieberman, Silverman, & Pawl, 2000), "toddler–parent psychotherapy" (Cicchetti, Toth, & Rogosch, 1999; Lieberman, 1992), and "preschooler–parent psychotherapy" (Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002). With preverbal, prelocomotive infants and their parents, CPP relies more extensively than treatment at later ages on the therapeutic techniques first described by Fraiberg (1980) to elucidate how real-life circumstances and the parents' psychological difficulties affect their capacity to cherish, nurture, and protect the infant. As the growing child becomes an increasingly more active participant in the sessions, the therapeutic focus moves from an exploration of the parents' subjective experiences to addressing the mutual parent–child perceptions, attributions, and emotional demands of the present moment. When the child is able to use language and symbolic play to articulate feelings, the child's understanding of external circumstances and his or her inner world moves to center stage during the sessions, and the parents' individual subjective
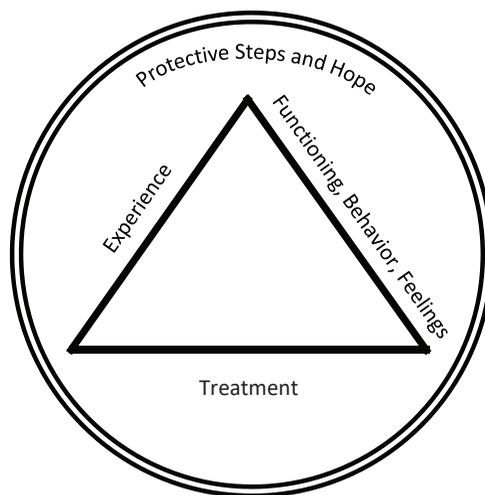

FIGURE 29.1. The formulation triangle: introducing the child to CPP. From Lieberman and Ghosh Ippen (2014).

experiences are incorporated as an adjunct to the intervention rather than as a discrete focus of attention.

The CPP developmental framework incorporates the normative developmental anxieties first identified by Freud (1959) and repeatedly elaborated in subsequent decades (see, e.g., Brenner, 1976; Marans, 2005; Pynoos, Steinberg, & Wraith, 1995)—namely, fear of separation and loss, fear of losing the parents' love, fear of body damage, and fear of not living up to the expectations of one's social group. Trauma and environmental adversities consistently exacerbate the intensity and pervasiveness of these normative anxieties and give them a firm basis in external reality. The persistence of these early anxieties in the parents' emotional responses as adults is often overlooked by clinicians who are not attuned to the nature and adaptive function of the normative fears of early childhood. Children manifest these fears through behaviors that often befuddle parents and evoke rejecting or punitive responses, including inconsolable bouts of crying, prolonged tantrums, adamant refusals to comply, self-endangering behavior, hitting, biting, and other forms of aggression. Many of the seemingly incomprehensible behaviors of infants and young children become not only understandable but also compellingly eloquent when understood in the context of specific situations or larger life circumstances that trigger or exacerbate these fears. Reciprocally, many parental responses that are frightening to their children and evoke critical judgment on the therapist's part are rooted in the parent's often unconscious fear of loss, rejection, body damage, and self-loathing. CPP therapists endeavor to reach a simultaneous understanding of the child's and the parent's emotional experiences as adaptations to these universal fears.

The following guidelines are used to expand parents' understanding and empathy for their children's experience and to guide their search for an emotionally contingent and developmentally appropriate response (Lieberman & Van Horn, 2008).

1. Young children cry and cling in order to communicate an immediate need for parental proximity and care.
2. Separation distress is an expression of the child's fear of losing the parent.
3. Young children want to please their parents and fear their disapproval.
4. Young children are afraid of being hurt and of losing parts of their bodies.
5. Young children imitate their parents' behavior because they want to be like them and assume that the parent's behavior is a model to emulate.
6. Young children feel responsible and blame themselves when the parent is angry or upset for whatever reason.
7. Young children harbor a conviction that parents know everything and are always right.
8. Young children need clear and consistent limits to their dangerous or culturally inappropriate behaviors in order to feel safe and protected.
9. Young children used the word "no" to establish and practice their autonomy.
10. Memory starts at birth. Babies and young children remember experiences before they can speak about them.
11. Young children need their parents' help and support in learning to express strong emotions without hurting themselves or others.
12. Child–parent conflicts are inevitable due to their different developmental needs, but they can be resolved in ways that promote trust and support development.

These developmental guidelines are the backdrop for CPP interventions. CPP therapists use them to guide their choice of interventions and may describe a guideline to the parent as a way of expanding parental understanding of child development. The guidelines can also be translated into language that is understandable to young children and used to facilitate the creation of a shared emotional agenda between parent and child. This is done, for example, when the therapist speaks for the child in the child's presence, in order to help the parent understand the child's experience.

Parents' Developmental Stage

Development is a lifelong process, and the parents' developmental stage is also incorporated into the treatment formulation. Parents' ability to integrate the parenting role into their sense of themselves is influenced by the extent to which they have attained the normative developmental milestones that precede parenthood, including a cohesive sense of self, mature intimacy in adult relationships, and satisfying engagement with everyday activities. The developmental

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guidelines described earlier are weaved into the intervention as ways of promoting not only the parent's understanding of the child but also the parent's increasing self-understanding, both as an adult and in the past, while growing up.

The ability to function adequately in adult roles is an important component of the parent's ability to nurture, protect, and socialize the child. Adverse life circumstances, traumatic stressors, and mental health problems are recurrent obstacles to adaptive parenting because these factors have a direct impact on the child's moment-to-moment experience, and because they distort the parent's ability to notice, interpret, and respond to the child's needs. The focus of treatment may expand or shift as needed in response to urgent material need or family crises in order to bolster the parents' functioning in their roles as providers and partners in adult relationships. When the parents' emotional needs are urgent and immediate, the CPP therapist resorts to a range of interventions to maintain or restore their capacity to attend to the child's experience. These interventions include dividing the therapist's focus of attention between the child's and the parents' individual needs, adding parallel individual sessions with the parents, telephone conversations focused on the parents' experience, and referral for individual or group psychotherapy when clinically indicated.

Child-Centered Focus

A hallmark of CPP is the child's presence in the session. Nevertheless, even when not physically present, the child is maintained as the organizing focus of the intervention in the mind of the CPP therapist. Individual sessions with the parent aim at helping the parents function more effectively as adults for the sake of the child, which includes becoming increasingly attuned to responses and feelings mobilized by their parenting role, and to the impact of their behavior and psychological states on the child (Lieberman & Van Horn, 2005).

The Role of Play

Play is the form of communication that most richly conveys young children's efforts to make meaning from their experiences. Through play, children express their understanding of their external circumstances, enact their fears and wishes, explore their internal world, and

rehearse a range of outcomes in an effort to achieve mastery over their reality (Erikson, 1964). Children's use of play to enact anxiety-provoking experiences, to express wishful fantasies, to symbolize and even to avoid emotionally charged themes makes playing a natural vehicle for therapeutic intervention. Like other child psychotherapies, CPP encourages play. CPP differs from other approaches in viewing play as not only as an individual child endeavor but also an opportunity to help the child and the parent to *play together* because joint play can become the vehicle to co-create trauma narratives and protective narratives that address the relevant emotional issues confronting them. In addition to this therapeutic function, play is also used in CPP as an opportunity for the child and parent to be together and enjoy the pleasures of mutuality and discovery, as illustrated in Slade's (1994) concept of "simply playing."

Theoretical Influences

CPP carries the imprint of its psychoanalytic origins in infant–parent psychotherapy, which became identified with the well known metaphor "ghosts in the nursery" (Fraiberg, Adelson, & Shapiro, 1975). This expression is used to describe the intergenerational transmission of psychopathology through the parents' re-enactment with their baby of unresolved conflicts from their own childhood. The lasting imprint of the "ghosts in the nursery" model is manifested in CPP's attention to the parent's and child's ongoing efforts to adapt to the characteristics of (1) their environment, (2) the psychological and relational origins of current mental health problems, and (3) the parent's and child's deployment of coping strategies and unconscious defense mechanisms for the purpose of self-protection against intolerable internal emotional states and external dangers. These premises, defined by Rapaport and Gil (1959) as the adaptive, genetic, and structural assumptions in the metapsychology of psychoanalysis, were also adopted by Bowlby (1969) as integral components of attachment theory.

In addition, CPP incorporates the points of view advanced in attachment theory that (1) the human infant is biologically predisposed to form an affective bond with the mother figure; (2) frightening experiences with attachment figures, as well as separation from and loss of

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attachment figures, are pathogenic events with long-term repercussions on personality structure; (3) maternal and paternal sensitivity to the infant's signals promote healthy adaptation; (4) observation of child behavior in ecologically representative environments is the bedrock for the understanding the etiology of early psychopathology; and (5) a prospective approach is essential to understanding the relationship between risk factors and their manifestations in the course of development (Ainsworth, Blehar, Waters, & Wall, 1979; Bowlby, 1969).

In addition to psychoanalytic and attachment theory, CPP encompasses other theoretical perspectives as well. Developmental psychopathology contributes an understanding of developmental outcomes that is informed by the inclusion of biological, psychological, social, and cultural levels of analysis and attention to the transactional processes among risk and protective factors within and between these domains (Cicchetti & Sroufe, 2000). Theory and clinical strategies from the field of adult and child trauma are incorporated when the child and/or the parents have experienced traumatic events (Pynoos, Steinberg, & Piacentini, 1999; van der Kolk, 1987). The influence of a cross-disciplinary, integrative perspective is also manifested in CPP's use of principles from cognitive-behavioral therapy (CBT) that aim at guiding cognitive change as a port of entry to effect affective and behavioral change (Cohen, Mannarino, & Deblinger, 2006), and principles from social learning theory about the transmission of coercive family patterns through imitation and learning of family roles (Patterson, 1982).

The philosophical outlook encompassing these different perspectives is the conviction that hope and positive engagement with the activities of living are the primary ingredients of any successful therapeutic endeavor. A new model of "angels in the nursery" has been incorporated into CPP as a necessary counterbalance to the "ghosts in the nursery" focus on unresolved conflict and psychopathology (Lieberman, Padrón, Van Horn, & Harris, 2005). The pain, anger, and despair generated by adverse relationships and life circumstances in the past and the present need to be countered with an affirmation that change for the better is possible, and that benevolent old memories can be retrieved from the past or new supportive memories can be created in the present to stand as "angels in the nursery" that will guard over the child's and the parents' well-being.

Intervention Modalities

CPP makes use of a variety of intervention modalities in response to different clinical needs (Lieberman & Van Horn, 2005). The unifying threads across modalities are the goal of promoting healthy development in the child and the parent, and the simultaneous attention to the child's and the parent's experiences for the purpose of supporting their relationship. The cross-disciplinary nature of CPP is reflected in the use of modalities informed by social work, along with modalities based on developmental psychology, psychoanalytic/attachment theory, trauma, social learning theory, and CBT. Several of these modalities were first described by Fraiberg (1980) as components of infant–parent psychotherapy.

Translating Behavioral Meanings Using Play, Physical Contact, and Language

Many problems in the child–parent relationship involve misunderstandings or distortions in the meaning that parent and child give to each other's behavior. This is a particularly salient problem when trauma exposure has a negative impact on the developmentally appropriate perceptions that parent and child have of each other. In response to trauma, children might develop a conviction—which may be accurate or distorted by their cognitive immaturity—that the parent is the agent of the traumatic event, the parent willfully failed to protect, or the child precipitated the traumatic behavior through bad behavior. CPP aims to clarify and correct inaccurate or maladaptive attributions by describing the motives and function of specific child behaviors to highlight how the behavior is an effort to cope with the normative anxieties of infancy and early childhood. As the child becomes increasingly attuned to parental motives in the course of development, the intervention also involves age-appropriate explanations of the parent's point of view. Putting feelings into words, play, and physical contact are used as vehicles to build up trust and expand empathic understanding.

To set the stage for the intervention, the therapist provides toys that are chosen according to the child's developmental stage and the goals of treatment, including toys that evoke relationship themes (a family of dolls that match the child's and family's ethnicity; farm animals; wild animals); toys that promote nurturing

and self-care (kitchen and eating utensils, toy food); materials that promote artistic expression (paper and crayons); toys that reflect the specific stressors endured by the child (police cars, ambulance); and toys that promote the theme of healing (medical kit). The selection of toys may change in the course of treatment as some themes are outgrown and new themes emerge. CPP encourages play between *the parent and the child,* with the clinician taking the role of encouraging play, participating as requested by the child, and serving as a translator of the play to clarify its meaning in ways that enlarge understanding and provide support for the child and the parent.

Putting feelings into words is systematically pursued as an avenue to help children understand and manage intense emotion. Strong feelings are always felt, first and foremost, through bodily sensations, and young children's need to translate these body sensations into words is an important building block in the ability to regulate affect. Describing in words what the child is experiencing helps to correct mutual misperceptions and misattributions. The parents' own emotional regulation improves when they participate in a therapeutic process in which putting feelings into words is an explicit focus of the intervention.

The role of touch and affection is woven into the intervention because physical contact is an important vehicle for building trust and conveying love between parent and child. When the child is frightened or upset and the parent does not intervene, for example, the clinician may first describe what the child is feeling, then speak about the reassuring power of picking up and holding a frightened child or letting the child sit on the parent's lap.

Unstructured Reflective Developmental Guidance

The developmental guidelines listed earlier are an example of the kinds of intervention employed in this modality. CPP developmental guidance is unstructured because it responds to the needs of the moment rather than following a prescribed curriculum, and it is reflective because it encourages the parent to integrate thinking and feeling into a new a more empathic understanding of development (Fonagy & Target, 2002). Developmental guidance also may incorporate reframing, empathy, and appropriate limit setting in response to the child's behavior. Toddlers and preschoolers also can profit from developmental guidance that is tailored to their cognitive and emotional resources because they are reassured by learning that other children also feel the way they do. Developmental guidance is not restricted to information about normal development. In the aftermath of stressful or traumatic events, providing psychoeducation about expectable responses can be extremely helpful both to the parent and, to the extent that it is age-appropriate, to the child because it normalizes their reactions and makes them feel understood and accepted.

Modeling Appropriate Protective Behavior

In this modality, the therapist takes action to stop dangerous or self-destructive behavior. Modeling protective action is particularly relevant to parents and children whose perceptions of danger and safety are unrealistic or distorted as the result of repeated exposure to family or community violence, or other traumatic experiences. Young children's ability to appraise danger is undermined when their own attachment figures become the agents of fear. When this happens, the therapist's protective actions are not only important in providing safety but also represent a commitment to help the parents learn or relearn how to protect their child.

Insight-Oriented Interpretation

This modality is used to clarify the unconscious or symbolic meaning of behavior in ways that increase self-understanding. Interpretation can be used with parents and with children capable of receptive language. Well-timed interpretations can help parents become aware of motives, negative attributions, and behaviors that interfere with their ability to nurture and protect their children. However, the therapist must exercise good clinical judgment in deciding whether offering an interpretation in the presence of the child may violate the parent's privacy. Interpretations can also help young children who blame themselves for the traumatic event(s) or for their parents' problems, by promoting a more accurate understanding of causality and of their own role in the family.

Addressing Traumatic Reminders

When the child is referred for treatment following a traumatic event, series of traumatic events,

or dangerous current circumstances, treatment must address traumatic play and other manifestations of traumatic stress by enabling the child to narrate the traumatic event through play, drawings, or verbal description, and by providing relaxation and reassurance experiences to address somatic reexperiencing and behavioral reenactments. Many events traumatize the child and the parent simultaneously, such as car accidents, community violence, and domestic violence. The parent also may experience vicarious trauma from witnessing what happened to the child, for example, when the child is abused by the other parent or attacked by a dog. Treatment in these cases needs to address the impact of the trauma on the parents as well, including appropriate referrals when necessary.

Retrieving Benevolent Memories

Just as it is important to identify and address traumatic cues, it is also therapeutic to bring to conscious awareness what William Harris (personal communication, February 2004) called "beneficial cues"—moments of well-being that bolster self-worth because they serve as reminders of experiences of being supported and cherished. Linking the past and the present is as important with benevolent experiences as with conflict-laden memories. Remembering episodes of loving care can give parents the impetus to provide such experiences to the child. When these benevolent memories are not available, the treatment must provide a setting for the creation of new memories that offer a sense of trust, pleasure, and self-worth.

Emotional Support

The therapist's emotional availability is a core component of all psychotherapies. It takes the forms of conveying, through words and action, a realistic hope that (1) the treatment goals can be achieved, (2) there may be sharing in the satisfaction of achieving personal goals and developmental milestones, (3) there may be help in maintaining effective coping strategies, (4) progress will be pointed out, (5) self-expression will be encouraged, (6) and reality testing will be supported (Luborsky, 1984; Wallerstein, 1986). In CPP, this stance on the part of the therapist has the additional goal of modeling for the parent and for the child ways of being with one another. Emotional support is particularly important in the treatment of parents and children whose sense of themselves is under assault by due to the hardships of poverty and discrimination. In these situations, emotional support becomes an end in itself, as well as a therapeutic tool because it affirms the parents' and the child's right to dignity and respect, and aims at increasing their self-worth as members of society.

Crisis Intervention, Case Management, and Concrete Assistance

Parents facing acute problems of living can become more receptive to mental health treatment when the therapist is actively involved in alleviating their negative life circumstances. These activities may include advocacy with different agencies, consultation with the child care provider to prevent expulsion of the child for inappropriate behavior, mediation between the parent and Child Protective Services if questions of abuse or neglect arise, or referral to other needed services. Crisis intervention is often the first intervention offered when the child is referred following a traumatic situation, such as maltreatment, community violence, or an accident. Ensuring safety is the first order of business in these circumstances, and concrete interventions can give the beleaguered parents a sense that change for the better may be possible as the result of treatment.

Selecting Ports of Entry for Therapeutic Interventions

Choosing what to address during a session can be daunting in joint child–parent sessions because the therapist may often be confused by the multiple stimuli that demand his or her attention. In CPP, the concept of "ports of entry"—developed by Stern (1995)—is adapted to refer to the variety of elements in the parent–child relationship system that may be used as the starting point for an intervention (Lieberman & Van Horn, 2005). Because CPP targets negative attributions and maladaptive parent and child behaviors, the therapist must choose ports of entry on the basis of clinical judgment of what needs attention in the moment. One port might be chosen because the moment is charged with emotional meaning; another might be selected because it has important long-term implications for the child's or the parent's mental health. Once an initial port of entry is chosen, other points of entry can open up in quick suc-

cession (although sometimes efforts to pursue a port of entry may seem to lead nowhere). Examples of different ports of entry as opportunities for intervention are provided below.

Child and/or Parent Individual Behavior

During a home visit that took place in the kitchen, a 3-week-old baby was crying loudly as his mother, still hurting from a C-section and exhausted by sleepless nights, was describing her anger at her obstetrician, who insisted on the C-section in spite of the mother's entreaty to wait. The therapist made a sympathetic comment about the fear and pain that the mother went through, then said, using the child's behavior as an initial portal of entry: "He is crying so hard! He seems to be saying that he also had a hard time." The mother replied angrily: "He thinks he had a hard time! He didn't even push well enough to be born normally!" Taken aback by the mother's blaming of the baby, the therapist turned her attention to the mother's experience and said, "You sound so disappointed with him!" The mother burst into tears, and for a while mother and baby cried simultaneously. The therapist felt torn between her impulse to pick up the baby, her anger at the mother for having a distorted perception of the child, and pity for the mother's despair.

After a silence, during which she struggled to sort out what would be the most helpful intervention, the therapist allied herself with the mother's experience as a bridge to build empathy for the baby, and said softly, "These first weeks can be so exhausting, and you are still hurting from the incision. Can I do something to help you right now?" The mother and the baby continued crying. The therapist went to the kitchen sink, poured a glass of water, and brought it to the mother. The mother drank the water and thanked the therapist with a weak voice.

The therapist asked, "Would you like me to see if I can soothe the baby? You look so tired right now." The mother nodded wordlessly. The therapist picked up and rocked the baby, humming softly. As the baby's crying subsided, she said to the baby, "Your mom did not want to have a C-section. She wanted you to be born naturally." The mother looked coldly at the baby. The therapist continued talking to the baby: "She was hoping that you would be stronger and would push more, but you were too little and did not know how to do it. You

tried and tried, but you couldn't do it." The mother's face softened and she looked very sad. She said in a whisper, "The doctor told me that my contractions were not strong enough." The therapist said gently, "Both of you tried so hard." The mother cried again, and the therapist asked what she was feeling. The mother replied, "I feel like a failure." The therapist said, "I know you are very sad and upset right now. But you are not a failure. You gave birth to a healthy and beautiful baby." The mother said in a surprised tone, as if the thought had not occurred to her, "I did, didn't I?" The therapist smiled at her and said, "You sure did!" She then nuzzled the baby's head and added, "And he smells so good."

The conversation shifted to baby shampoo and the pleasure of the baby's father in giving him a bath. The therapist talked about the hormonal changes that the mother was undergoing, and the impact of these changes on her mood, and said lightly that the body takes a while to adjust. By the end of the session, the mother's mood was considerably brighter.

In this example, the therapist used the child's and the mother's individual behavior as ports of entry into the meaning of their respective experiences. By speaking to the baby's earnest but unsuccessful efforts to be born vaginally, the therapist facilitated a reframe of the mother's negative attributions to the baby and enabled her to acknowledge her own sense of failure at not having sufficiently strong contractions to prevent the C-section. The therapist also normalized the mother's feelings by providing developmental guidance about the hormonal changes she was going through. The combination of these interventions with concrete helpfulness in offering water and soothing the baby led to a more positive frame of mind on the mother's part by the end of the session.

Interactive Exchanges between Parent and Child

Three-year-old Sam pushed his 18-month-old brother when the toddler swiped at the tower of the blocks Sam was building and made it fall. The little boy fell on the floor and started crying frantically. His mother picked him up while screaming at Sam: "You are a murderer! You will kill him!" Sam started crying loudly, but his mother ignored him while consoling the younger son. The therapist turned to Sam and said, "Your mommy got mad when you hit

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Manny, but you were mad because Manny hit your tower and made it fall down." She started rebuilding the tower, and invited the crying Sam: "Let's put it back together again." Sam's crying subsided and he joined the therapist in rebuilding the tower.

While engaged in this activity, the therapist turned to the mother and asked, "What did you mean when you told Sam that he is a murderer?" The mother, still angry, answered that Sam was aggressive toward Manny and she feared that he would seriously hurt his brother someday. The therapist suppressed her wish to contradict the mother directly by telling her that this was an unrealistic fear. Instead, she made herself remember that this was a mother with a long history of childhood abuse and domestic violence with the children's father. She answered, "I agree with you that Sam needs to learn not to hit Manny. What have you tried to teach him not to hit?" The mother shrugged her shoulders and said, "I tell him 'no,' but he doesn't listen." Turning to Sam, the therapist said, "Your mom doesn't like it when you hit Manny. She wants to teach you not to hit because hitting hurts." Sam continued building the tower and did not respond. The mother screamed, "Listen to what she is saying!" The therapist said, speaking to both mother and child, "Learning not to hit is very hard and takes a long time. Even grownups are still learning." The mother's body relaxed, and sensing that she was less angry and more receptive, the therapist said to her, "I think anytime you see any kind of hitting you get scared that it will get out of control because of everything that you went through." This statement opened the door for a discussion of the mother's fear of Sam's anger.

Relieved that the mother could identify the fear underlying her anger at the child, the therapist moved to make the mother more aware of her attribution to Sam of adult-like destructive aggression. She said, "Maybe you see Sam as bigger and stronger than he actually is, and forget that he is also a scared little boy trying to protect himself. I think Sam also thinks that Manny is bigger and stronger than he actually is." The mother listened attentively. The therapist then turned to Sam and said, "Hitting is too scary. Your mom remembers how scary it was when your daddy hit. She wants to keep you and Manny safe."

In this session, which occurred 2 months into treatment, the therapist used the mother's perception of Sam as a murderer as a port of entry to start exploring the themes of aggression and victimization that were prevalent in this family. The therapist was careful not to address the mother's perception of Sam as a murderer directly because the mother was still unsure about the value of treatment and became easily defensive when she felt criticized. The therapist affirmed instead the mother's appropriate desire to teach Sam not to hit, using this shared goal as a platform to explore the larger themes of danger and of appropriate and hurtful responses to danger. The therapist also dared to name the lingering fear of the father's aggression as a possible model for Sam's behavior—a theme that had been described in the formulation triangle both during the feedback session and during Sam's first treatment session with his mother.

Child Mental Representations of the Self and the Parent: Mobilizing Protection

A 2½-year-old boy was trying unsuccessfully to put a block into a shape container. He suddenly banged his head against the wall. His mother laughed and said, "Don't do that." The boy hit his head again. The mother said to the therapist, "He is so weird." The therapist addressed both mother and child by speaking to the child: "Your mommy doesn't want you to hit yourself, but I think you are punishing yourself because you couldn't put the shape in the box." The child looked fixedly at the therapist and hit his head again, but this time more slowly. The therapist turned to the mother and said, "I think he needs help to know that it's okay if he can't put the shape in." The mother said, "He's weird," but then she turned to the child and said, "Come here, baby." The child went to her and the mother sat him on her lap and put her arms around him. The therapist commented, "All better now." She then brought the shape sorter to mother and child and said, "Now you can try again." This time the mother directed the child on how to put the shape into the container, and the child succeeded in doing so.

The beginning of this scene revealed the intricate connection between this child's mental representation of himself and his perception of how his mother saw him. The mother's dismissal of the child's distress at not succeeding reinforced his sense that he deserved punishment. Instead of treating the mother's use of the word *weird* as an entrenched negative attribution that called for direct intervention, the therapist en-

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couraged instead a concrete maternal response that reassured the child, both by providing reassuring physical contact and by moving on to successful problem solving as a way of dispelling the child's self-perception of having failed and showing him that he could achieve his goal with his mother's help.

Each of the previous examples illustrates a particular way in which the parents and/or the child were conveying a view of themselves or the other that detracted from nurturing, protection, and age-appropriate socialization. The therapists' interventions began with efforts to understand the motives underlying the child and parent perceptions and behavior, framing them in a supportive developmental context. As they unfolded, the interventions moved back and forth between child and parent individual behaviors, feelings, and mental representations of themselves and each other. The choice of ports of entry is extensive because relationships affect relationships, and these influences are expressed in a multiplicity of ways that open up many possibilities for intervention (Emde, Everhart, & Wise, 2004; Lieberman & Van Horn, 2005; Sameroff & Emde, 1989). The specific port of entry may be determined by factors such as the psychotherapist's theoretical preferences; the parent's cultural mores, educational level, and temperamental style; the child's temperamental style and ability to symbolize; the quality of the working relationship between the parent and the therapist; and the urgency of the clinical issues involved.

Some parents are willing to reflect on the child's thoughts and feelings but become guarded or angry when the therapist addresses their parenting practices. Other parents want to focus on their own situation and fend off efforts to include the child's experience in the treatment. For these reasons, there are no "typical" CPP cases, and therapeutic strategies are tailored to the specific characteristics of the child and the parents. In general, the match between the therapist's therapeutic strategies and the parent's and the child's receptiveness is the best predictor of treatment outcome. The timing of questions, suggestions, and interpretations is a crucial element in fostering treatment motivation. The therapist needs to cultivate a careful balance between addressing the relevant clinical issues and remaining tactfully alert to the parent's and child's ability to tolerate and make use of these interventions.

Empirical Evidence

CPP has been accredited as an evidence-based treatment since 2011 by the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based and Promising Practices. CPP efficacy has been empirically documented in five randomized trials with high-risk groups of toddlers and preschoolers. The samples include anxiously attached toddlers of impoverished, unacculturated Latina mothers with trauma histories (Lieberman, Weston, & Pawl, 1991); toddlers of depressed mothers (Cicchetti, Rogosch, & Toth, 2000; Cicchetti et al., 1999); maltreated infants and maltreated preschoolers in the child protection system (Toth et al., 2002; Toth, Rogosch, Manly, & Cicchetti, 2006); toddlers of mothers with clinical depression (Cicchetti et al., 1999); and preschoolers exposed to domestic violence (Lieberman et al., 2005, 2015).

Findings from these randomized controlled trials (RCTs) have demonstrated that this approach results in improvements in a variety of domains, including reduced child and maternal symptoms, more positive child attributions (of parents, themselves, and relationships), improvements in the mother–child relationship and the child's attachment security, and improvements in child cognitive functioning. The five RCTs include more than 500 racially/ethnically diverse children in households ranging from poverty to middle-class backgrounds and populations of maltreated infants, toddlers, and preschoolers in the child welfare system and preschoolers exposed to an average of five traumatic events. Across studies, CPP groups had significantly better outcomes than comparison groups posttreatment and at follow-up 6 months, 1 year, and 9 years later in measures of child cortisol patterns, security of attachment, behavior problems, aggression, PTSD symptoms, comorbid conditions, cognitive performance, maternal avoidance, psychiatric symptoms, and marital satisfaction (e.g., Cicchetti et al., 1999, 2000, 2006; Ghosh Ippen, Harris, Van Horn, & Lieberman, 2011; Lieberman, Ghosh Ippen, & Van Horn, 2006; Lieberman, Weston, & Pawl, 1991; Lieberman, Van Horn, & Ghosh Ippen, 2005; Pickreign Stronach, Toth, Rogosch, & Cicchetti., 2013; Toth et al., 2002).

CPP also has evidence of cost-effectiveness. In one follow-up study with children who had open cases in the child welfare system, pre-

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schoolers in the CPP group had a 2% placement in foster care 1 year posttreatment compared with 21% in the comparison group (J. T. Manly, personal communication, 2016). In an effectiveness study with preschoolers in foster care who received CPP and matched controls who received treatment as usual at the Illinois Department of Child and Family Services, the CPP group had 50% fewer placement changes than the comparison group (Habib et al., 2008). A second effectiveness study at the University of California, San Francisco (UCSF) found that after 20 weeks of CPP, preschoolers and mothers had statistically significant declines in PTSD symptoms, with large effect sizes (0.88–1.20). These findings indicate that significant improvements in children and in mothers are evident with a briefer dosage of CPP than the dosage of approximately 35 sessions used in the RCTs of CPP efficacy. The CPP treatment manual is now in its second edition, with updated fidelity forms (Lieberman et al., 2015). Training materials also include two books with clinical case studies (Lieberman, Compton, Van Horn, & Ippen, 2003; Lieberman & Van Horn, 2008) and the CPP Train the Trainers Manual (Ghosh Ippen, Van Horn, & Lieberman, 2015). CPP therapists receive fidelity measures to input, which are scored using a REDCap database or PDF data entry forms.

Training and Community Dissemination

CPP is disseminated nationally through the Early Trauma Treatment Network, a center of the SAMHSA National Child Traumatic Stress Network (NCTSN) that involves the collaboration of four university-based programs: UCSF Child Trauma Research Program as lead program; Child Witness to Violence at Boston Medical Center (Boston site); Child Violence Exposure Program at Louisiana State University Health Sciences Center; and the Infant Team at Tulane University School of Medicine. The training of clinicians in CPP is conducted within the NCTSN learning collaborative model, which combines didactic teaching with competence training through case-focused consultation for 18 months. Trainings incorporate the areas recommended by the Institute of Medicine and the National Research Council (2015) Transforming the Workforce report (*www.iom.edu/birthtoeight*): (1) foundational

knowledge of early childhood development; (2) specialized trauma knowledge; (3) knowledge and competencies specific to the learners' roles; (4) ongoing practice; (5) evaluation of professional practice; (6) engaging supervisors and key administrators to develop leadership; (7) interdisciplinary training to address intersystem fragmentation; and (8) consultation and support to promote sustainability. In addition to learning collaboratives, CPP is taught through internships and fellowships for master's, doctoral, and postdoctoral students. CPP currently has 55 CPP trainers in 30 states, who maintain peer consultation through listserv exchanges and twice-monthly conference calls for fidelity and cultural and system adaptations. Since 2011, 96 implementation-level CPP trainings were conducted in more than 30 states. International outreach includes implementation-level trainings in Australia, Colombia, Israel, and the Scandinavian countries.

Community outreach is conducted to reach infants and young children in need of mental health services, whose families are unlikely to bring them to a mental health clinic.

Through a model developed at the UCSF Child Trauma Research Program called the Tipping Point Mental Health Initiative, postdoctoral students are placed in community-based agencies to provide onsite CPP and integrate this approach with other services provided in the community agency. CPP supervisors provide clinical supervision to the postdoctoral fellows, as well as technical assistance to the community agency staff, in order to increase efficiency in service delivery. Community agencies participating in the Tipping Point Mental Health Initiative include a primary care clinic, a child care center, and family resource centers.

In summary, CPP is a trauma-informed treatment for young children from birth to age 5 and their families that endeavors to address the internalization of pathogenic life circumstances into maladaptive psychological patterns starting in infancy, with potential lifelong consequences for adult mental health and parenting practices. Through direct service, training, and dissemination activities, CPP practitioners are committed as a group to enhancing the mental health of children and families, with special attention to the needs of underserved minority groups with histories of marginalization and historical trauma as a vehicle to enhance

individual well-being and increase public commitment to redress the impact of adversity on children, families, and communities.

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