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Child-Parent Psychotherapy Training for Mental Health Agencies to Address Symptoms of PTSD in Trauma-Exposed Children in Early Childhood

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Child-Parent Psychotherapy Training for Mental Health Agencies to Address Symptoms of PTSD in Trauma-Exposed Children in Early Childhood

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Abstract

Approaches for working with trauma-exposed populations have been critical in addressing the widespread prevalence and impact of trauma across the lifespan (Young et al., 2011). With early intervention being critical for reducing the impact of posttraumatic stress disorder symptoms persisting throughout the lifespan (Buss et al., 2015), approaches for early childhood populations are essential. One such approach, Child Parent Psychotherapy, has been shown to be one of the most effective approaches for working with trauma-exposed populations under five years old (Lieberman et al., 2015). This literature review and training manual explores the current research and implementation of Child Parent Psychotherapy for clinical mental health counselors. The objective of this training is to provide more information on this empirically supported approach and its implementation to increase the field's awareness of effective approaches for young children exposed to trauma.

Keywords: Child Parent Psychotherapy, posttraumatic stress disorder, early childhood

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Introduction

Trauma has been an important topic of discussion for mental health workers for many years now due to its widespread impact and prevalence (Smith et al., 2019). According to the National Child Traumatic Stress Network (NCTS, n.d.), trauma is defined as exposure to a scary, dangerous, or violent situation that poses a threat to the individual's life or wellbeing. Additionally, a trauma response can develop through secondary exposure to a traumatic event, such as a loved one being threatened (NCTS, n.d.). It is hard to determine what experiences may be traumatic for each unique individual, however, some examples of traumatic experiences include exposure to abuse (physical, sexual, psychological, or neglect), exposure to natural disasters, exposure to violence (family or community), exposure to bullying, exposure to sudden loss of a loved one, exposure to war, or serious accidents or life-threatening illnesses (NCTS, n.d.).

With our view of trauma expanding in more recent years, implementing trauma-focused interventions and approaches for counselors is essential. Children ages 0-6 are at high risk for exposure to trauma due to their dependence on parents and caregivers, having limited coping skills, and their developmental level (Buss et al., 2015; Young et al., 2011). Due to the fact that post-traumatic stress can continue to have a chronic impact on adults into the future, addressing the effects of trauma should occur early to reduce impacts on development and into the future (Young et al., 2011). One approach for trauma-exposed children under six is Child Parent Psychotherapy (CPP), an intervention designed to address symptoms of trauma-exposure for both the child and the caregiver.

Providing applicable training for interventions to ensure clinicians' competence can lead to improved outcomes on mental health (Sandler et al., 2014). It is essential to ensure that the

counseling field works towards trauma-informed care in all settings. This training manual will serve to explore existing literature regarding trauma and its treatment and provide an informational overview of Child Parent Psychotherapy and how to implement it, so that the field can continue to address the needs of trauma-exposed populations with empirically supported approaches.

Literature Review

Trauma and Posttraumatic Stress Disorder

Prevalence Rate

The exact prevalence of trauma can be incredibly hard to determine due to the many complexities involved with traumatic events (Saunders & Adams, 2014). Saunders and Adams (2014) explain that there are many things that impact prevalence and incidence rates of traumatic events, such as the characteristics or nature of traumatic events (i.e., fear of stigmatization, shame or guilt, or inability to identify the action as wrong), contextual factors that may impact the individual's ability to report trauma (i.e., ethnicity, culture, religion, gender, and developmental level), inadequate ability to detect and report these events (i.e., systemic level inadequacies), and differences in conceptualization of what constitutes trauma and definitions of different types of trauma. As such, it is hard to tell how many children and adolescents are impacted by trauma across the world.

Despite these challenges, it is estimated that a large portion of children and adolescents experience potentially traumatic events, based on existing research (McLaughlin et al., 2013; Saunders & Adams, 2014; Smith et al., 2019; WHO, 2022). In a national sample of adolescents aged 13-17, McLaughlin et al. (2013) found that 61.8% of adolescents have experienced potentially traumatic events in their lifetime. The World Health Organization (2022) estimates that nearly 3 in 4 children, ages 2-4, suffer from physical punishment and or psychological violence from their caretaker. The World Health Organization further reports that being under the age of four is one of the biggest risk factors for childhood maltreatment. In a literature review of existing research, Saunders and Adams (2014) also indicate that many children become

victims of multiple types of traumatic experiences and may encounter multiple incidents of the same traumatic events, making exposure even greater.

Impact of Trauma

With the prevalence of trauma exposure, it is important to consider the impact that it has on children. As Dye (2018) explains, exposure to early childhood trauma has been shown to have long-term impacts on physiological, behavioral, and neurobiological and psychological functioning that can persist into adulthood. The groundbreaking adverse childhood experiences study (ACEs) by the Centers for Disease Control and Prevention and Kaiser Permanente in 1998 (Felitti et al., 1998) shed light on the connection between adverse childhood experiences and the leading causes of death in adulthood, establishing the need for more research on the impact of trauma.

The ACEs study was one of the biggest studies of the impact of childhood trauma on wellbeing over the lifespan that has ever been conducted (Centers for Disease Control and Prevention, 2021). Over 17,000 participants in Southern California of diverse backgrounds completed surveys and physical examinations to determine how their experiences had impacted their wellbeing into adulthood. Experiences of trauma were divided into three categories, abuse, household challenges, and neglect. The abuse category included emotional abuse, physical abuse, and sexual abuse. Household challenges included witnessing domestic violence, substance abuse or mental illness in the household, having a household member attempt or complete suicide, parental separation, and having an incarcerated household member. The final category, neglect, included both emotional and physical neglect (Centers for Disease Control and Prevention, 2021).

The study found that ACEs were common across all populations (genders, races, ages, and education level), though some populations were more vulnerable to exposure to ACEs due to social and economic conditions (Felitti et al., 1998; Centers for Disease Control and Prevention, 2021). Researchers found that two-thirds of the study participants had an adverse childhood experience, with the most prevalent being exposure to physical abuse and substance abuse in the household. More than one in five reported having three or more adverse childhood experiences. The study additionally discovered that for each adverse childhood experience the individual reported, the more likely they were to have negative health and wellbeing outcomes as adults. Negative health outcomes included more risk for severe injuries (traumatic brain injuries, fractures, burns), mental health disorders (depression, anxiety, PTSD), complications during pregnancy, unsafe sexual behaviors resulting in unintended pregnancies or STDs, chronic diseases (cancer, diabetes), and substance abuse. (Centers for Disease Control and Prevention, 2021). Individuals exposed to four or more ACEs had significantly increased health risks for substance abuse, depression, suicide attempts, risky sexual behaviors, and smoking (Felitti et al., 1998).

Since this study has been released the field has continued to research and explore the long-term implications of trauma exposure on physiological functioning, behavioral functioning, neurobiological functioning, and psychological functioning. Early intervention appears essential to reduce the long-term impact of trauma exposure and adverse childhood experiences into adulthood (Buss et al., 2015).

Physiological Functioning. Exposure to trauma can result in long-term effects on physiological functioning, such as a higher likelihood of conditions like obesity (Felitti et al., 1998; Mundi et al., 2021), high blood pressure, and higher cholesterol levels (Dye, 2018).

Individuals who have experienced trauma also have an increased risk of chronic physical conditions, such as skeletal fractures (Felitti et al., 1998; Scott et al., 2013) and chronic diseases, such as chronic lung and liver disease (Felitti et al., 1998) and heart-related conditions (Dye, 2018; Edmondson et al., 2013). In a meta-analysis of the association of post-traumatic stress disorder (PTSD) with Chronic Heart Disease (CHD), Edmondson et al., (2013) found that PTSD was associated with a 55% increase in risk for developing CHD due to changes in biological and neurobiological functioning after being exposed to trauma.

Behavioral Functioning. Behavior problems are also a significant concern for trauma-exposed children. In a study conducted by Greeson et al. (2014), results indicated that for each additional trauma type children or adolescents experience, their odds for having clinically significant behavioral problems increased. This was true of all behaviors measured with the Child Behavior Checklist (CBL). Some examples of behavioral problems associated with trauma include aggressive behavior, rule breaking, attention deficits, emotional dysregulation, sleep disturbances, or becoming more withdrawn (Greeson et al., 2014). Exposure to childhood trauma has also been linked to substance use as an adult (Mandavia et al., 2016; Waldrop & Cohen, 2014). Additionally, the original ACEs study (Felitti et al., 1998) found that adults exposed to four or more adverse childhood experiences had a 4-12-fold increased risk for alcoholism and drug use, and 2-4-fold increased risk of smoking and an excessive amount of sexual intercourse partners, increasing the risk of sexually transmitted diseases. These maladaptive behaviors may be due to the impact of trauma on impulsivity and rule breaking behaviors (Greeson et al., 2014).

Neurobiological Functioning. Trauma has been shown to have an impact on neurobiological functioning for individuals who have been exposed to trauma and has been linked to changes in brain structure, hormone levels, and mental responses (Dye, 2018). It has

been suggested that exposure to childhood trauma influences important neurological processes, such as executive functioning and emotional regulation and additionally increases risk of disassociation and development of depression and PTSD (Cross et al., 2017). As Cross et al. (2017) explains, exposure to trauma can cause dysfunction in the HPA Axis, a pivotal part of regulating stress responses. Dysfunction can include overproduction of stress-related hormones, slower declines in stress-hormone levels following the stressing event, or even blunted reactions to stress (Cross et al., 2017; Nemeroff, 2004). According to Nemeroff (2004) exposure to traumatic stress during critical development periods in early childhood leads to a higher vulnerability to heightened stress responses, ultimately leading to higher risk of developing mental health disorders.

Psychological Functioning. Exposure to trauma can also result in long-term impacts on psychological functioning, such as alternations in mood and emotions, developmental regressions in emotional, cognitive, and behavioral functioning in children (Greeson et al., 2014), and increased risk of comorbid psychiatric disorders (Dye, 2018). Trauma can have a significant impact on children's ability to regulate emotions properly (Cross et al.,2017; Powers et al., 2015). As Cross et al. (2017) explains, multiple things may be their ability to appropriately regulate emotions. Some potential factors influencing this include lack of adequate modeling of emotions from caregivers in homes where the caregiver is violent or neglectful or the neurobiological effects of trauma on executive functioning, which helps to manage emotional regulation (Cross et al., 2017).

Development of mental health conditions that impact the individual's ability to function is one of the most significant concerns of exposure to trauma. Children exposed to trauma may be at greater risk for developing ADHD (Schilpzand et al., 2017), bipolar disorder, schizophrenia

(Xie et al., 2018), and long-term substance use (Dye, 2018; Felitti et al., 1998; Mandavia et al., 2016; Waldrop & Cohen, 2014). The most prevalent mental health conditions after being exposed to trauma are depression and post-traumatic stress disorder (Alisic et al., 2014; Dye, 2018; Vibhakar et al., 2019; Xie et al., 2018). Approximately 1 in 4 children or adolescents exposed to trauma meet diagnostic requirements for a clinically significant depression diagnosis (Vibhakar et al., 2019). Similarly, approximately 15.9%, or one in six children or adolescents develop post-traumatic stress disorder (Alisic et al., 2014). Both mental health conditions can cause long-term negative impacts if left untreated, with Meiser-Stedman et al. (2017) finding that PTSD symptoms can be persist for several years if left untreated in young children. As such, it is important to consider how to address mental health concerns early in development.

Posttraumatic Stress Disorder

According to the DSM-5-TR (APA, 2022) post-traumatic stress disorder (PTSD) is a mental health disorder that results in distress and impairment in daily functioning due to exposure to a traumatic event. It requires exposure to actual or threatened death, serious injury, or sexual violence. This definition of trauma excludes psychosocial situations that could still potentially be harmful, such as divorce, exposure to loss, or non-life-threatening illness (Pai et al., 2017). In these situations, a diagnosis of other specified trauma and stressor-related disorder or unspecified trauma and stressor-related disorder would be made due to full criteria for posttraumatic stress disorder not being met. The exposure to a traumatic event may be direct or indirect, as individuals indirectly exposed to trauma can also experience trauma responses (APA, 2022). Indirect exposure to trauma includes situations such as witnessing trauma to others or learning of the trauma experience of a loved one or family member (Pai et al., 2017).

Symptoms of PTSD must last for more than a month, cause distress, and interfere with the individual's daily functioning. Symptoms fall into four categories in the DSM-5-TR: intrusion, avoidance, alterations in cognition and mood, and alterations in arousal and reactivity (APA, 2022). Symptoms under the intrusion category include intrusive thoughts, which can manifest as reoccurrences of memories or flashbacks of the experienced trauma. These flashbacks or intrusive thoughts can be incredibly realistic, and the individual may feel as if they are happening in real-time, leading to distress (Dye, 2018). Symptoms in the avoidance category of the DSM-5-TR (APA, 2022) consist of avoidance of anything that may remind the individual of their traumatic experiences. For example, the individual may avoid activities, objects, or situations in order to avoid thinking about or remembering the traumatic event. Avoidance may manifest through avoidant coping styles as well, such as utilizing distractions (i.e. TV, sleeping, reading), substance use, behavioral disengagement, denial, and stoicism (Street et al., 2005). Symptoms in the alterations in cognitions and mood category consist of distorted thoughts and beliefs about self or others, experiences of fear or frustration, detachment from others, less interest in previously enjoyed activities, and increased negative mood. Symptoms in the alterations in arousal and reactivity category consist of increased irritability, increased reckless or self-destructive behaviors, unwarranted wariness, and problems with concentration and sleeping (APA, 2022).

Additionally, there are two specifiers for posttraumatic stress disorder: "with dissociative symptoms" and "with delayed expression" (APA, 2022). The "with dissociative symptoms" specifier is included when the individual meets full criteria for PTSD, but also experiences persistent depersonalization, which is feelings of detachment from one's mental processes or body, or derealization, which is distorted experiences of the reality of surroundings.

These dissociative symptoms must not be related to substance use or medical conditions. The second specifier, “with delayed expression” is included when the individual does not meet full criteria for PTSD until 6 months after the event.

PTSD Symptoms in Early Childhood. PTSD symptoms may appear slightly different in children under the age of 5. Symptoms of trauma during early childhood most frequently fall under the reexperiencing, avoidance/numbing, and hyperarousal categories, like adults and adolescents (Young et al., 2011). Differences appear in the ways symptoms manifest during early adolescence due to developmental level. Symptoms under the reexperiencing category are frequently recognized in post-traumatic play, where children may recreate themes from their trauma experience (APA, 2022; Buss et al., 2015; Cohen et al., 2010; Young et al., 2011). In a study by Cohen et al., (2010), children exposed to trauma engaged in less play, were more likely to act out or create morbid themes in pla

y and exhibited more difficulties with engaging in fantasy play. Scenes acted out during the play often revolved around themes related to their experiences with terrorism (Cohen et al., 2010). Reexperiencing can also appear in the child’s artwork or in distressing nightmares (Young et al., 2011).

Symptoms of avoidance in early childhood are often observed in efforts to avoid conversations, people, places, or objects that may remind the child of the trauma (Buss et al., 2015; Young et al., 2011). Children may demonstrate avoidance through more passive (i.e., avoiding eye contact) or active (i.e., crying or refusal to engage) methods (Young et al., 2011). Diminished interest in play may also be a symptom of avoidance for trauma-exposed children (Cohen et al., 2010; Young et al., 2011). Symptoms of hyperarousal in early childhood often mirror hyperarousal symptoms in adolescence, with increased irritability, sleep disturbances,

exaggerated startle responses, and difficulties with concentration (Buss et al., 2015; Young et al., 2011). Children under five exposed to trauma may also exhibit hyperarousal through temper tantrums and fussiness (Buss et al., 2015). Additional symptoms of PTSD in early childhood include excessive separation anxiety, physical aggression, excessive fears, and regressions in developmental skills (Buss et al., 2015; Young et al., 2011).

Treatment

With the prevalence and impact of PTSD, it is important to identify beneficial and effective treatment options for individuals struggling with PTSD symptomology. Substantial research has suggested some effective treatments for PTSD (Dorsey et al., 2017; Morina et al., 2016; Smith et al., 2019), that have had positive effects on PTSD symptoms, as well as positive effects on comorbid symptoms such as depression or anxiety symptomology (Gutermann et al., 2016). The interventions that appear to have the biggest effect sizes are cognitive behavioral therapy (CBT) and trauma-focused cognitive behavioral therapy (TF-CBT; Dorsey et al., 2017; Gutermann et al., 2016; Morina et al., 2016; Smith et al., 2019). An additional treatment that has seen growing evidence is eye-movement desensitization and reprocessing (EMDR; Dorsey et al., 2017; Gutermann et al., 2016; Moreno-Alcazár et al., 2017; Smith et al., 2019).

However, these treatments are more frequently used with older children, adolescents, and adults, and may not be developmentally suitable for addressing trauma symptoms with infants and toddlers. Early intervention is critical for minimizing the impact of trauma exposure on the individual's functioning (Buss et al., 2015), and as such, identifying developmentally appropriate treatment approaches is essential. One of the most widely used treatment approaches for trauma-exposed children between birth and six years of age is Child Parent Psychotherapy (Buss et al., 2015).

Child Parent Psychotherapy

Child Parent Psychotherapy was developed through the Child Trauma Research Program at the University of California as a modification of an existing approach, Infant-Parent Psychotherapy (Lieberman et al., 2015). The developers hoped to expand the approach in order to include children ages 3 to 5 years old to increase the applicability of the approach. The official manual for Child Parent Psychotherapy, *Don't Hit My Mommy: A Manual for Child-Parent Psychotherapy with Young Children Exposed to Violence and Other Trauma* was published in 2005 by Alicia Lieberman and Patricia Van Horn. The second edition, and current version, of the manual was released in 2015 with updated examples, research, and the addition of CPP Fidelity (Lieberman et al., 2015). The manual is required reading for certification in Child Parent Psychotherapy and provides a comprehensive review of the CPP model.

Lieberman et al. (2015) describe Child Parent Psychotherapy (CPP) as a treatment intervention for children ages 0-5 designed to help repair and restore the child's mental health, trust, and feelings of attachment with the caregiver following exposure to traumatic experiences. This approach involves both the child and the caregiver, as it operates under the fundamental concept that the caregiver-child relationship is essential for overcoming traumatic responses and maintaining therapeutic gains (Reyes et al., 2017). Exceptions may be made if the parent or caregiver's presence may be damaging to the therapeutic process, leading to individual sessions being more suitable for the dyad (Lieberman et al., 2015).

The primary goal of CPP is to strengthen the relationship between the caregiver and the child, which serves as the vehicle to address emotional difficulties, behavioral concerns, attachment concerns, and maladaptive thoughts associated with exposure to trauma (Reyes et al., 2017). During Child Parent Psychotherapy, the parent engages, interacts, and plays with the child

to further facilitate trust and attachment (Liberman et al., 2015). Although designed for trauma-based treatment, children and caregivers with negatively impacted relationships as a result of other mental illnesses, grief, or chronic stress may also benefit from this intervention (Liberman et al., 2015). Targets of the intervention are often main symptoms of the trauma, including returning to normal development, increased capability to respond to traumatic stress, managing affective arousal, restabling trust within the caregiver-client dyad, strengthening attachment, normalizing trauma responses, and putting the traumatic experience and behaviors into context (Liberman et al., 2015).

The clinician's role in Child Parent Psychotherapy is to develop a working alliance with the child-parent dyad to help parents better understand the impact of trauma on presenting problems and to assist the dyad with processing the traumatic experience(s) (Liberman et al., 2015). As the clinician, the focus is on instilling hope for the child and caregiver to build towards better wellbeing and a hopeful future (Reyes et al., 2017). Interventions are focused on providing trauma-informed psychoeducation and culminates in guiding the parent-child dyad in developing a trauma narrative so that they may normalize and understand responses to trauma (Liberman et al., 2015). However, CPP emphasizes a flexible approach to intervention modalities implemented and does not have a distinct curriculum (Reyes et al., 2017). As the clinician joins the parent-child dyad, they must find "ports of entry" for meaningful interventions and reflections between the more spontaneous interactions between child and parent (Lieberman et al., 2015). Interventions may include parenting skills, psychoeducation regarding trauma, relationship skills, CBT-based interventions, and emotional regulation skills (Reyes et al., 2017). The clinician utilizes their clinical judgment to implement developmentally and contextually

appropriate interventions based on the needs of the client throughout treatment (Liberman et al., 2015).

Theoretical Background. The theoretical framework of Child Parent Psychotherapy pulls from a variety of theories including psychoanalysis, attachment, developmental, trauma-based, social learning, and cognitive behavioral theories (The Child Trauma Research Program, n.d.). However, CPP is primarily based on attachment theory, as it operates under the core conceptual premise that the attachment system is essential for understanding and protecting the child's mental health (Liberman et al., 2015). It is not only important to attend to the child's symptoms and post-traumatic stress, but the caregiver's as well.

Research has shown that post-traumatic stress in either member of the parent-child dyad can impact and exacerbate symptoms in the other member, regardless of if the traumatic event is shared between the dyad (Scheeringa & Zeanah, 2001). With treatment, research suggests that some of the most effective treatment outcomes occur when there is a supportive and beneficial relationship with the caregiver (Scheeringa & Zeanah, 2001). Implementing a relational-based intervention focused on the child-parent dyad can help lead to long-term improvements in parental functioning to help them better support and appropriately care for their child (Lieberman et al., 2011). The emphasis is placed on the relationship between caregiver and child and their perceptions of each other, which are explored and addressed throughout the course of treatment so that the parent may return to their role of "protector" (Lieberman et al., 2015).

Child Parent Psychotherapy also emphasizes the importance understanding trauma and the treatment process in the context of the dyad's cultural and socioeconomic background (Liberman et al., 2015). The intervention is specifically tailored to the needs of the child and caregiver as it recognizes that cultural and socioeconomic hardships must also be addressed in

order to help the parent reach a place where they can be emotionally available and supportive for their child (Liberman et al., 2015). As such crisis intervention and advocacy may be a large part of Child Parent Psychotherapy for those with economic and cultural hardships, as well as those who may still be actively living their trauma experiences (i.e., families still living with a domestic abuser; Reyes et al., 2017). Additional steps may be taken to help establish safety and security for the parent-child dyad before treatment may begin in full (Reyes et al., 2017).

CPP also acknowledges differences in symptom expression across cultures and is mindful to avoid pathologizing or generalizing behaviors associated with trauma when working with multicultural populations (NCTSN, 2012; Liberman et al., 2015). Additionally, interventions and engagement techniques may be incorporated throughout treatment, such as utilizing the dyad's native language, traditions, etc. (NCTSN, 2012). Randomized clinical trials have shown its effectiveness with a variety of ethnic and sociocultural backgrounds (Lieberman et al., 2011), and as such, it is regarded as one of the most culturally sensitive treatment interventions for trauma.

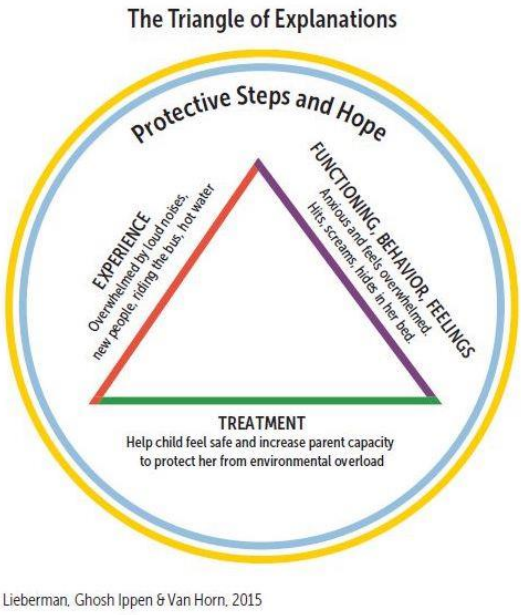
Conceptual Premises. In addition to parental involvement and consideration of context and culture, Child Parent Psychotherapy has several main conceptual premises. Another core premise in CPP is "speaking the unspeakable" (Lieberman et al., 2015). CPP operates under the core principle that to progress in treatment, there must be open exploration and acknowledgement of the adversities and traumatic experiences the child and caregivers have experienced (Lieberman et al., 2015). However, this is done in a supportive atmosphere with commitment to the safety and repair of the child and caregiver's mental health (Lieberman et al., 2015). As clinicians, it is essential to recognize the curative power of recognizing and

acknowledging the pain and difficulties surrounding trauma, while balancing it with equally curative positives, such as supportive relationships and playfulness (Lieberman et al., 2015).

Another important concept in CPP, is the connection between emotional/behavioral concerns and the child's experiences (Lieberman et al., 2015). This is known as the CPP Triangle or the "triangle of explanations" (see Figure 1). The triangle explains the link between the traumatic event, the behavioral responses as a result of the trauma, and the goals for treatment. This triangle is developed in collaboration with the parent during the feedback session in the foundational phase. The Triangle of Explanations developed by both caregiver and clinician is then used to help guide the treatment process (Lieberman et al., 2015). For example, you may explain trauma symptoms to a child who has witnessed domestic violence as follows: "You saw your mom and dad fight each other (experience), and now you sometimes feel worried or upset when you think people are going to leave (behaviors). This is a place where we can learn to understand these worries and why they came up after seeing mom and dad fight (Treatment)" (Lieberman et al., 2015). This triangle is also surrounded by a circle, known as protective steps and hope. It is essential to highlight the protective steps the parent has taken for the child, such as engaging in therapy, to instill hope (Lieberman et al., 2015).

Figure 1

The Triangle of Explanations



Lieberman, Ghosh Ippen, & Van Horn, 2015

Format. Child Parent Psychotherapy consists of weekly hour-long sessions for approximately 20-32 weeks depending on the complexity of the case (Reyes et al., 2017). The location of services is flexible for the needs of the client. It is most frequently conducted in the office playroom or in-home, which both have benefits and drawbacks. In-office treatment allows for a more controlled setting with limited distractions for both the clinician and the child-parent dyad. In comparison, in-home treatment allows the provider to understand and join the family in their authentic environment. The ultimate determinant of location is both clinician and client safety, as with trauma-work, in-home or in-office may be unfeasible due to safety concerns (Lieberman et al., 2015).

Child Parent Psychotherapy is broken down into three stages: the foundational phase, the core intervention/treatment phase, and the Recapitulation and Termination Phase. The

foundational phase consists of developing the therapeutic relationship and gathering information (Reyes et al., 2017). During this phase individual sessions with the caregiver are utilized to develop a joint definition of the child's presenting problem in the context of trauma and build a treatment plan for CPP together (Lieberman et al., 2015). This may also allow caregivers to discuss details of trauma that may be too graphic or traumatizing for the child. Parents may have extra resistance and difficulty discussing trauma during initial sessions, and extra care should be taken to develop a safe therapeutic atmosphere for caregivers to be vulnerable (Lieberman et al., 2015).

The clinician utilizes assessment tools and skills to build a better clinical conceptualization of the child and caregiver's experience to inform the treatment process (Reyes et al., 2017). Additional steps may be taken to help stabilize and ensure the safety of the child and caregiver as needed (Lieberman et al., 2015). The final session of the Foundational Phase is the feedback session, which focuses on reviewing what the clinician learned during the assessment process with the caregiver and connecting presenting symptoms with the child's trauma experience (Reyes et al., 2017). Additionally, the clinician and caregiver collaborate in deciding how the caregiver would like the child to understand the trauma by developing the Triangle of Explanations. It helps to lay the framework for the intervention phase and to prepare the parent to incorporate the child into treatment (Lieberman et al., 2015).

The second phase is the Core Intervention or Treatment Phase. In this phase, the child is introduced into treatment, and the dyadic format begins (Reyes et al., 2017). The initial sessions of the intervention phase focus on introducing the child to the CPP Triangle and encouraging the child to share how they feel. The therapist identifies and names the trauma experience, opening dialogue regarding trauma symptoms, experiences, and reminders, which may lead to stronger

avoidance symptoms. Themes related to trauma are explored through play, with the clinician encouraging the parent to intervene and interact with the child as much as possible. The child may recreate their traumatic experience in the form of dolls, art, or play-acting. Additional interventions and psychoeducation based on the dyad's symptoms, behaviors, and experiences are implemented by the clinician throughout the natural flow of the play process (Lieberman et al., 2015). Treatment culminates in creating a joint trauma narrative for the child and parent that explores the trauma, how the child and parent feel about it now, and acknowledging the impact trauma has on symptoms and behaviors (Reyes et al., 2017). Additionally, the parent works to develop a protective narrative alongside the trauma narrative to communicate a commitment to safety and repair. The protective narrative describes what the parent did to try to address the problem and identifies therapy as a safe place to work towards future safety and support (Lieberman et al., 2015).

The final phase of treatment is recapitulation and termination which focuses on wrapping up services and ensuring treatment outcomes into the future (Reyes et al., 2017). The clinician helps the child-parent dyad to shift from focusing on areas of difficulties, and instead shifts their focus to the more positive changes and gains from participating in CPP (Lieberman et al., 2015). As loss can be a significant trauma reminder, the termination process is an integral and carefully planned phase of Child Parent Psychotherapy (Reyes et al., 2017). Considerable time ahead of the final session, an individual session with the caregiver and the clinician are held to discuss progress in treatment and potential for ending services. Time is spent in sessions leading up to termination addressing and reflecting on feelings associated with loss and termination. The clinician additionally works with the parent to address any challenges or concerns that remain or that the parent foresees in the future (Lieberman et al., 2015). As the ending nears, engaging the

child and caregiver in termination activities, such as decorating a calendar or creating a picture to take with them, can help provide structure and support for the termination process (Reyes et al., 2017).

Outcomes. Child Parent Psychotherapy has received empirical support for positive outcomes in several randomized clinical trials (Cicchetti et al., 2000; Cicchetti et al., 1999; Lieberman et al., 2015; Lieberman et al., 2005; Lieberman et al., 1991; Toth et al., 2002; Toth et al., 2006) with varying ages, concerns, and ethnic and socioeconomic backgrounds (Lieberman et al., 2011). Some preliminary research suggests that children exposed to multiple traumatic stressors showed the most improvements in PTSD and Depression symptoms, other developmentally appropriate diagnoses, and total behavior problems following involvement with CPP (Ghosh Ippen et al., 2011). Additionally, children saw improvements in attachment style (Guild et al., 2021), more regulated cortisol levels (Cicchetti et al., 2011), more positive attributions to themselves and the parent-child relationship, and improvements in cognitive functioning (Lieberman et al., 2011).

Research has also suggested that Child Parent Psychotherapy has significant effects on parent post-traumatic stress symptoms (Hagan et al., 2017; Lieberman et al., 2006). Randomized controlled trials showed significant improvements in maternal trauma-related avoidance symptoms (Lieberman et al., 2006). Symptom change in the caregiver may also be correlated with improvements in hyperarousal for the child (Hagan et al., 2017), as well as improved marital satisfaction following treatment (Pelts et al., 2015). With research showing that post-traumatic stress for either member of the child-parent dyad impacts the other member (Scheeringa & Zeanah, 2001), seeing improvements in parental symptoms is also important for Child Parent Psychotherapy.

Certification. To become certified to implement the Child Parent Psychotherapy model into practice, the provider must engage in formal training which is offered by the developers of Child Parent Psychotherapy. Training is offered to master's or doctorate level psychotherapists with a degree in a mental health-related field, though there are some locations that provide endorsed CPP internships for students in mental health-related fields. There are three different implementation-level trainings provided by the creators of CPP. The first is the 18-month CPP Learning Collaborative, which is the standard CPP training for practitioners. The second is the CPP Agency Mentorship Program (C.A.M.P.), which is an agency level training designed for organizations that have already completed the CPP-LC model, and hope to continue to teach additional providers within their agency. The final model is the Endorsed CPP Internship model, which trains students in Child Parent Psychotherapy at specific internship sites across the United States (Child Parent Psychotherapy, 2018).

Child Parent Psychotherapy training is not often completed by a single clinician, but rather in teams sponsored by their agencies. These teams consist of multiple clinicians, at least one supervisor, and a senior leader associated with the organization if possible. This process better supports clinicians as they deal with the challenges of working with young children exposed to trauma and their families and, additionally, provides the opportunity to participate in reflective consultation as a group, one of the key components of this training. Additional requirements for training include reading CPP's manual, *Don't Hit My Mommy: A Manual for Child-Parent Psychotherapy with Young Children Exposed to Violence and Other Trauma* (Lieberman et al., 2015), attending scheduled seminars, sitting in on weekly CPP Consultation Calls, which focus on case conceptualizations and ways to utilize the CPP model, and practicing the CPP model through hands-on work with families. Clinicians are expected to have at least 4

CPP cases in an 18-month period, with at least two of the cases spanning at least 16 sessions. Providers also engage in consistent CPP supervision with their supervisor who, ideally, also participates in the CPP training. Providers spend time processing the personal impact of the trauma on the provider and receive support with any challenges that may arise. Providers who successfully complete CPP-LC trainings are eligible to be added to the Child Parent Psychotherapy roster, which is maintained by the Child Trauma Research Program, the official development site for the CPP model (Child Parent Psychotherapy, 2018).

Conclusions

With the prevalence and impact of trauma, providing effective treatment should be a priority for clinical mental health counselors. Finding beneficial treatment approaches to address the needs of our trauma-exposed populations is essential. Knowing that early intervention is critical for minimizing the impact of trauma exposure on the individual's functioning in the future (Buss et al., 2015), developing trainings in trauma-informed approaches, such as Child Parent Psychotherapy is one way to address the field's concerns regarding trauma. Based on the positive outcomes on PTSD symptoms (Hagan et al., 2017), attachment (Guild et al., 2021), and improvements in cognitive functioning, CPP may be one of the best approaches for trauma work during early childhood (Lieberman et al., 2011).

This training aims to teach clinical mental health counselors how to implement Child Parent Psychotherapy to increase trauma-informed care in community mental health settings. By developing an informational training for CPP, this writer's goal is to help ensure clinical mental health counselors are exposed to evidence-based trauma-informed approaches to address the needs of trauma-exposed children. This training will be introductory in nature regarding the use of Child Parent Psychotherapy as a beneficial treatment approach for these populations. This

training will not result in certification; however, the certification process will be discussed within the training. By furthering the competency and effectiveness of treatment approaches for trauma through formal training, the field can continue to work towards a trauma-informed and hopeful future for trauma-exposed populations.

Training Manual Outline

This training is expected to be a one-time three-hour training presented by a clinical mental health provider trained in Child Parent Psychotherapy. The trainer must have completed the CPP-LC training model provided by the developers of Child Parent Psychotherapy in order to present this training. The provider may be a licensed clinical mental health counselor or in the process of gaining licensure as long as they are practicing under a licensed supervisor.

The intended audience will be mental health workers in agency settings. This training is recommended for counselors, however, it may also be presented to other professionals in the mental health field to build further awareness regarding the use of Child Parent Psychotherapy as a trauma-informed approach for treatment. Allowing other professionals from the field to attend this training may result in better informed referrals for CPP providers. This training will be focused towards improving overall understanding of this model in community mental health service settings.

The purpose of the training is to provide an introductory course for mental health counselors regarding the implementation of Child Parent Psychotherapy in an agency setting. Participants will learn about the prevalence and impact of trauma and to address trauma symptoms in children ages 0-6 utilizing a Child Parent Psychotherapy approach. Goals of the training include:

- Identifying impacts of trauma on physiological, behavioral, neurobiological, and psychological functioning
- Understanding the key concepts associated with Child Parent Psychotherapy such as the Triangle of Explanations

- Implementing and utilizing developmentally appropriate trauma narratives for the parent-child dyad
- Learning interventions and skills needed to be a Child Parent Psychotherapy clinician (i.e., parenting skills, emotion regulation skills, communication skills, and attachment-based interventions)

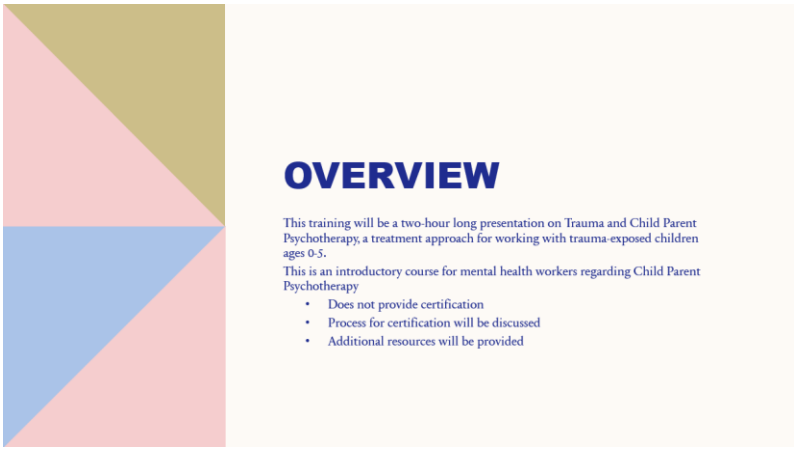
The training will be presented at a community seminar to increase awareness of additional treatment models for trauma-exposed children and adolescents. The presentation will be available both in-person and via Zoom. Skills and approaches will be demonstrated in a case study and a video included in the presentation. Resources and existing literature regarding CPP will be included within the presentation. A pre-test and post-test assessment regarding trauma, trauma symptoms, and Child Parent Psychotherapy concepts will be utilized throughout the training to assess effectiveness and interest in official CPP training.

Training Presentation

Slide One – *Title Screen*

Script: "*Introduce yourself and your background* This presentation will provide an overview regarding child parent psychotherapy, an empirically supported treatment approach for working with trauma-exposed populations aged 0-6. My hope is that this training will work towards better informing providers' work when it comes to trauma-work with young children."

Slide Two – *Overview*



Script: “The intent of this presentation is to garner more awareness of Child Parent Psychotherapy as an empirically supported treatment model for trauma exposed populations 0-6 years old. This presentation does not provide certification to become a CPP certified therapist and resources to become a certified CPP provider will be discussed at the end of this presentation.”

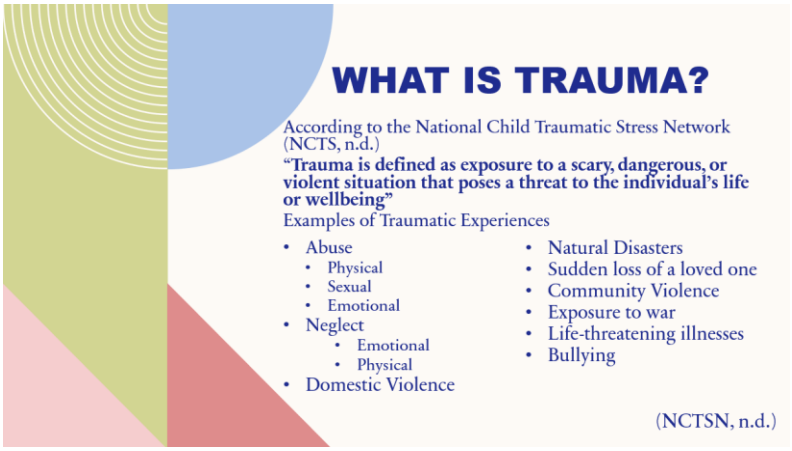
Slide Three – *Pre-training survey*

Script: “We will take a moment to do a pre-training survey to help inform us of the effectiveness of our training and for you to assess your preliminary knowledge regarding child parent psychotherapy and trauma exposure in young children. If you are in person, there will be a physical copy handed out to you. Please take a moment to complete it and turn it in. For those of you joining us via Zoom, I have provided you with a link to a digital version of the survey. Please take a moment to complete the survey on whichever digital device you have available.”

Slide Four – *Agenda*

Script: “Here is a brief agenda of the topics we will be covering in today’s presentation, including the prevalence and impact of trauma, the posttraumatic stress disorder diagnosis in the DSM-5, and existing treatments for posttraumatic stress disorder. The second half of the presentation will focus on a general overview of Child Parent Psychotherapy, the research supporting it, and how the certification process works. Finally, we will end our presentation with resources to provide both clinicians and families.”

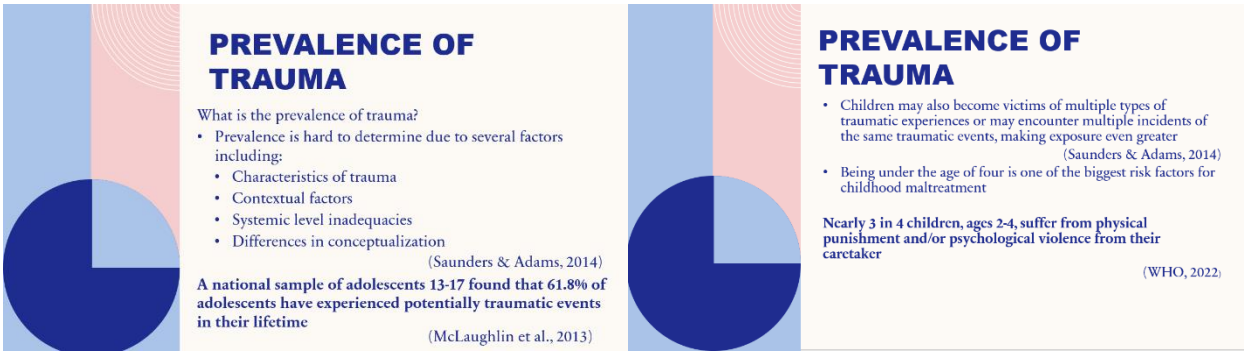
Slide Five – *What is Trauma?*



Script: "First let's get a working definition of trauma going. I would like everyone to quickly jot down their definition of trauma. Would anyone like to share?" *Allow time for a large group discussion on the definition of trauma*

"Let's look at one proposed definition of trauma, according to the National Child Traumatic Stress Network (n.d.). Trauma is defined as exposure to a scary, dangerous, or violent situation that poses a threat to the individual's life or wellbeing. Now it is important to understand that what constitutes a traumatic event differs from person to person. Two people can experience the same car accident, and one person can walk away without any long-term impact on their functioning, and the other can walk away with a lifetime of persistent distress and dysfunction in many areas of their life. It's what makes a definition of trauma so tricky, as it is not A + B = C. For our purposes, understanding that trauma is exposure to a harmful situation the is a threat to the individual's life or wellbeing will work. Now, what are some examples of traumatic experiences under this definition." *Allow space for people to share some examples of trauma and discuss what is shared* "Here is an additional list of some potential examples of traumatic experiences. Once again, it is important to understand that not all of these may be a traumatic experience to every individual, and the impact of each varies per person."

Slide Six and Seven– *Prevalence of Trauma*

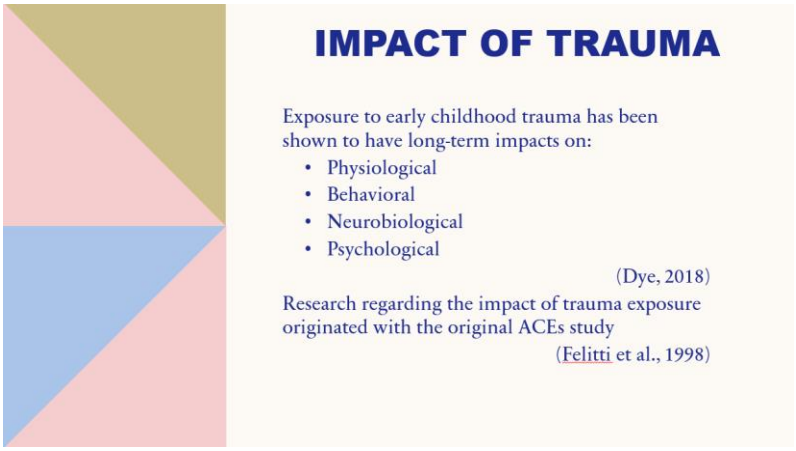


Script (Slide Six): "Does anyone have an estimate of what the prevalence of trauma is?" *Allow space for people to make guesses regarding prevalence rates* "If you don't know what the prevalence rate of trauma is don't be surprised. It is extremely difficult to determine overall prevalence rates of trauma exposure worldwide. The difficulties stem from a variety of factor including characteristics or the nature of traumatic events, such as fear of stigmatization and shame or guilt, contextual factors that limit the individual's ability to report trauma, such as culture, religion, or gender, systemic level inadequacies that may limit the individual's options for reporting trauma, and different conceptualizations or definitions of trauma (Saunders & Adams, 2014). Despite these difficulties, we can still make an estimate of the prevalence. From a national survey conducted by McLaughlin et al. (2013), 61.8% of adolescents have experienced potentially traumatic events by the time they are between the ages of 13-17 years old.

Script (Slide Seven): "This estimated prevalence rate does not account for children who become victims of multiple types of traumatic experiences or those who experience repeat incidences of the same traumatic experiences, which could make exposure even greater (Saunders & Adams, 2014). It is also important to consider prevalence rates of trauma in early childhood due to their dependence on their caregivers. The WHO (2022) estimates that nearly 3 in 4 children suffer from physical punishment and or psychological violence from their caretaker

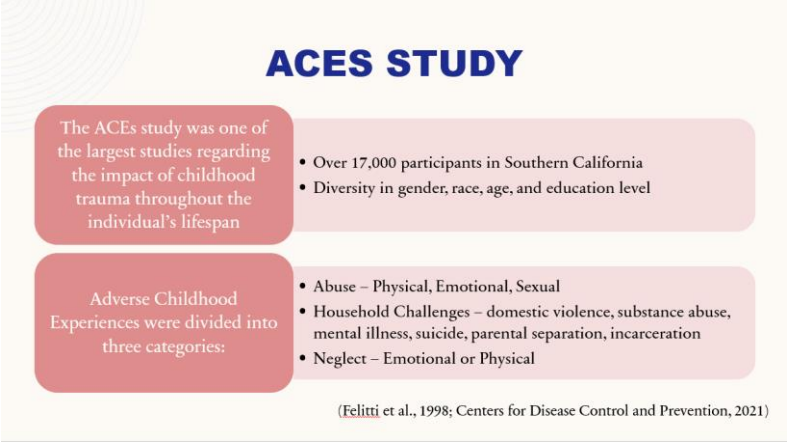
from ages 2-4 years old. Overall, these adverse childhood experiences appear to be happening at an alarming rate and substantial research has shown that these exposures can result in disturbances in a variety of domains throughout the individual's life, as I will get into in the next few slides."

Slide Eight – Impact of Trauma



Script: "Now that we know the prevalence of trauma, the question is, why does this matter? It matters because exposure to trauma during early childhood has been shown to have long-term impacts on physiological, behavioral, neurobiological, and psychological functioning that can persist into adulthood (Dye, 2018). Our understanding of trauma's impacts has expanded immensely in the last few decades, but much of the research originated with the groundbreaking "ACE" or adverse childhood experiences study by the Centers for Disease Control and Prevention and Kaiser Permanente in 1998 (Felitti et al., 1998)."

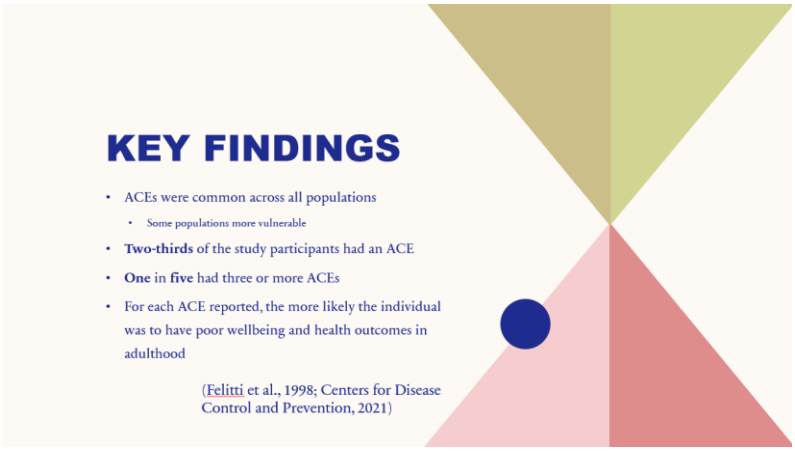
Slide Nine- *ACEs Study*



Script: "The ACEs study is one of the largest-scale research studies regarding outcomes of trauma exposure that has ever been conducted. Research participants consisted of 17,000 residents of Southern California from diverse backgrounds, with different genders, races, ages, and education levels represented. The researchers defined adverse childhood experiences by dividing them into three different categories. The first, abuse, includes instances of physical abuse such as being pushed, grabbed, slapped, or hit by an adult or caregiver in the home. Emotional abuse, such as an adult or caregiver swearing, insulting, being verbally malicious, or threatening the safety of the individual. Finally, sexual abuse, such as an adult, family member, family friend, or stranger who is at least 5 years older than the individual, touching, fondling, making them touch their body, or attempting to have sexual intercourse with the individual. The household challenges category includes witnessing domestic violence in the home, having a family member who struggles with substance abuse or mental illness in the household, having a member of the household attempt or complete suicide, parental separation, and incarceration of a family member in the household. The final category of neglect, includes emotional neglect, such as family members or caregivers never helping the individual feel loved or providing limited sense of support, and physical neglect, such as caregivers or family members not taking steps to

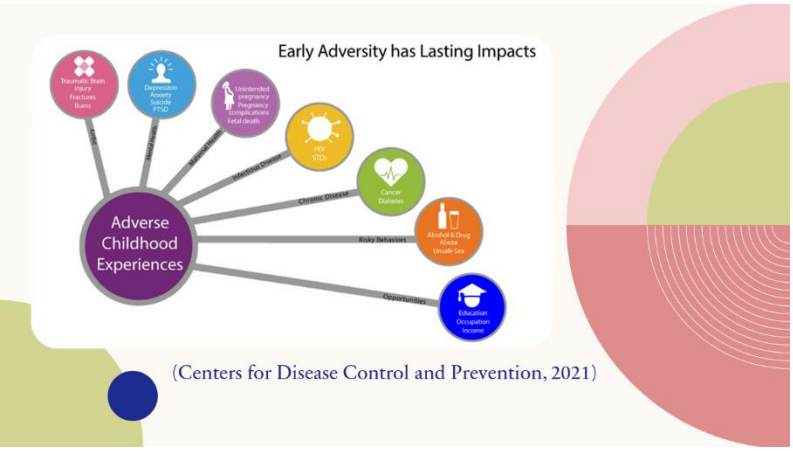
protect the individual or failing to meet the individual's basic needs, such as food, shelter, clean clothes, etc. (Centers for Disease Control and Prevention, 2021; Felitti et al., 1998)

Slide Ten – *Key Findings*



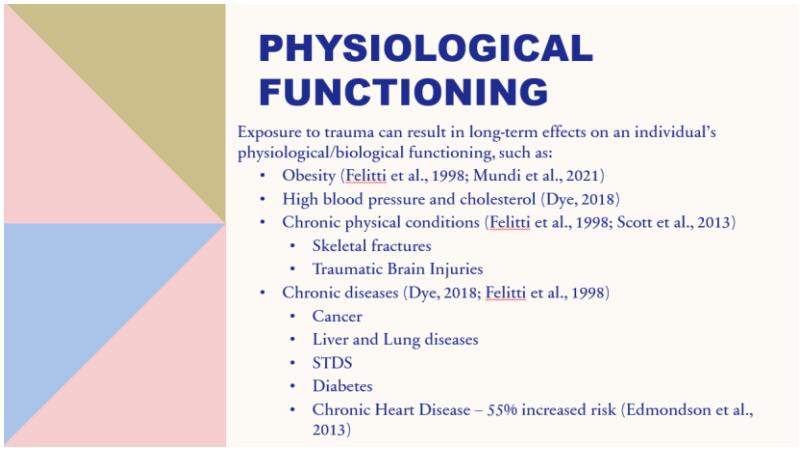
Script: "Moving on to the key findings of the study, researchers discovered that ACEs were common across all populations, though some populations were more vulnerable to exposure to ACEs due to social and economic conditions. Overall, two-thirds of the study participants had exposure to an adverse childhood experience, with the most prevalent ACE being physical abuse and substance use. Additionally, one in five participants had three or more adverse childhood experiences. The higher the ACE score, or number of ACEs the individual has been exposed to, the more likely they are to have poor health outcomes and overall well-being (Centers for Disease Control and Prevention, 2021; Felitti et al., 1998).

Slide Eleven – *ACEs Impact Graphic*



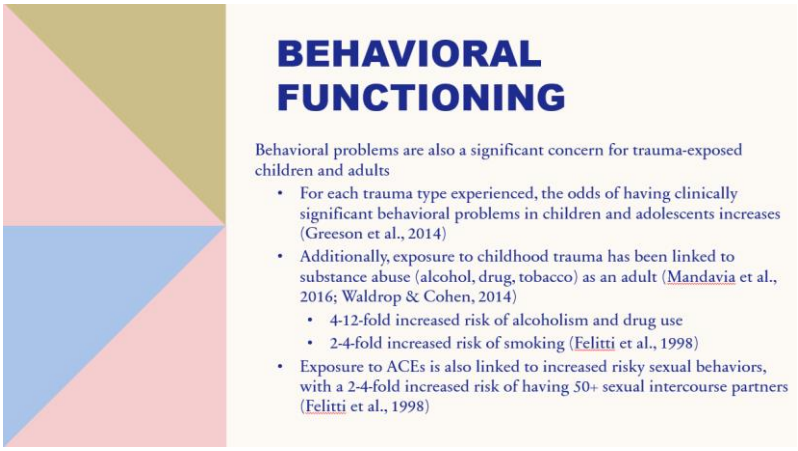
Script: "Looking more in depth at the lasting impacts of trauma through this graphic created by the CDC (2021), ACEs have been connected to increased risk for injury, mental health concerns, maternal health complications, infectious diseases, chronic diseases, risky behaviors, and limited opportunities. It is important to note that those who experienced more than 4 ACEs had especially increased health risks for substance abuse, depression, suicide attempts, risky sexual behaviors, and smoking. As the field has continued expanding the research on the ACEs study, we have developed a bigger picture of the full impact of exposure to trauma on the individual's physiological, behavioral, neurobiological, and psychological functioning."

Slide Twelve – *Physiological Functioning*



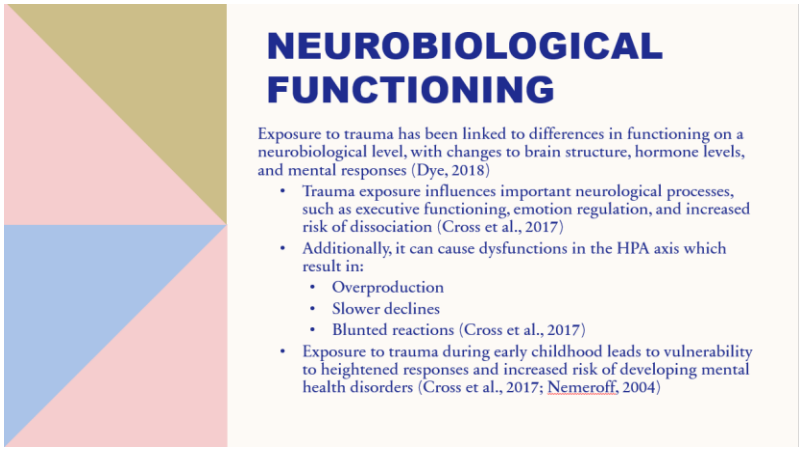
Script: "Exposure to trauma can result in long-term effects on an individual's physiological/biological functioning such as a higher likelihood of obesity and inactivity (Felitti et al., 1998; Mundi et al., 2021), high blood pressure, and cholesterol (Dye, 2018). Exposure to trauma has also been linked to increased risk of chronic physical conditions such as skeletal fractures and traumatic brain injuries (Felitti et al., 1998; Scott et al., 2013). Additionally, exposure to traumatic events during childhood have been connected to increased risk of chronic diseases such as cancers, chronic lung and liver diseases, STDs, Diabetes, and Chronic Heart Disease (Dye 2018; Felitti et al., 1998). In a study by Edmondson et al. (2013), researchers found that individuals with PTSD even had as much as a 55% increased risk of developing chronic heart disease due to changes in biological and neurobiological functioning after being exposed to trauma."

Slide Thirteen – *Behavioral Functioning*



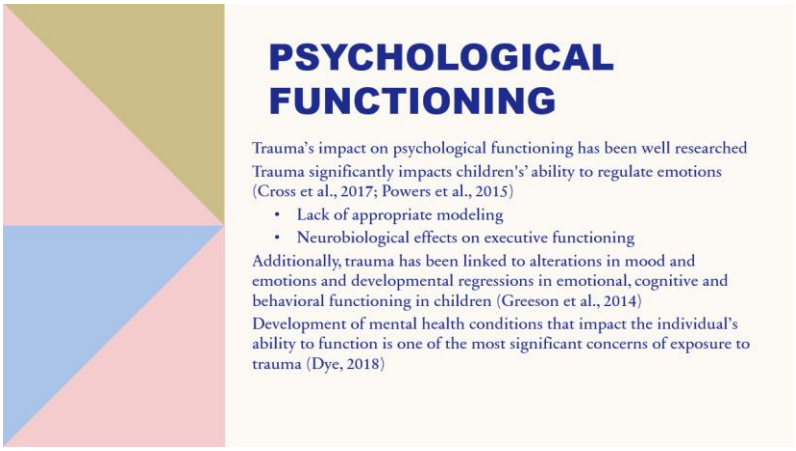
Script: "Behavioral concerns are also a significant problem for trauma-exposed children and adults. Greeson et al. (2014) found that for each additional trauma type experienced, the odds of having clinically significant behavioral problems in children and adolescents increased. Examples of behavioral problems include aggressive behavior, rule breaking, attention deficits, emotional dysregulation, sleep disturbances, and withdrawing. These maladaptive behaviors may be due to the impact of trauma on impulsivity. Exposure to childhood trauma has also been linked to difficulties with substance use, such as alcohol, drugs, and tobacco, as an adult (Mandavia et al., 2016; Waldrop & Cohen, 2014). The original ACEs study (Felitti et al., 1998) found that adults exposed to four or more adverse childhood experiences had a 4-12-fold increased risk for alcoholism and drug use, and a 2-4-fold increased risk of smoking. Additionally, the ACEs study (Felitti et al., 1998) showed an increased risk of excessive amounts of sexual intercourse partners and risky sexual behaviors that result in STDs, as discussed in the previous slide."

Slide Fourteen – *Neurobiological Functioning*



Script: "Trauma has also been linked to changes on a neurobiological level, with differences in brain structure, hormone levels, and mental responses (Dye, 2018). Trauma can influence important neurological processes such as executive functioning, which is responsible for cognitive control of our behaviors and attaining our goals, emotion regulation, which is responsible for ability to experience the range of emotions in a way that is tolerable, and increased risk of dissociation, which is the disconnection between our thoughts, memories, surroundings, actions, and our identity (Cross et al., 2017). More specifically, trauma exposure can cause dysfunctions in the HPA Axis, which is a fundamental part of regulating our stress responses. Dysfunction in the HPA Axis can result in overproduction of stress-related hormones, slower declines in stress-hormone levels following the stressful event, and blunted reactions to stress (Cross et al., 2017). Exposure to trauma during early childhood can lead to increased vulnerability to heightened stress responses and development of mental health disorders, especially during a critical developmental period (Cross et al., 2017; Nemeroff, 2004)

Slide Fifteen – *Psychological Functioning*

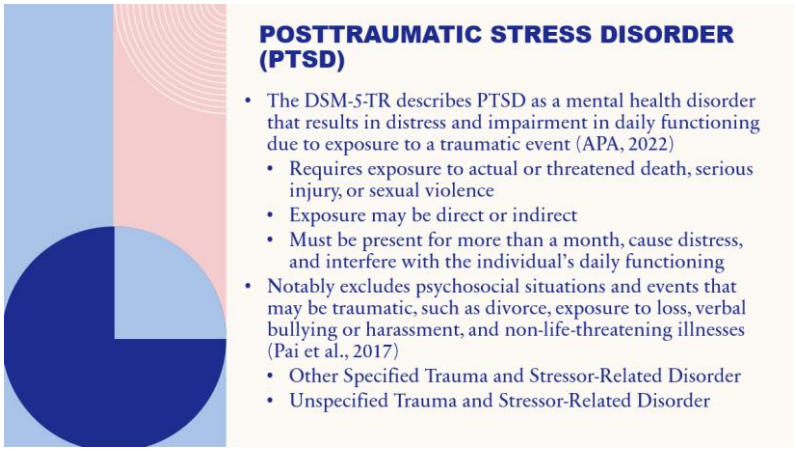


Script: "Trauma's impact on psychological functioning is where the most research has been conducted. Trauma appears to significantly impact children's ability to regulate emotions (Cross et al., 2017; Powers et al., 2015). Impairment in emotion regulation may stem from lack of appropriate modeling of emotions from caregivers, such as in households where there is physical abuse, domestic violence, or neglect. Additionally, trauma leads to neurobiological changes on executive functioning that can impair emotional regulation processes . Trauma has also been linked to significant alterations in mood and emotions as well as developmental regressions in emotional, cognitive, and behavioral functioning (Greeson et al., 2014). Perhaps the most significant concern regarding trauma's impact, however, is the increased likelihood of development of mental health conditions that impact the individual's ability to function (Dye, 2018)."

Slide Sixteen – *Comorbid Psychiatric Disorders*

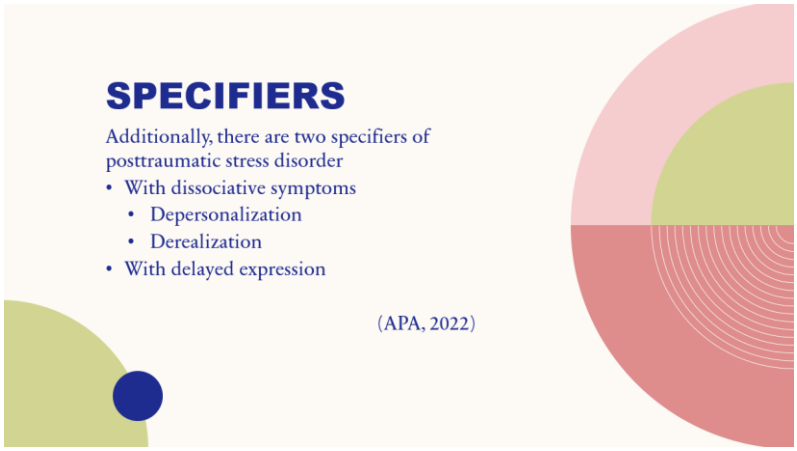
Script: "Research has shown that children exposed to trauma may be at greater risk for developing ADHD (Schilpzand et al., 2017), bipolar disorder (Xie et al., 2018), and schizophrenia (Xie et al., 2018). However, the three most prevalent mental health conditions following trauma exposure are long-term substance use disorders (Dye 2018; Felitti et al., 1998; Mandavia et al., 2016; Waldrop & Cohen, 2014), as we discussed earlier when covering behavioral impacts, depression (Dye, 2018; Felitti et al., 1998; Vibhakar et al., 2019; Xie et al., 2018), with approximately one in four children meeting diagnostic requirements for a clinically significant depression diagnosis, and finally posttraumatic stress disorder (Alisic et al., 2014; Dye et al., 2018; Xie et al., 2018), with 15.9%, or one in six children meeting full criteria for posttraumatic stress disorder. When left untreated, symptoms of posttraumatic stress disorder can persist for years and continue to impact functioning across all domains as the individual progresses through their lifespan. Although the other disorders listed are of significance and important to consider when looking at diagnosis, for the purposes of this presentation, we will focus on PTSD, as it is the diagnosis associated with trauma in the DSM-5-TR."

Slide Seventeen – *Posttraumatic Stress Disorder (PTSD)*



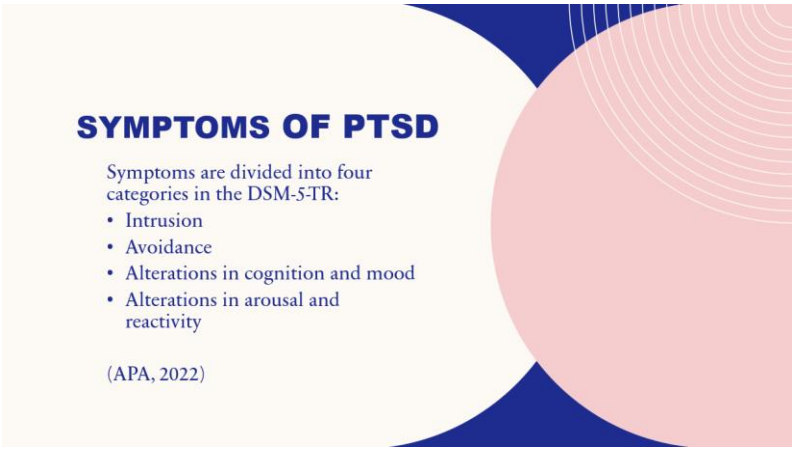
Script: "Going into more depth with posttraumatic stress disorder, the DSM (APA, 2022) describes PTSD as a mental health disorder that results in distress and impairment in daily functioning due to exposure to a traumatic event. Traumatic events are described as exposure to actual or threatened death, serious injury or sexual violence and can be experienced directly or indirectly. Indirect experiences of trauma include continuous exposure as a first responder or police officer, or learning about or witnessing traumatic events happen to a caregiver or family member, especially as a child or adolescent due to their dependent nature. Additionally, individuals may experience multiple traumatic events or multiple incidents of same event. This definition of trauma notably excludes psychosocial situations and events that may be interpreted as traumatic, such as divorce, exposure to loss, verbal bullying or harassment, and non-life-threatening illness (Pai et al., 2017). In these instances, a diagnosis of other specified trauma and stressor-related disorder or unspecified trauma and stressor-related disorder would be made due to full criteria not being met.

Slide Eighteen– *Specifiers*



Script: “There are additionally two specifiers to the posttraumatic stress disorder diagnosis, which are the “with dissociative symptoms specifier” and the “with delayed expression” specifier. The “with dissociative symptoms specifier is used when the individual meets full criteria for PTSD, but also experiences persistent depersonalization, which is the sensation of feeling detached from one’s mental processes or body, or derealization, which is the sensation of feeling like one’s surroundings are unreal, dreamlike, or distant. The second specifier is “with delayed expression” which is used when the individual does not meet full criteria for PTSD until 6 months after the event (APA, 2022).”

Slide Nineteen – *Symptoms of PTSD*

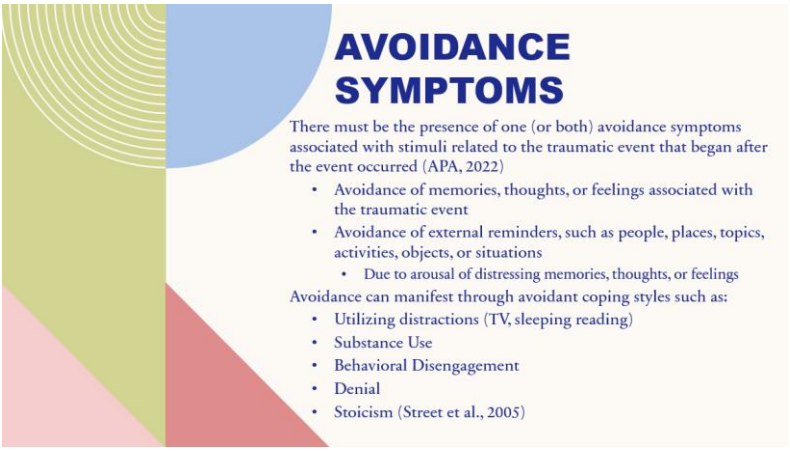


Script: “Looking more closely at symptoms, the DSM splits symptoms into four different categories, intrusion, avoidance, alterations in cognition and mood, and alterations in arousal and reactivity (APA, 2022).”

Slide Twenty – *Intrusion Symptoms*

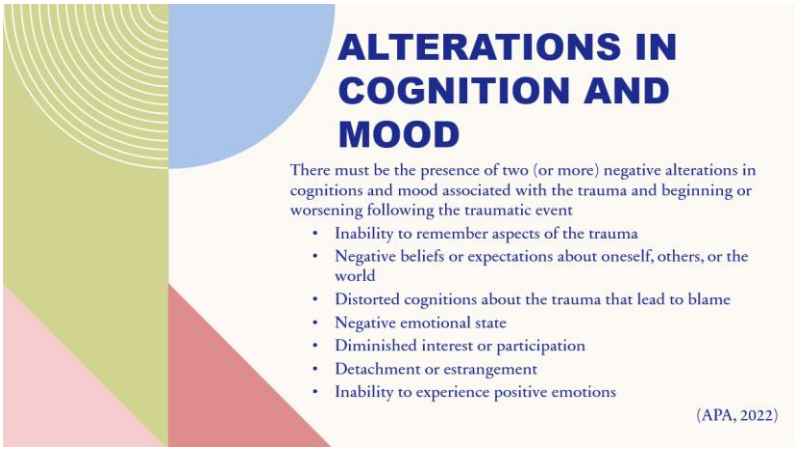
Script: "For the intrusion category, there must be one or more intrusion symptoms associated with the traumatic event that began after the event occurred. Intrusive symptoms include intrusive thoughts or distressing memories of the event. Reoccurring dreams with content related to the traumatic event. It is important to note that in children, frightening dreams may occur without recognizable content, as they are unable to process or understand the traumatic event. Dissociative reactions, in which the individual reexperiences the traumatic event as if it were occurring in the present moment. Intense psychological distress or physiological reactions to internal or external cues that symbolize the traumatic event, such as certain locations, sounds, or smells. In children, intrusion symptoms may appear differently due to their developmental level. Themes related to the traumatic experience or reenactment of the experience through play are more typically observed in young children. Dissociation may be observed during play as well, as the individual may reexperience their trauma (APA, 2022)."

Slide Twenty-One – *Avoidance Symptoms*



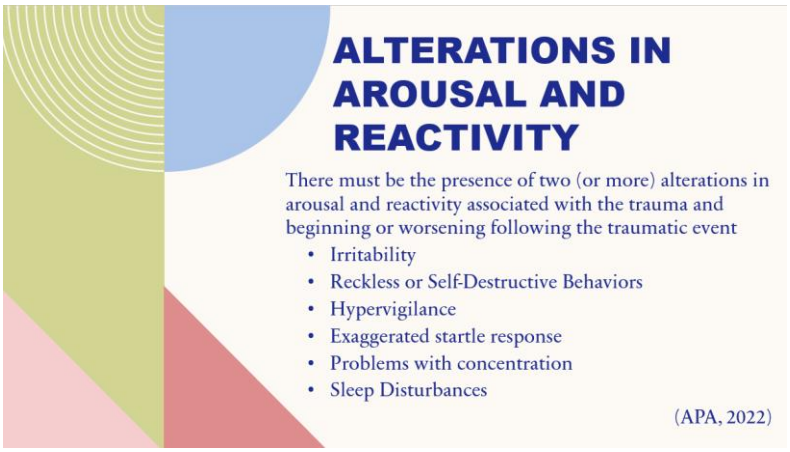
Script: "The second category of symptoms is Avoidance, in which there must be the presence of one (or both) avoidance symptoms associated with stimuli related to the traumatic event that began after the event occurred. The two symptoms are avoidance of memories, thoughts or feelings associated with the traumatic event and avoidance of external reminders, such as people, places, topics, activities, objects, or situations. This is largely due to the arousal associated with the distressing memories, thoughts, or feelings that come up with the external reminders (APA, 2022). Avoidance can additionally manifest through avoidant coping styles. Avoidant coping styles are not discussed in the DSM-5 and are not specific to trauma but may be worth considering when assessing for avoidance symptoms. These may be things like utilizing distractions, such as TV, sleeping, or reading, to make yourself think about it less. Utilizing alcohol or drugs to avoid being sober and cognizant of the trauma. Behavioral Disengagement or giving up trying to deal with the trauma. Denial, or refusing that the problem is real. And finally, stoicism, or ignoring your emotions (Street et al., 2005)."

Slide Twenty-Two – *Alterations in Cognition and Mood*



Script: “The third category is alterations in cognition and mood. There must two or more negative alterations in mood or cognitions associated with the trauma and beginning or worsening following the traumatic event. The symptoms are inability to remember aspects of the trauma. This is more typically due to dissociative amnesia and must not be related to other factors such as head injury or being under the influence of alcohol or drugs. Negative beliefs or expectations about oneself, others, or the world. Some examples of this included in the DSM are “I am bad”, “No one can be trusted”, “The world is dangerous”. A sense of blame towards oneself or others due to distorted cognitions about the cause of or consequences of the traumatic event. Persistent negative emotional state, such as fear, anger, or guilt. Diminished interest or participation in enjoyed activities. Feelings of detachment or estrangement from others. And persistent inability to experience positive emotions such as happiness, love, and satisfaction (APA, 2022).”

Slide Twenty-Three - *Alterations in Arousal and Reactivity*



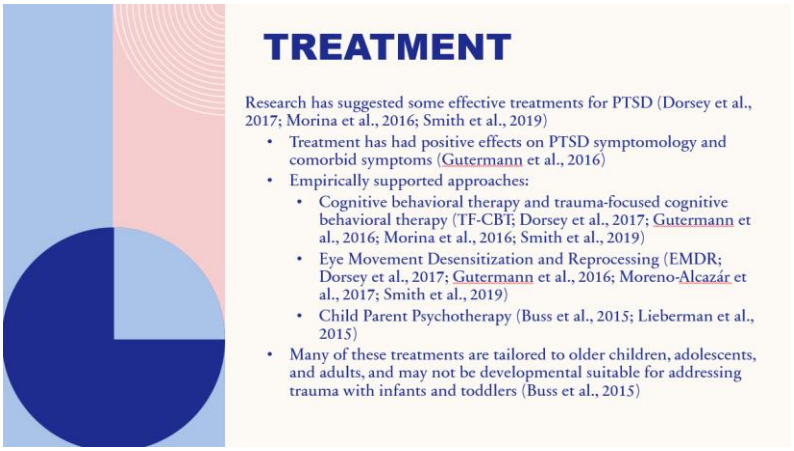
Script: “The final category is alterations in arousal and reactivity. There must be the presence of two more alterations to arousal and reactivity that are associated with the trauma and that began or worsened following the traumatic event. Symptoms include irritability or angry outbursts. Self-destructive behaviors such as substance use, driving recklessly, or self-harm. Hypervigilance or constantly assessing potential threats. An exaggerated startle response, with the individual being more likely to jump or be jarred by a sudden sound or movement. Difficulties with concentrating. And finally, sleep disturbances, such as difficulties falling asleep, staying asleep throughout the night, or sleeping restlessly (APA, 2022).”

Slide Twenty-Four – *PTSD Symptoms in Early Childhood*

Script: "In children under the age of 5, PTSD symptoms may present differently due to their developmental level. Reexperiencing or Intrusion symptoms for children under 5 are most often seen through post-traumatic play, where children may recreate themes from their traumatic experiences. Children may act out or create more morbid themes, exhibit difficulties with engaging in fantasy play, or more frequently act out scenes during play that revolve around themes related to their trauma. Some examples may be a child hitting a toy due to witnessing domestic violence or acting out themes of loneliness and lack of safety with children who have been neglected. Reexperiencing can also be observed in a child's artwork or through distressing dreams or nightmares. Symptoms of avoidance are most typically observed by efforts to avoid conversations, people, places, or objects that remind them of trauma, which closely mirrors older populations. Children may be more passive with their avoidance through eye contact or more active through crying, throwing a fit, or refusing to engage. Additionally, diminished interest in play may also be a symptom of avoidance, as the child maybe avoiding recreating themes from their trauma. Hyperarousal closely mirrors symptoms of hyperarousal in adults and adolescents, with sleep disturbances, exaggerated startle responses, and difficulties with concentration. Hyperarousal may also be observed through frequent temper tantrums or general fussiness. Some

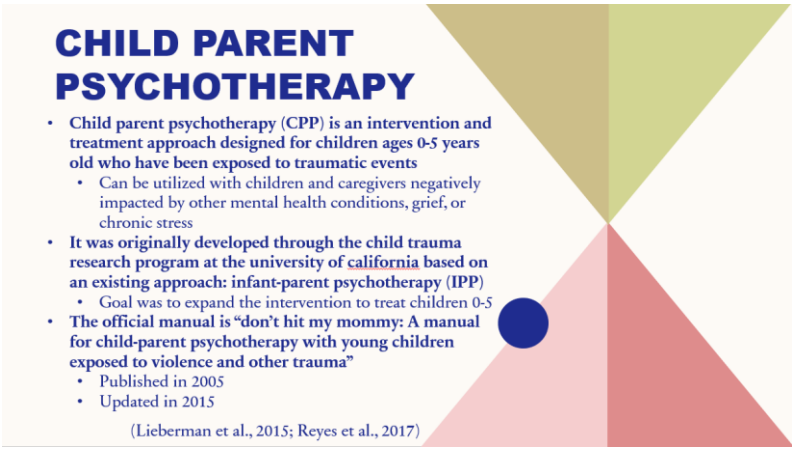
additional expressions of symptoms of PTSD in early childhood include excessive separation anxiety, physical aggression, and regressions in developmental skills (APA, 2022; Buss et al., 2015; Cohen et al., 2010; Young et al., 2011).”

Slide Twenty-Five – *Treatment*



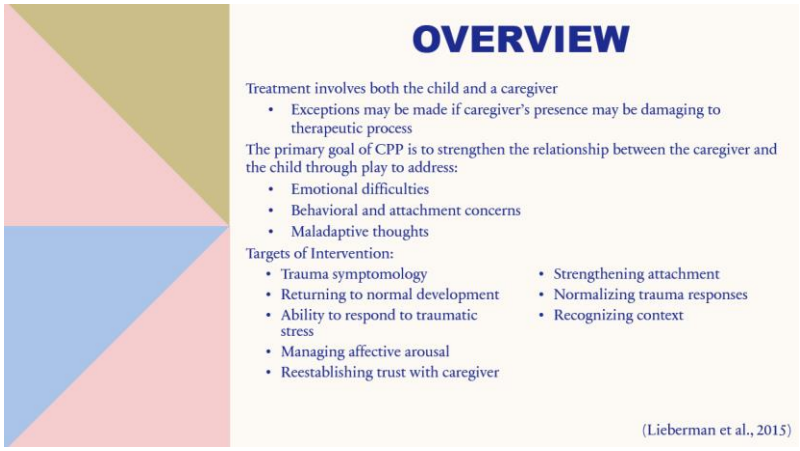
Script: "Now that we more broadly know about trauma, its impact, and the diagnostic criteria associated with trauma, it is important to consider how to treat this major concern. Some research has suggested positive treatment effects on PTSD symptomology and comorbid symptoms (Dorsey et al., 2017; Morina et al., 2016; Smith et al., 2019). The most well-researched and empirically supported treatment approaches for working with trauma-exposed populations are cognitive behavioral therapy (Dorsey et al., 2017; Guttermann et al., 2016; Morina et al., 2016; Smith et al., 2019), and trauma-focused cognitive behavioral therapy, eye-movement desensitization and reprocessing (Dorsey et al., 2017; Gutermann et al., 2016; Moreno-Alcazar et al., 2017; Smith et al., 2019), and child parent psychotherapy (Buss et al., 2015; Liberman et al., 2015). Most research on CBT and EMDR tend to be centered on the effects on older children, adolescents, and adults (Buss et al., 2015). For children under the age of 5, who are especially at risk of trauma exposure due to their dependency on caregivers, we must explore approaches such as Child Parent Psychotherapy, which is developed to be developmentally appropriate and effective with this population."

Slide Twenty-Six- *Child Parent Psychotherapy*



Script: "Child Parent Psychotherapy or CPP is an intervention and treatment approach designed for children ages 0-5 years old who have been exposed to traumatic events. CPP can be utilized with children and caregivers negatively impacted by other mental health conditions, grief, or chronic stress, but was originally designed with the intention to address the needs of young children exposed to trauma. The approach was originally developed through the Child Trauma Research Program at the University of California based on an existing approach: Infant-Parent Psychotherapy. The researchers worked to expand the intervention in order to treat children ages 0-5 rather than from 0-2. The first official manual for Child Parent Psychotherapy, "Don't Hit my Mommy: A Manual for Child Parent Psychotherapy with Young Children Exposed to Violence and other Trauma" was originally published in 2005 by Alicia Lieberman, Chandra Ghosh Ippen, and Patricia Van Horn. In 2015, the second edition of the manual was published with updated examples, research, and the addition of CPP Fidelity, which I will discuss in later slides. This manual is required reading for anyone looking to become certified in Child Parent Psychotherapy and provides a comprehensive review of the CPP model. (Lieberman et al., 2015; Reyes et al., 2017)"

Slide Twenty-Seven – *Overview*



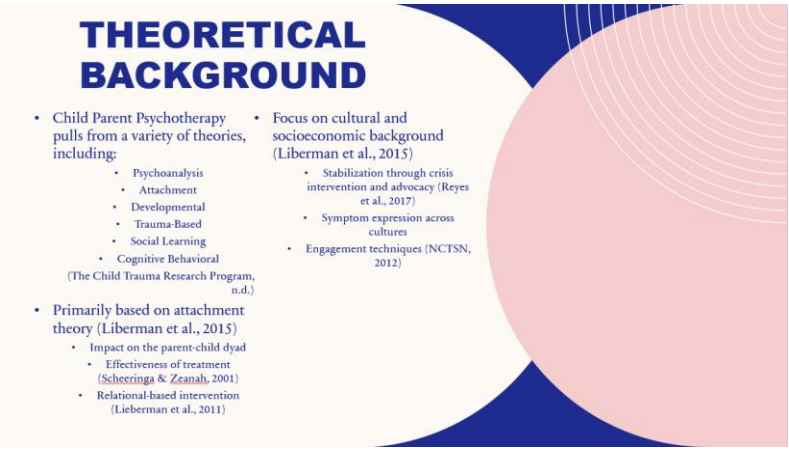
Script: "So that we can understand Child Parent Psychotherapy a little bit more, we'll cover a brief overview of the essential components. Treatment involves both the child and the caregiver, as it operates under the fundamental concept that the child-caregiver relationship is essential in order to overcome trauma responses and to maintain therapeutic gains as the child develops. Exceptions may be made if the parent's presence may be damaging to therapeutic process, and a different caregiver figure may be selected, such as a grandparent, an adult sibling, or foster parents. Accommodations for individual sessions may also be made, but often switching to a different treatment approach is more suitable if there are no caregiving figures to support the child through treatment. The primary goal of Child Parent Psychotherapy is to strengthen the relationship between the caregiver and the child through play, as it serves as the primary vehicle to address emotional difficulties, behavioral concerns, dysfunctional attachment styles, and maladaptive thoughts. By having the parent engage, interact, and play with the child, it facilitates feelings of trust and attachment that may have been lost as a result of the traumatic experience. Targets of the intervention include reducing trauma symptomology, returning the child to normal development, increasing the child's coping skills and ability to manage traumatic stress, managing affective arousal, reestablishing the child's trust and attachment with their caregiver,

normalizing trauma responses, and putting the traumatic experience and behaviors into context (Lieberman et al., 2015).”

Slide Twenty-Eight – *Clinician's Role*

Script: "The clinician's role in CPP is to instill hope for the child and the caregiver to work towards better wellbeing and a hopeful future. To achieve this the clinician works to making a strong and supportive working alliance with the child-parent dyad. The clinician often focuses on helping the parent and the child better understand the impact of trauma on their presenting problems and to assist them with processing the traumatic experience. The culmination of the working is joining the parent-child dyad in developing a joint trauma narrative that explores their experience of the trauma and normalizes trauma responses. Throughout treatment, the clinician plays a more passive role and encourages the parent to interact and play with the child as much as possible to restore feelings of trust. The clinician, rather than being the director of the session, finds "ports of entry" to incorporate meaningful reflections, interventions, and support for the child-parent dyad as they continue to play and interact with each other. The CPP model does not have a distinct curriculum, and instead encourages the clinician to incorporate whatever meaningful interventions they see fit based on the needs of the client. Some examples of interventions may include parenting skills, psychoeducation regarding trauma, relationship and communication skills, CBT-based interventions, and emotion regulation or relaxation skills (Lieberman et al., 2015)."

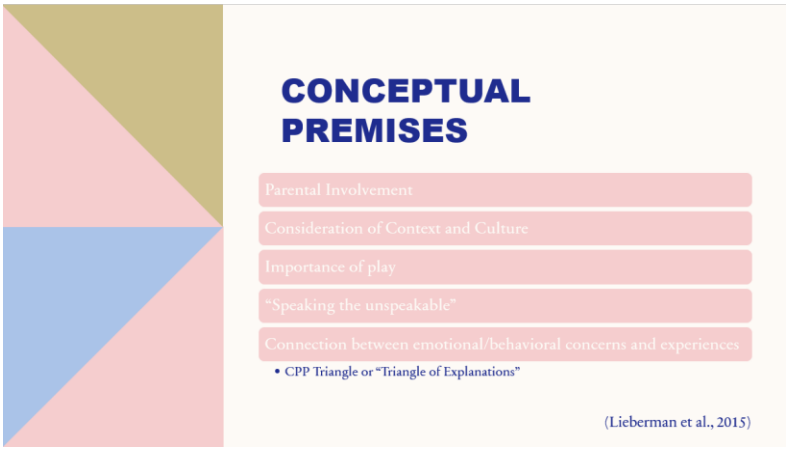
Slide Twenty-Nine - *Theoretical Background*



Script: The theoretical framework of Child Parent Psychotherapy is influenced by a variety of approaches that come together to form its model, including psychoanalysis, attachment theory, developmental theories, trauma-based theories, social learning theory, and cognitive behavioral therapy (The Child Trauma Research Program, n.d.). It is most closely aligned with attachment theory, as it operates under the core premise that the parent-child dyad is essential to understanding and protecting the child's mental health (Lieberman et al., 2015). Research has shown that post-traumatic stress in either member of the parent-child dyad can impact and exacerbate symptoms in the other member, regardless of if both were involved in the traumatic incident (Scheeringa & Zeanah, 2001). As such, the most effective treatment outcomes appear to occur when there is a strong attachment and connection between child and caregiver, which guides the CPP model. Implementing a relational-based intervention, such as CPP, can help lead to long-term improvements in parental functioning overall that help them to better support and appropriately care for their child, thus improving the child's mental health and feelings of trust (Lieberman et al., 2011). Child Parent Psychotherapy also emphasizes the importance of understanding trauma and planning the treatment approach based in the context of the dyad's cultural and socioeconomic background (Lieberman et al., 2015). The model stresses that

cultural and socioeconomic hardships must also be addressed in order to help the parent reach a place where they are able to return to their role as protector. This may mean that additional steps of crisis intervention and advocacy may be a large part of CPP for those with economic and cultural hardships, as well as those who may still be actively living their trauma experience, such as those who are still in the household with a domestic abuser. Safety, security, and stabilization are essential for seeing therapeutic gains, and as such, additional steps may need to be taken prior to starting the model (Reyes et al., 2017). Additionally, CPP emphasizes adapting the model to recognize the differences in symptom expression when working with multicultural populations. Adapting interventions to incorporate the client's native language, traditions, etc., is encouraged and suggested to improve effectiveness with a variety of ethnic and sociocultural backgrounds (NCTSN, 2012)."

Slide Thirty – *Conceptual Premises*



Script: "In addition to parental involvement and consideration of context and culture, which we discussed in the last slide, CPP has several main conceptual premises. I will cover the importance of play, speaking the unspeakable, and the CPP Triangle in the next few slides (Lieberman et al., 2015)."

Slide Thirty-One – *Play*

Script: “Play is the primary vehicle through which Child Parent Psychotherapy occurs and is one of the primary ways we begin to repair the attachment between caregiver and child. In this video, Chandra Ghosh Ippen, provides an overview of the types of toys used in Child Parent Psychotherapy and the ways they are used in play with children exposed to trauma. (Present video https://www.youtube.com/watch?v=sK-2uZXGCxA)

Script (Following video): “As we saw from Chandra, there are many ways to explore themes of trauma through play, whether that’s providing diverse families of dolls, emergency vehicles, or medical supplies. Additional ways to explore trauma through play may include artwork, sand trays, or developmentally appropriate books. As mentioned before, incorporating the parent into play with the child is one of the most essential parts of CPP, and should be emphasized throughout the course of treatment.”

Slide Thirty-Two – *Speaking the Unspeakable*

Script: "There's also the concept of speaking the unspeakable. Child parent psychotherapy operates under the idea that in order to progress and overcome the traumatic experience and its impact, there must be an open exploration and acknowledgement of the traumatic event. This is expected of both the parent and the child, and is heavily emphasized in the initial phases of treatment. This is done in a supportive atmosphere with a commitment to the safety and repair of child and caregiver's mental health, with the therapist being there to support them along the way. Although acknowledging the painful and challenging moments surrounding the trauma, it is equally important to balance out the difficulties with equally curative positives, such as recognizing the supportive relationships and playfulness that exists in the dyad (Lieberman et al., 2015)."

Slide Thirty-Three and Thirty-Four - *Triangle of Explanations and Small Group Discussion*

Script (Slide Thirty-Three): The final conceptual premise that guides the CPP model, is the idea that there is a connection between emotional/behavioral concerns and what the child has experienced. This is described through the CPP Triangle or the triangle of explanations. The triangle explains the links between the traumatic event, or the experience, the behavioral responses as a result of the trauma, and connects them into the goals for treatment and treatment planning process. This is discussed in depth with the parent during the initial sessions of Child Parent Psychotherapy, in which the parent and the provider collaborate to determine the present concern, how the caregiver would like the child to understand the trauma, and the goals for treatment. This is also described to the child during the initial treatment phase in a developmentally appropriate way. The triangle is also surrounded by a circle, which is known as protective steps and hope. As the provider, we are encouraged to frequently highlight the protective steps the parent has taken for the child, such as engaging in therapy or removing the child from an unsafe environment (Lieberman et al., 2015).

Script (Slide Thirty-Four): “As an example, the CPP Triangle may be explained to a child who has witnessed domestic violence as follows: “You saw your mom and dad fight each other.” This focuses on the experience of domestic violence. “Now sometimes you feel worried or upset when you think people are going to leave, and when you get angry, you may sometimes hit.”

This focuses on the behaviors and presenting concern. “This is a place where we can learn to understand these worries and why they came up after seeing mom and dad fight.” This statement focuses on the purposes of treatment. Finally, “Your mom is here now so we can help her to help you when you feel angry or scared”, which focuses on protective factors.

Now we’ll proceed with a small group activity. Like the example provided on this slide, in small groups, brainstorm some ways you could explain the CPP Triangle to a child and their parent who have experienced a different type of trauma.” *Allow 10-15 minutes for small group discussion on CPP Triangle as well as a follow up discussion with the full group for people to share examples*

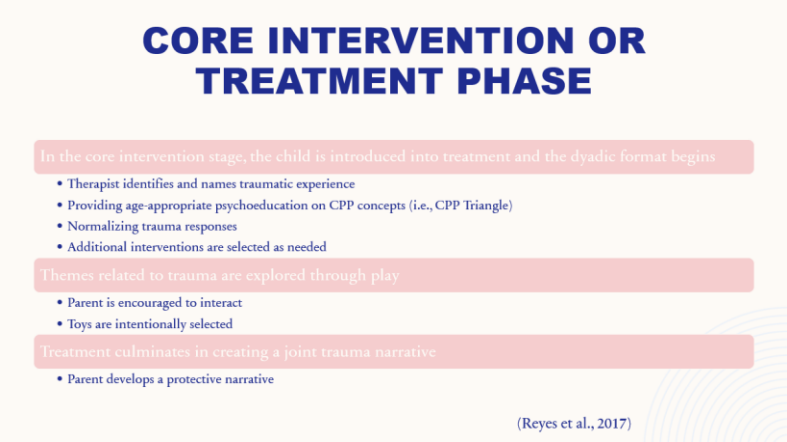
Slide Thirty-Five – *Format*

Script: Sessions are conducted weekly and are roughly about an hour-long to 45 minutes. Treatment can take from 20-32 weeks depending on the complexity of the case. The location of services is up to the clinical judgement of the clinician, but is most often in-office or in-home. In office treatment allows for a more controlled setting with limited distractions versus an in-home setting which allows the provider to understand and join the family in their authentic environment. The safety of both the clinician and the client is the number one determinant and location can be adjusted based on safety concerns. Understanding a bit more about the format, Child Parent Psychotherapy is split into three stages, the foundational phase, the core intervention and treatment, and the recapitulation and termination phase (Reyes et al., 2017)."

Slide Thirty-Six – *Foundational Phase*

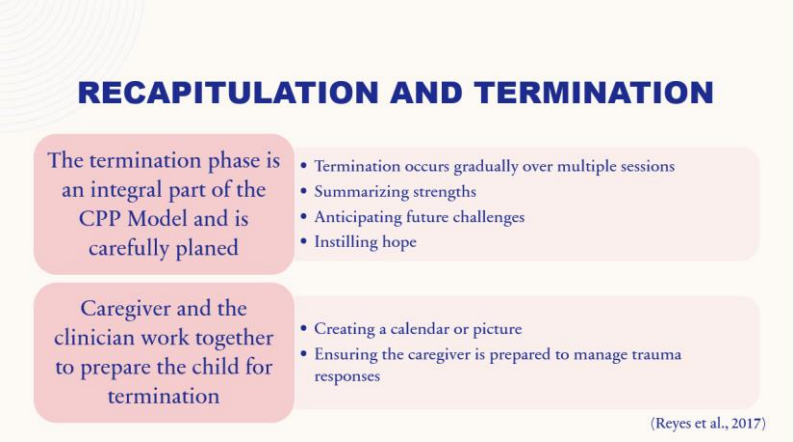
Script: "Starting with the foundational phase, the provider begins to develop therapeutic rapport and gather information. It typically starts with individual sessions with the caregiver in order to develop a joint definition of the presenting concern, to understand the trauma and the concern in context, and to create a treatment plan to meet the caregiver's identified goals. This may also provide caregivers the opportunity to discuss details that may be too graphic or traumatizing for the child. Extra care should be taken to develop a safe therapeutic atmosphere for the caregiver to be vulnerable to speak the unspeakable. Additionally, during this phase the clinician utilizes assessment tools to build a conceptualization of the case and the dyad's experiences. Stabilization and crisis intervention would also occur during this phase as needed. The provider spends much of their time providing psychoeducation to the caregiver to normalize trauma responses, understand the impact of the trauma, and to prepare them to engage in play. The final session of the foundational phase is the feedback session, which focuses on reviewing what was assessed during the initial few sessions and laying the framework for the start of the intervention phase (Reyes et al., 2017)."

Slide Thirty-Seven – *Core Intervention/Treatment Phase*



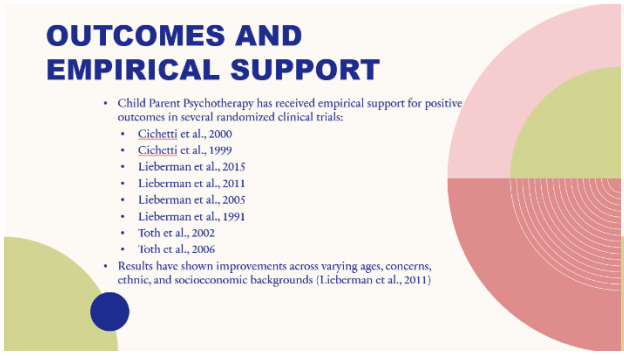
Script: "Following the foundation phase, we move into the core intervention or treatment phase, where the child is introduced into treatment. The initial sessions of the treatment phase focus introducing the child to the CPP Triangle created in collaboration with the caregiver and encouraging the child to share how they feel. The provider may name and discuss the trauma experience, symptoms, and reminders, which may result in avoidance. Play is often used to help establish connection between the caregiver and the child and allows an outlet for themes related to the trauma to surface. Toys are intentionally selected to help reflect the traumatic experience, such as including a hospital setting, a police car, and diverse sets of families for the child to play with. The culmination of the treatment phase is the joint creation of a trauma narrative by the parent-child dyad. This trauma narrative explores what occurred, how the child and parent feel about it now, and acknowledges the impact the trauma has on current concerns. The parent creates a protective narrative alongside the trauma narrative to communicate a commitment to safety and repair. They may discuss what they did to try to address the problem at the time or things they will continue to do in the future to protect the child. The trauma narrative can be created through any form or medium, such as creating a play, making a book, acting it out in a dollhouse, etc. (Reyes et al., 2017)."

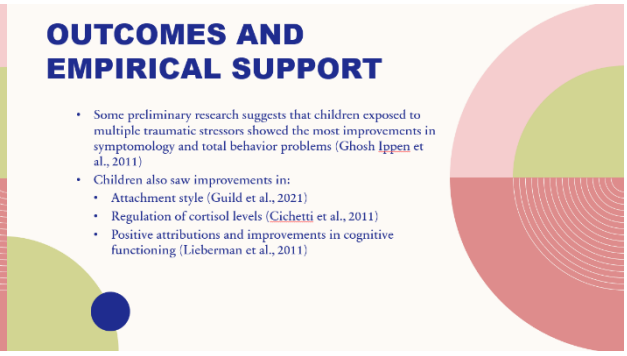
Slide Thirty-Eight – *Recapitulation and Termination Phase*

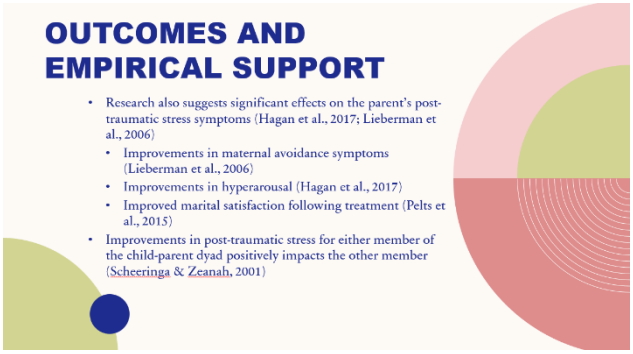


Script: “The final phase is the termination phase, which is an integral part of the CPP model. This phase tends to be very carefully planned, as loss or separation may be a significant trauma reminder. Rather than a single session, termination occurs gradually over multiple sessions in order to prepare the child for the end of services. During the last few sessions, the provider may focus on emphasizing positive changes and gains from participating in CPP, and anticipating and preparing the caregiver for anticipated future challenges. As the end of services nears, the clinician may prepare the child for termination with fun activities such as decorating a calendar or taking a picture to take with them (Reyes et al., 2017).”

Slides Thirty-Nine, Forty, and Forty-One – *Outcomes and Empirical Support*







Script (Slide Thirty-Nine): "Pivoting to the research supporting Child Parent Psychotherapy, there have been several randomized clinical trials that have shown empirical support for positive outcomes (Cichetti et al., 2000; Cichetti et al., 1999; Lieberman et al., 1999; Lieberman et al., 2011; Lieberman et al., 2005; Lieberman et al., 1991; Toth et al., 2002; Toth et al., 2006). I will not go through these studies in depth, but the general findings stressed improvements in trauma symptoms for both child and caregiver across varying ages, ethnic and socioeconomic backgrounds, and types of traumas experienced. Additionally therapeutic gains appeared to be maintained over time (Lieberman et al., 2011)."

Script (Slide Forty): "Some preliminary research also suggests that children exposed to multiple traumatic events saw the most significant improvements in trauma and comorbid psychiatric symptoms as well as total behavior problems following CPP (Ghosh Ippen et al., 2011). Additional outcomes included more secure attachment styles (Guild et al., 2021),

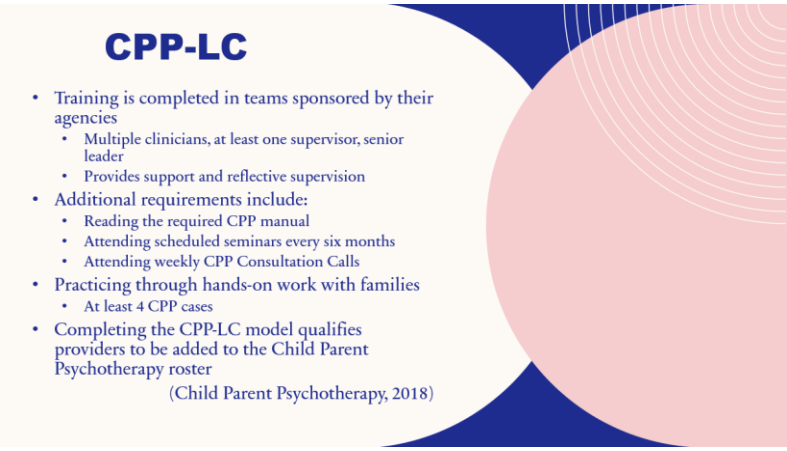
improved regulation of cortisol levels (Cichetti et al., 2011), more positive attributions to oneself or others, and improvements in cognitive functioning (Lieberman et al., 2011)."

Script (Forty-One): "Research also shows that CPP has significant impact on the caregiver's trauma symptoms (Hagan et al., 2017; Lieberman et al., 2006). They additionally found improvements in maternal avoidance symptoms (Lieberman et al., 2006), improvements in regulation as a result of improvements to hyperarousal symptoms of their children (Hagan et al., 2017), and improved marital satisfaction (Pelts et al., 2015). Overall, improvements for one member of the child-parent dyad has been shown to positive affect the other member of the dyad, and as such focusing on the therapeutic gains of the caregiver is equally important (Scheeringa & Zeanah, 2001)."

Slide Forty-Two – *Certification*

Script: "As this presentation does not count as certification in Child Parent Psychotherapy, I believe it is important to cover how the certification process works for any providers who are interested in formal training and certification. To become certified, providers must engage in formal training offered by the developers of Child Parent Psychotherapy. This training is available to master's or doctorate level psychotherapists who have degrees in mental health-related fields. There are three different implementation-level training courses provided. The first, the 18-month CPP Learning Collaborative or CPP-LC, is the standard training to become certified, which I will discuss further in the next slide. The second model is the CPP Agency Mentorship Program or CAMP, which is an agency-level training designed for organizations that have already had teams trained in CPP-LC. This model helps the organization to continue to teach providers internally to continue to disseminate empirically supported trauma-based approaches into the community. The final model is the Endorsed CPP Internship model, which is the only opportunity available to train students from mental health-related fields in Child Parent Psychotherapy. Internships are offered at specific internship sites across the United States. A full list can be found on their website (Child Parent Psychotherapy, 2018)."

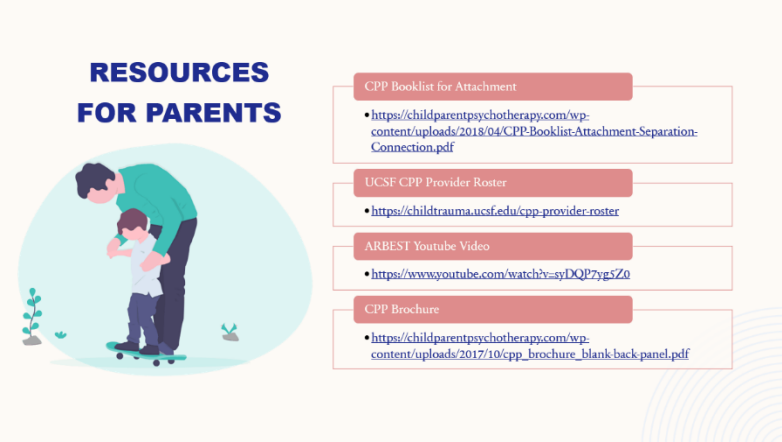
Slide Forty-Three – *CPP-LC*



Script: "We will be focusing on the 18-month CPP-LC training, as this is the most widely used training for becoming certified in Child Parent Psychotherapy. Training is completed in teams sponsored by their agencies rather than by individual providers. Teams typically consist of multiple clinicians, at least one supervisor, and a senior leader associated with the organization if possible. Training in teams better supports the clinicians and the agency to deal with the challenges of working with young children exposed to trauma. This also allows the providers to receive consistent reflective supervision, which is a key component of the training. Additional requirements for the training include reading the official manual for Child Parent Psychotherapy, which is *Don't Hit My Mommy: A Manual for Child-Parent Psychotherapy with Children Exposed to Violence* by Alicia Lieberman, Chandra Ghosh Ippen, & Patricia Van Horn. The manual can be acquired through Zero to Three both in paperback and digitally. Additionally, teams are expected to attend a scheduled seminar once every six months, where the brunt of the training content is presented. In between seminars, providers are expected to sit in on weekly CPP Consultation Calls, which focus on case conceptualizations and ways to utilize the CPP model, and to receive consistent reflective CPP supervision, which helps providers spend time processing the personal impact of the trauma on the provider. Another key part of the training is

for the provider to engage in practicing the CPP model through hands-on work with families at their agency. Clinicians are expected to have at least 4 CPP cases in an 18-month period, with at least two of the cases spanning at least 16 sessions. Additionally, one of the cases must start from the very beginning of the process. After completing the 18-month training, the provider is then eligible to be included on the Child Parent Psychotherapy roster maintained by the Child Trauma Research Program (Child Parent Psychotherapy, 2018).”

Slide Forty-Four– *Resources for Parents*

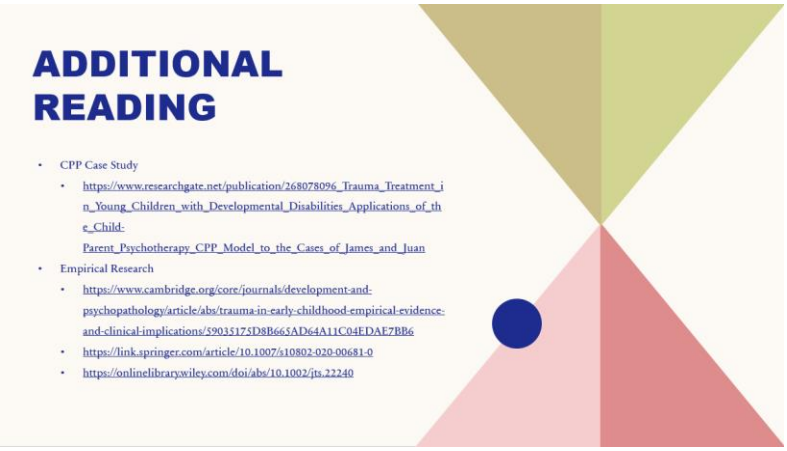


Script: "Additionally here are some resources to provide to parents who are interested in child parent psychotherapy, or who would like to know more. One resource for parents is this booklist of books related to attachment, separation, and connection from the developers of Child Parent Psychotherapy. Parents can utilize these books to continue reinforcing themes and concepts related to attachment discussed in CPP. Another resource to provide to parents who may potentially be interested in pursuing Child Parent Psychotherapy with their child is the CPP provider roster from the University of California San Francisco (UCSF) Child Trauma Research Program. This list is not exhaustive but does provide a list of providers who are certified in Child Parent Psychotherapy. The list provides filters that allow the individual to search for a provider who will fit best with their needs. Additionally, this YouTube video created by Arkansas Building Effective Services for Trauma (ARBEST) at the UAMS Psychiatric Research Institute provides a short introductory explanation of Child Parent Psychotherapy for parents that can help them to understand it's use in relation to their child's experiences of trauma. This brochure created by the developers of Child Parent Psychotherapy can be printed and handed out to parents to provide introductory information regarding CPP."

Slide Forty-Five - *Resources for Providers*

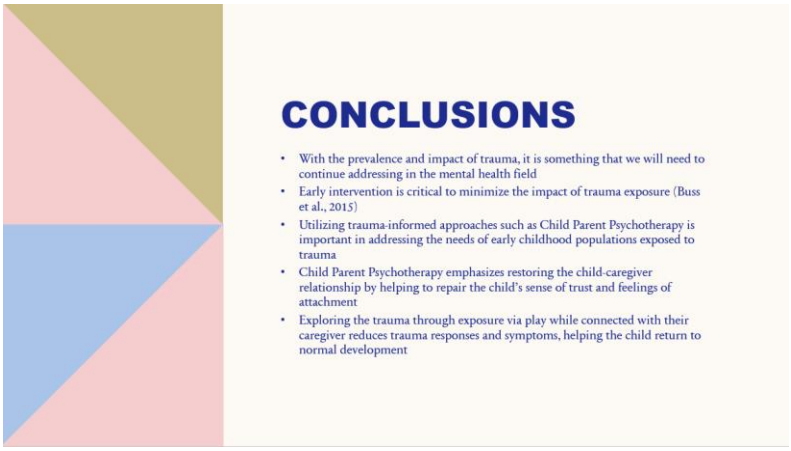
"Here are some additional resources for providers that may be helpful. The National Child Traumatic Stress Network has created a fact sheet regarding Child Parent Psychotherapy which includes basic information such as a description of the treatment approach, target populations, existing research, outcomes, and training materials. This may be helpful for introducing agencies, supervisors, providers, or families to CPP as a potential treatment approach. Additionally, a culturally specific version of the fact sheet is also available that details Child Parent Psychotherapy's use with various culturally diverse populations. Additionally, the official child parent psychotherapy website provides a multitude of resources for providers who are interested in Child Parent Psychotherapy and becoming certified. For those interested in more reading materials related to CPP, the most common manuals are "Don't Hit my Mommy: A Manual for Child Parent Psychotherapy with Children Exposed to Violence, by Lieberman, Ghosh Ippen, and Van Horn and Psychotherapy with Infants and Young Children: Repairing the Effects of Stress and Trauma on Early Attachment by Lieberman and Van Horn, both of which are linked here."

Slide Forty-Six – *Additional Reading*



Script: "Listed here are some links to additional readings related to CPP, including a more in-depth case study that explores the use of CPP with children with developmental disabilities. Additionally, I have listed some of the more recent empirical articles that explore the effectiveness and outcomes of Child Parent Psychotherapy."

Slide Forty-Seven – *Conclusions*



Script: "Looking back over the rest of our training here today, let's review some of the conclusions. With the prevalence and impact of trauma, we will need to continue to address this pressing problem within our field. Early intervention is critical for trauma-exposed populations to reduce the impact of trauma exposure long-term, especially for children and adolescents (Buss et al., 2015). Utilizing trauma-informed approaches, such as Child Parent Psychotherapy is critical in addressing the needs of early childhood populations exposed to trauma. The CPP model emphasizes restoring the child/caregiver relationship by repairing the sense of trust and the feelings of attachment between the pair, which are important for maintaining therapeutic gains. Exploring the trauma through play while connected with their caregiver can help to reduce the trauma responses and symptoms experienced by the child, resulting in more positive outcomes and a return to healthy development. I hope that today's presentation has provided you some information regarding working with trauma-exposed populations and Child Parent Psychotherapy as an empirically supported and beneficial model."

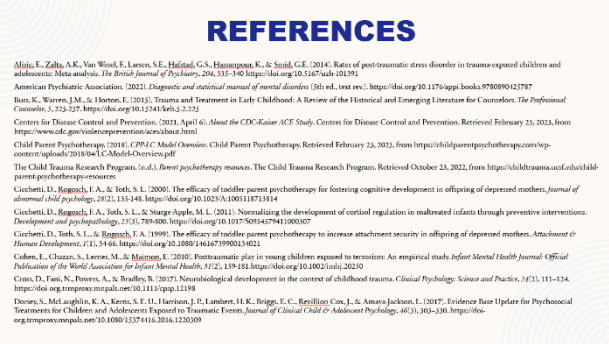
Slide Forty-Eight – *Post-Training Survey*

Script: “We will take a moment to do a post-training survey to help inform us of the effectiveness of our training. If you are in person, there will be a physical copy handed out to you. Please take a moment to complete it and turn it in. For those of you joining us via Zoom, I have provided you with a link to a digital version of the survey. Please take a moment to complete the survey on whichever digital device you have available. Following the post-training survey we will be taking questions.”

Slide Forty-Nine - *Questions*

Script: “We will open up the floor for any questions” *Allow the remaining time for any questions from participants*

Slide Fifty, Fifty-One, Fifty-Two, Fifty-Three, and Fifty-Four – *References*



REFERENCES

Alisic, E., Zalta, A.K., Van Wesel, F., Larsen, S.E., Hafstad, G.S., Hassanpour, K., & Smid, G.E. (2014). Rates of post-traumatic stress disorder in trauma-exposed children and adolescents: Meta-analysis. *The British Journal of Psychiatry, 204*, 335–340 https://doi.org/10.5167/uzh-101391

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Bass, K., Warren, J.M., & Horton, E. (2015). Trauma and Treatment in Early Childhood: A Review of the Historical and Emerging Literature for Counselors. *The Professional Counselor, 5*, 253–257. https://doi.org/10.15241/keb.5.2.232

Centers for Disease Control and Prevention. (2021, April 6). *About the CDC-Kaiser ACE Study*. Centers for Disease Control and Prevention. Retrieved February 25, 2023, from https://www.cdc.gov/violenceprevention/aces/about.html

Child Parent Psychotherapy. (2018). *CPP.1.C Model Overview*. Child Parent Psychotherapy. Retrieved February 23, 2023, from https://childparentpsychotherapy.com/wp-content/uploads/2018/04/1.C-Model-Overview.pdf

The Child Trauma Research Program. (n.d.). *Parent psychotherapy resources*. The Child Trauma Research Program. Retrieved October 23, 2022, from https://childtrauma.ucsf.edu/child-parent-psychotherapy-resources

Cicchetti, D., Rogosch, F.A., & Toth, S. L. (2000). The efficacy of toddler parent psychotherapy for fostering cognitive development in offspring of depressed mothers. *Journal of abnormal child psychology, 28*(2), 135-148. https://doi.org/10.1023/A:1005117813814

Cicchetti, D., Rogosch, F.A., Toth, S. L., & Sturge-Apple, M. L. (2011). Normalizing the development of cortisol regulation in maltreated infants through preventive interventions. *Development and psychopathology, 23*(3), 789-800. https://doi.org/10.1017/S0954579411000307

Cicchetti, D., Toth, S. L., & Rogosch, F.A. (1999). The efficacy of toddler parent psychotherapy to increase attachment security in offspring of depressed mothers. *Attachment & Human Development, 1*(1), 34-66. https://doi.org/10.1080/14616739900134021

Cohen, E., Chazan, S., Lerner, M., & Maimon, E. (2010). Posttraumatic play in young children exposed to terrorism: An empirical study. *Infant Mental Health Journal: Official Publication of the World Association for Infant Mental Health, 31*(2), 159-181.https://doi.org/10.1002/imhj.20250

Cross, D., Tarsi, N., Powers, A., & Bradley, B. (2017). Neurobiological development in the context of childhood trauma. *Clinical Psychology: Science and Practice, 24*(2), 111–124. https://doi.org.trmproxy.mnpals.net/10.1111/cpsp.12198

Dorsey, S., McLaughlin, K. A., Kerns, S. E. U., Harrison, J. P., Lambert, H. K., Briggs, E. C., Revillion Cox, J., & Amaya-Jackson, L. (2017). Evidence Base Update for Psychosocial Treatments for Children and Adolescents Exposed to Traumatic Events. *Journal of Clinical Child & Adolescent Psychology, 46*(3), 303–330. https://doi-org.trmproxy.mnpals.net/10.1080/15374416.2016.1220309

REFERENCES

Dye, H. (2018). The impact and long-term effects of childhood trauma. *Journal of Human Behavior in the Social Environment, 28*(3), 381–392. https://doi-org.trmproxy.mnpals.net/10.1080/10911359.2018.1435328

Edmondson, Kronish, I. M., Shaffer, J. A., Falzon, L., & Burg, M. M. (2013). Posttraumatic stress disorder and risk for coronary heart disease: A meta-analytic review. *The American Heart Journal, 166*(5), 806–814. https://doi.org/10.1016/j.ahj.2013.07.031

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine, 14*(4), 245-258. https://doi.org/10.1016/S0749-3797(98)00017-8

Ghosh Ippen, C., Harris, W. W., Van Horn, P., & Lieberman, A. F. (2011). Traumatic and stressful events in early childhood: can treatment help those at highest risk?. *Child abuse & neglect, 35*(7), 504–513. https://doi.org/10.1016/j.chiabu.2011.03.009

Greeson, J. K., Briggs, E. C., Layne, C. M., Belcher, H. M., Ostrowski, S. A., Kim, S., Lee, R.C., Vivrette, R.L., Pynoos, R.S. & Fairbank, J. A. (2014). Traumatic childhood experiences in the 21st century: Broadening and building on the ACE studies with data from the National Child Traumatic Stress Network. *Journal of Interpersonal Violence, 29*(3), 536-556. https://doi.org/10.1177/0886260513505217

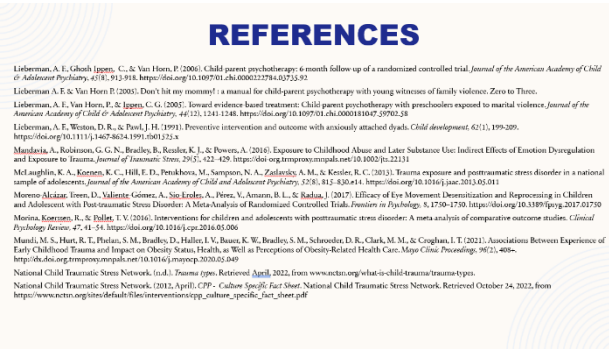
Guild, D. J., Alto, M. E., Handley, E. D., Rogosch, F., Cicchetti, D., & Toth, S. L. (2021). Attachment and Affect between Mothers with Depression and their Children: Longitudinal Outcomes of Child Parent Psychotherapy. *Research on Child & Adolescent Psychopathology, 49*(5), 563–577. https://doi-org.trmproxy.mnpals.net/10.1007/s10802-020-00681-0

Gutermann, J., Schreiber, F., Matulis, S., Schwartzkopff, L., Deppe, J., & Steil, R. (2016). Psychological Treatments for Symptoms of Posttraumatic Stress Disorder in Children, Adolescents, and Young Adults: A Meta-Analysis. *Clinical Child & Family Psychology Review, 19*(2), 77–93. https://doi-org.trmproxy.mnpals.net/10.1007/s10567-016-0202-5

Hagan, M. J., Browne, D. T., Sulik, M., Ippen, C. G., Bush, N., & Lieberman, A. F. (2017). Parent and Child Trauma Symptoms During Child-Parent Psychotherapy: A Prospective Cohort Study of Dyadic Change. *Journal of Traumatic Stress, 30*(6), 690–697. https://doi-org.trmproxy.mnpals.net/10.1002/jts.22240

Lieberman, A., Chu, A., Van Horn, P., & Harris, W. (2011). Trauma in early childhood: Empirical evidence and clinical implications. *Development and Psychopathology, 23*(2), 397-410. https://doi.org/10.1017/S0954579411000137

Lieberman, A.F., Ghosh Ippen, C., & Van Horn, P. (2015). Don't hit my mommy: A manual for Child-Parent Psychotherapy with young children exposed to violence and other trauma. Second Edition. Washington, DC: Zero to Three.



REFERENCES

Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2006). Child-parent psychotherapy: 6 month follow up of a randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 45*(8), 913-918. https://doi.org/10.1097/01.chi.0000222784.03733.92

Lieberman A. F. & Van Horn P. (2005). Don't hit my mommy! : a manual for child-parent psychotherapy with young witnesses of family violence. Zero to Three.

Lieberman, A. F., Van Horn, P., & Ippen, C. G. (2005). Toward evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(12), 1241-1248. https://doi.org/10.1097/01.chi.0000181047.59702.58

Lieberman, A. F., Weston, D. R., & Pawl, J. H. (1991). Preventive intervention and outcome with anxiously attached dyads. *Child development, 62*(1), 199-209. https://doi.org/10.1111/j.1467-8624.1991.tb01523.x

Mandavia, A., Robinson, G. G. N., Bradley, B., Ressler, K. J., & Powers, A. (2016). Exposure to Childhood Abuse and Later Substance Use: Indirect Effects of Emotion Dysregulation and Exposure to Trauma. *Journal of Traumatic Stress, 29*(5), 422–429. https://doi-org.trmproxy.mnpals.net/10.1002/jts.22131

McLaughlin, K. A., Koenen, K. C., Hill, E. D., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2013). Trauma exposure and posttraumatic stress disorder in a national sample of adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 52*(8), 815–830.e14. https://doi.org/10.1016/j.jaac.2013.05.011

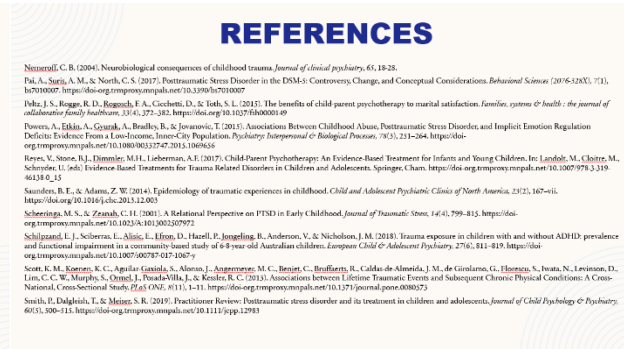
Moreno-Alcázar, Ieven, D., Valiente Gómez, A., Sin Ereño, A., Pérez, V., Amann, B. L., & Radua, J. (2017). Efficacy of Eye Movement Desensitization and Reprocessing in Children and Adolescent with Post-traumatic Stress Disorder: A Meta-Analysis of Randomized Controlled Trials. *Frontiers in Psychology, 8*, 1750–1750. https://doi.org/10.3389/fpsyg.2017.01750

Morina, Koerssen, R., & Pollet, T. V. (2016). Interventions for children and adolescents with posttraumatic stress disorder: A meta analysis of comparative outcome studies. *Clinical Psychology Review, 47*, 41–54. https://doi.org/10.1016/j.cpr.2016.05.006

Mundi, M. S., Hurt, R. T., Phelan, S. M., Bradley, D., Haller, I. V., Bauer, K. W., Bradley, S. M., Schroeder, D. R., Clark, M. M., & Croghan, I. T. (2021). Associations Between Experience of Early Childhood Trauma and Impact on Obesity Status, Health, as Well as Perceptions of Obesity-Related Health Care. *Mayo Clinic Proceedings, 96*(2), 408–. http://dx.doi.org.trmproxy.mnpals.net/10.1016/j.mayocp.2020.05.049

National Child Traumatic Stress Network. (n.d.). *Trauma types*. Retrieved April, 2022, from www.nctsn.org/what-is-child-trauma/trauma-types.

National Child Traumatic Stress Network. (2012, April). *CPP - Culture Specific Fact Sheet*. National Child Traumatic Stress Network. Retrieved October 24, 2022, from https://www.nctsn.org/sites/default/files/interventions/cpp_culture_specific_fact_sheet.pdf



REFERENCES

Neuroff, C. B. (2004). Neurobiological consequences of childhood trauma. *Journal of clinical psychiatry, 65*, 18-28.

Pai, A., Suris, A. M., & North, C. S. (2017). Posttraumatic Stress Disorder in the DSM-5: Controversy, Change, and Conceptual Considerations. *Behavioral Sciences (2076-328X), 7*(1), bs7010007. https://doi-org.trmproxy.mnpals.net/10.3390/bs7010007

Peltz, J. S., Rogge, R. D., Rogosch, F. A., Cicchetti, D., & Toth, S. L. (2015). The benefits of child-parent psychotherapy to marital satisfaction. *Families, systems & health : the journal of collaborative family healthcare, 33*(4), 372–382. https://doi.org/10.1037/fsh0000149

Powers, A., Etkin, A., Gyurak, A., Bradley, B., & Jovanovic, T. (2015). Associations Between Childhood Abuse, Posttraumatic Stress Disorder, and Implicit Emotion Regulation Deficits: Evidence From a Low-Income, Inner-City Population. *Psychiatry: Interpersonal & Biological Processes, 78*(3), 253–264. https://doi-org.trmproxy.mnpals.net/10.1080/00332747.2015.1069656

Reyes, V., Stone, B.J., Dimmler, M.H., Lieberman, A.F. (2017). Child-Parent Psychotherapy: An Evidence-Based Treatment for Infants and Young Children. In: Landolt, M., Cloitre, M., Schnyder, U. (eds) Evidence-Based Treatments for Trauma Related Disorders in Children and Adolescents. Springer, Cham. https://doi-org.trmproxy.mnpals.net/10.1007/978-3-319-46138-0_15

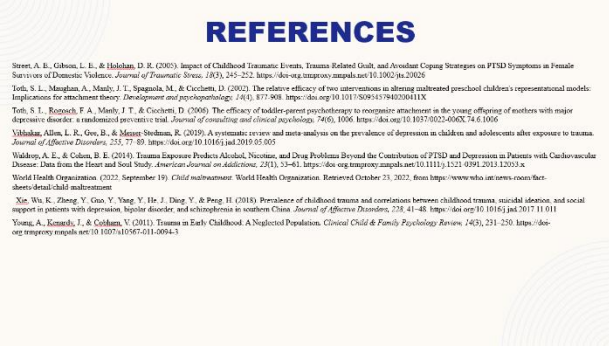
Saunders, B. E., & Adams, Z. W. (2014). Epidemiology of traumatic experiences in childhood. *Child and Adolescent Psychiatric Clinics of North America, 23*(2), 167–vii. https://doi.org/10.1016/j.chc.2013.12.003

Scheeringa, M. S., & Zeanah, C. H. (2001). A Relational Perspective on PTSD in Early Childhood. *Journal of Traumatic Stress, 14*(4), 799–815. https://doi-org.trmproxy.mnpals.net/10.1023/A:1013003207972

Schlgrand, L. J., Scilzerras, L., Alisic, E., Elfon, D., Hazell, P., Jongeling, B., Anderson, V., & Nicholson, J. M. (2018). Trauma exposure in children with and without ADHD: prevalence and functional impairment in a community-based study of 6-8-year-old Australian children. *European Child & Adolescent Psychiatry, 27*(6), 811–819. https://doi-org.trmproxy.mnpals.net/10.1007/s00787-017-1067-y

Scott, K. M., Koenen, K. C., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., Benjet, C., Bruffaerts, R., Caldas de Almeida, J. M., de Girolamo, G., Florescu, S., Iwata, N., Levinson, D., Lim, C. C. W., Murphy, S., Ormel, J., Posada-Villa, J., & Kessler, R. C. (2013). Associations between Lifetime Traumatic Events and Subsequent Chronic Physical Conditions: A Cross-National, Cross-Sectional Study. *PLoS ONE, 8*(11), 1–11. https://doi-org.trmproxy.mnpals.net/10.1371/journal.pone.0080573

Smith, P., Dalgleish, T., & Meiser, S. R. (2019). Practitioner Review: Posttraumatic stress disorder and its treatment in children and adolescents. *Journal of Child Psychology & Psychiatry, 60*(5), 500–515. https://doi-org.trmproxy.mnpals.net/10.1111/jcpp.12983



REFERENCES

Street, A. E., Gibson, L. E., & Holohan, D. R. (2005). Impact of Childhood Traumatic Events, Trauma Related Guilt, and Avoidant Coping Strategies on PTSD Symptoms in Female Survivors of Domestic Violence. *Journal of Traumatic Stress, 18*(3), 245–252. https://doi-org.trmproxy.mnpals.net/10.1002/jts.20026

Toth, S. L., Maughan, A., Manly, J. T., Spagnola, M., & Cicchetti, D. (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory. *Development and psychopathology, 14*(4), 877-908. https://doi.org/10.1017/S0954579402004114X

Toth, S. L., Rogosch, F. A., Manly, J. T., & Cicchetti, D. (2006). The efficacy of toddler-parent psychotherapy to reorganize attachment in the young offspring of mothers with major depressive disorder: a randomized preventive trial. *Journal of consulting and clinical psychology, 74*(6), 1006. https://doi.org/10.1037/0022-006X.74.6.1006

Vibhakar, Allen, L. R., Gee, B., & Meiser-Stedman, R. (2019). A systematic review and meta-analysis on the prevalence of depression in children and adolescents after exposure to trauma. *Journal of Affective Disorders, 255*, 77–89. https://doi.org/10.1016/j.jad.2019.05.005

Waldrop, A. E., & Cohen, B. E. (2014). Trauma Exposure Predicts Alcohol, Nicotine, and Drug Problems Beyond the Contribution of PTSD and Depression in Patients with Cardiovascular Disease: Data from the Heart and Soul Study. *American Journal on Addictions, 23*(1), 53–61. https://doi-org.trmproxy.mnpals.net/10.1111/j.1521-0391.2013.12053.x

World Health Organization. (2022, September 19). *Child maltreatment*. World Health Organization. Retrieved October 23, 2022, from https://www.who.int/news-room/fact-sheets/detail/child-maltreatment

Xie, Wu, K., Zheng, Y., Guo, Y., Yang, Y., He, J., Ding, Y., & Peng, H. (2018). Prevalence of childhood trauma and correlations between childhood trauma, suicidal ideation, and social support in patients with depression, bipolar disorder, and schizophrenia in southern China. *Journal of Affective Disorders, 228*, 41–48. https://doi.org/10.1016/j.jad.2017.11.011

Young, A., Kenardy, J., & Cobham, V. (2011). Trauma in Early Childhood: A Neglected Population. *Clinical Child & Family Psychology Review, 14*(3), 231–250. https://doi-org.trmproxy.mnpals.net/10.1007/s10567-011-0094-3

References

Alisic, E., Zalta, A.K., Van Wesel, F., Larsen, S.E., Hafstad, G.S., Hassanpour, K., & Smid, G.E. (2014). Rates of post-traumatic stress disorder in trauma-exposed children and adolescents: Meta-analysis. *The British Journal of Psychiatry*, *204*, 335–340 https://doi.org/10.5167/uzh-101391

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Buss, K., Warren, J.M., & Horton, E. (2015). Trauma and Treatment in Early Childhood: A Review of the Historical and Emerging Literature for Counselors. *The Professional Counselor*, *5*, 225-237. https://doi.org/10.15241/keb.5.2.225

Centers for Disease Control and Prevention. (2021, April 6). *About the CDC-Kaiser ACE Study*. Centers for Disease Control and Prevention. Retrieved February 25, 2023, from https://www.cdc.gov/violenceprevention/aces/about.html

Child Parent Psychotherapy. (2018). *CPP-LC Model Overview*. Child Parent Psychotherapy. Retrieved February 23, 2023, from https://childparentpsychotherapy.com/wp-content/uploads/2018/04/LC-Model-Overview.pdf

The Child Trauma Research Program. (n.d.). *Parent psychotherapy resources*. The Child Trauma Research Program. Retrieved October 23, 2022, from https://childtrauma.ucsf.edu/child-parent-psychotherapy-resources

Cicchetti, D., Rogosch, F. A., & Toth, S. L. (2000). The efficacy of toddler-parent psychotherapy for fostering cognitive development in offspring of depressed mothers. *Journal of abnormal child psychology, 28*(2), 135-148. https://doi.org/10.1023/A:1005118713814

Cicchetti, D., Rogosch, F. A., Toth, S. L., & Sturge-Apple, M. L. (2011). Normalizing the development of cortisol regulation in maltreated infants through preventive interventions. *Development and psychopathology*, *23*(3), 789-800. https://doi.org/10.1017/S0954579411000307

Cicchetti, D., Toth, S. L., & Rogosch, F. A. (1999). The efficacy of toddler-parent psychotherapy to increase attachment security in offspring of depressed mothers. *Attachment & Human Development*, *1*(1), 34-66. https://doi.org/10.1080/14616739900134021

Cohen, E., Chazan, S., Lerner, M., & Maimon, E. (2010). Posttraumatic play in young children exposed to terrorism: An empirical study. *Infant Mental Health Journal: Official Publication of the World Association for Infant Mental Health*, *31*(2), 159-181.https://doi.org/10.1002/imhj.20250

Cross, D., Fani, N., Powers, A., & Bradley, B. (2017). Neurobiological development in the context of childhood trauma. *Clinical Psychology: Science and Practice*, *24*(2), 111–124. https://doi-org.trmproxy.mnpals.net/10.1111/cpsp.12198

Dorsey, S., McLaughlin, K. A., Kerns, S. E. U., Harrison, J. P., Lambert, H. K., Briggs, E. C., Revillion Cox, J., & Amaya-Jackson, L. (2017). Evidence Base Update for Psychosocial Treatments for Children and Adolescents Exposed to Traumatic Events. *Journal of Clinical Child & Adolescent Psychology*, *46*(3), 303–330. https://doi-org.trmproxy.mnpals.net/10.1080/15374416.2016.1220309

Dye, H. (2018). The impact and long-term effects of childhood trauma. *Journal of Human Behavior in the Social Environment*, *28*(3), 381–392. https://doi-org.trmproxy.mnpals.net/10.1080/10911359.2018.1435328

Edmondson, Kronish, I. M., Shaffer, J. A., Falzon, L., & Burg, M. M. (2013). Posttraumatic stress disorder and risk for coronary heart disease: A meta-analytic review. *The American Heart Journal*, *166*(5), 806–814. https://doi.org/10.1016/j.ahj.2013.07.031

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, *14*(4), 245-258. https://doi.org/10.1016/S0749-3797(98)00017-8

Ghosh Ippen, C., Harris, W. W., Van Horn, P., & Lieberman, A. F. (2011). Traumatic and stressful events in early childhood: can treatment help those at highest risk?. *Child abuse & neglect*, *35*(7), 504–513. https://doi.org/10.1016/j.chiabu.2011.03.009

Greeson, J. K., Briggs, E. C., Layne, C. M., Belcher, H. M., Ostrowski, S. A., Kim, S., Lee, R.C., Vivrette, R.L., Pynoos, R.S. & Fairbank, J. A. (2014). Traumatic childhood experiences in the 21st century: Broadening and building on the ACE studies with data from the National Child Traumatic Stress Network. *Journal of Interpersonal Violence*, *29*(3), 536-556. https://doi.org/10.1177/0886260513505217

Guild, D. J., Alto, M. E., Handley, E. D., Rogosch, F., Cicchetti, D., & Toth, S. L. (2021). Attachment and Affect between Mothers with Depression and their Children: Longitudinal Outcomes of Child Parent Psychotherapy. *Research on Child & Adolescent*

Psychopathology, *49*(5), 563–577. https://doi-org.trmproxy.mnpals.net/10.1007/s10802-020-00681-0

Gutermann, J., Schreiber, F., Matulis, S., Schwartzkopff, L., Deppe, J., & Steil, R. (2016). Psychological Treatments for Symptoms of Posttraumatic Stress Disorder in Children, Adolescents, and Young Adults: A Meta-Analysis. *Clinical Child & Family Psychology Review*, *19*(2), 77–93. https://doi-org.trmproxy.mnpals.net/10.1007/s10567-016-0202-5

Hagan, M. J., Browne, D. T., Sulik, M., Ippen, C. G., Bush, N., & Lieberman, A. F. (2017). Parent and Child Trauma Symptoms During Child-Parent Psychotherapy: A Prospective Cohort Study of Dyadic Change. *Journal of Traumatic Stress*, *30*(6), 690–697. https://doi-org.trmproxy.mnpals.net/10.1002/jts.22240

Lieberman, A., Chu, A., Van Horn, P., & Harris, W. (2011). Trauma in early childhood: Empirical evidence and clinical implications. *Development and Psychopathology*, *23*(2), 397-410. https://doi.org/10.1017/S0954579411000137

Lieberman, A.F., Ghosh Ippen, C., & Van Horn, P. (2015). Don't hit my mommy: A manual for Child-Parent Psychotherapy with young children exposed to violence and other trauma, Second Edition. Washington, DC: Zero to Three.

Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2006). Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, *45*(8), 913-918. https://doi.org/10.1097/01.chi.0000222784.03735.92

Lieberman A. F. & Van Horn P. (2005). Don't hit my mommy! : a manual for child-parent psychotherapy with young witnesses of family violence. Zero to Three.

Lieberman, A. F., Van Horn, P., & Ippen, C. G. (2005). Toward evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child & Adolescent Psychiatry*, *44*(12), 1241-1248. https://doi.org/10.1097/01.chi.0000181047.59702.58

Lieberman, A. F., Weston, D. R., & Pawl, J. H. (1991). Preventive intervention and outcome with anxiously attached dyads. *Child development*, *62*(1), 199-209. https://doi.org/10.1111/j.1467-8624.1991.tb01525.x

Mandavia, A., Robinson, G. G. N., Bradley, B., Ressler, K. J., & Powers, A. (2016). Exposure to Childhood Abuse and Later Substance Use: Indirect Effects of Emotion Dysregulation and Exposure to Trauma. *Journal of Traumatic Stress*, *29*(5), 422–429. https://doi-org.trmproxy.mnpals.net/10.1002/jts.22131

Meiser-Stedman, R., Smith, P., Yule, W., Glucksman, E., & Dalgleish, T. (2017). Posttraumatic stress disorder in young children 3 years posttrauma: prevalence and longitudinal predictors. *The Journal of Clinical Psychiatry*, *78*(3), 20891. https://doi.org/10.4088/JCP.15m10002

McLaughlin, K. A., Koenen, K. C., Hill, E. D., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2013). Trauma exposure and posttraumatic stress disorder in a national sample of adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, *52*(8), 815–830.e14. https://doi.org/10.1016/j.jaac.2013.05.011

Moreno-Alcázar, Treen, D., Valiente-Gómez, A., Sio-Eroles, A., Pérez, V., Amann, B. L., & Radua, J. (2017). Efficacy of Eye Movement Desensitization and Reprocessing in Children and Adolescent with Post-traumatic Stress Disorder: A Meta-Analysis of

Randomized Controlled Trials. *Frontiers in Psychology*, *8*, 1750–1750. https://doi.org/10.3389/fpsyg.2017.01750

Morina, Koerssen, R., & Pollet, T. V. (2016). Interventions for children and adolescents with posttraumatic stress disorder: A meta-analysis of comparative outcome studies. *Clinical Psychology Review*, *47*, 41–54. https://doi.org/10.1016/j.cpr.2016.05.006

Mundi, M. S., Hurt, R. T., Phelan, S. M., Bradley, D., Haller, I. V., Bauer, K. W., Bradley, S. M., Schroeder, D. R., Clark, M. M., & Croghan, I. T. (2021). Associations Between Experience of Early Childhood Trauma and Impact on Obesity Status, Health, as Well as Perceptions of Obesity-Related Health Care. *Mayo Clinic Proceedings*, *96*(2), 408+. http://dx.doi.org.trmproxy.mnpals.net/10.1016/j.mayocp.2020.05.049

National Child Traumatic Stress Network. (n.d.). *Trauma types*. Retrieved April, 2022, from www.nctsn.org/what-is-child-trauma/trauma-types.

National Child Traumatic Stress Network. (2012, April). CPP - Culture Specific Fact Sheet. National Child Traumatic Stress Network. Retrieved October 24, 2022, from https://www.nctsn.org/sites/default/files/interventions/cpp_culture_specific_fact_sheet.pdf

Nemeroff, C. B. (2004). Neurobiological consequences of childhood trauma. *Journal of clinical psychiatry*, *65*, 18-28.

Pai, A., Suris, A. M., & North, C. S. (2017). Posttraumatic Stress Disorder in the DSM-5: Controversy, Change, and Conceptual Considerations. *Behavioral Sciences (2076-328X)*, *7*(1), bs7010007. https://doi-org.trmproxy.mnpals.net/10.3390/bs7010007

Peltz, J. S., Rogge, R. D., Rogosch, F. A., Cicchetti, D., & Toth, S. L. (2015). The benefits of child-parent psychotherapy to marital satisfaction. *Families, systems & health : the journal of collaborative family healthcare*, *33*(4), 372–382. https://doi.org/10.1037/fsh0000149

Powers, A., Etkin, A., Gyurak, A., Bradley, B., & Jovanovic, T. (2015). Associations Between Childhood Abuse, Posttraumatic Stress Disorder, and Implicit Emotion Regulation Deficits: Evidence From a Low-Income, Inner-City Population. *Psychiatry: Interpersonal & Biological Processes*, *78*(3), 251–264. https://doi-org.trmproxy.mnpals.net/10.1080/00332747.2015.1069656

Reyes, V., Stone, B.J., Dimmler, M.H., Lieberman, A.F. (2017). Child-Parent Psychotherapy: An Evidence-Based Treatment for Infants and Young Children. In: Landolt, M., Cloitre, M., Schnyder, U. (eds) Evidence-Based Treatments for Trauma Related Disorders in Children and Adolescents. Springer, Cham. https://doi-org.trmproxy.mnpals.net/10.1007/978-3-319-46138-0_15

SAMHSA. (2022, September 27). Understanding Child Trauma. SAMHSA. Retrieved October 23, 2022, from https://www.samhsa.gov/child-trauma/understanding-child-trauma#:~:text=At%20least%201%20in%207,this%20is%20likely%20an%20underestimate.

Sandler, I., Wolchik, S. A., Cruden, G., Mahrer, N. E., Ahn, S., Brincks, A., & Brown, C. H. (2014). Overview of meta-analyses of the prevention of mental health, substance use, and conduct problems. *Annual review of clinical psychology*, *10*, 243–273. https://doi.org/10.1146/annurev-clinpsy-050212-185524

Saunders, B. E., & Adams, Z. W. (2014). Epidemiology of traumatic experiences in childhood. *Child and Adolescent Psychiatric Clinics of North America*, *23*(2), 167–vii. https://doi.org/10.1016/j.chc.2013.12.003

Scheeringa, M. S., & Zeanah, C. H. (2001). A Relational Perspective on PTSD in Early Childhood. *Journal of Traumatic Stress*, *14*(4), 799–815. https://doi-org.trmproxy.mnpals.net/10.1023/A:1013002507972

Schilpzand, E. J., Sciberras, E., Alisic, E., Efron, D., Hazell, P., Jongeling, B., Anderson, V., & Nicholson, J. M. (2018). Trauma exposure in children with and without ADHD: prevalence and functional impairment in a community-based study of 6-8-year-old Australian children. *European Child & Adolescent Psychiatry*, *27*(6), 811–819. https://doi-org.trmproxy.mnpals.net/10.1007/s00787-017-1067-y

Scott, K. M., Koenen, K. C., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., Benjet, C., Bruffaerts, R., Caldas-de-Almeida, J. M., de Girolamo, G., Florescu, S., Iwata, N., Levinson, D., Lim, C. C. W., Murphy, S., Ormel, J., Posada-Villa, J., & Kessler, R. C. (2013). Associations between Lifetime Traumatic Events and Subsequent Chronic Physical Conditions: A Cross-National, Cross-Sectional Study. *PLoS ONE*, *8*(11), 1–11. https://doi-org.trmproxy.mnpals.net/10.1371/journal.pone.0080573

Smith, P., Dalgleish, T., & Meiser, S. R. (2019). Practitioner Review: Posttraumatic stress disorder and its treatment in children and adolescents. *Journal of Child Psychology & Psychiatry*, *60*(5), 500–515. https://doi-org.trmproxy.mnpals.net/10.1111/jcpp.12983

Street, A. E., Gibson, L. E., & Holohan, D. R. (2005). Impact of Childhood Traumatic Events, Trauma-Related Guilt, and Avoidant Coping Strategies on PTSD Symptoms in Female

Survivors of Domestic Violence. *Journal of Traumatic Stress*, *18*(3), 245–252. https://doi-org.trmproxy.mnpals.net/10.1002/jts.20026

Toth, S. L., Maughan, A., Manly, J. T., Spagnola, M., & Cicchetti, D. (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory. *Development and psychopathology*, *14*(4), 877-908. https://doi.org/10.1017/S095457940200411X

Toth, S. L., Rogosch, F. A., Manly, J. T., & Cicchetti, D. (2006). The efficacy of toddler-parent psychotherapy to reorganize attachment in the young offspring of mothers with major depressive disorder: a randomized preventive trial. *Journal of consulting and clinical psychology*, *74*(6), 1006. https://doi.org/10.1037/0022-006X.74.6.1006

Vibhakar, Allen, L. R., Gee, B., & Meiser-Stedman, R. (2019). A systematic review and meta-analysis on the prevalence of depression in children and adolescents after exposure to trauma. *Journal of Affective Disorders*, *255*, 77–89. https://doi.org/10.1016/j.jad.2019.05.005

Waldrop, A. E., & Cohen, B. E. (2014). Trauma Exposure Predicts Alcohol, Nicotine, and Drug Problems Beyond the Contribution of PTSD and Depression in Patients with Cardiovascular Disease: Data from the Heart and Soul Study. *American Journal on Addictions*, *23*(1), 53–61. https://doi-org.trmproxy.mnpals.net/10.1111/j.1521-0391.2013.12053.x

World Health Organization. (2022, September 19). Child maltreatment. World Health Organization. Retrieved October 23, 2022, from https://www.who.int/news-room/fact-sheets/detail/child-maltreatment

Xie, Wu, K., Zheng, Y., Guo, Y., Yang, Y., He, J., Ding, Y., & Peng, H. (2018). Prevalence of childhood trauma and correlations between childhood trauma, suicidal ideation, and social support in patients with depression, bipolar disorder, and schizophrenia in southern China. *Journal of Affective Disorders*, *228*, 41–48. https://doi.org/10.1016/j.jad.2017.11.011

Young, A., Kenardy, J., & Cobham, V. (2011). Trauma in Early Childhood: A Neglected Population. *Clinical Child & Family Psychology Review*, *14*(3), 231–250. https://doi-org.trmproxy.mnpals.net/10.1007/s10567-011-0094-3

Appendix I

Pre-Training Survey

Pre-Training Survey – *CPP Informational Training*

A Pre-Test Assessment for the "Child Parent Psychotherapy in Community Mental Health Agencies" informative training for mental health counselors. This assessment is meant to assess your preliminary knowledge of child parent psychotherapy and trauma exposure in young children. Asterisk indicates required.

Please fill out the following questions on the scale provided. *

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I am familiar with the prevalence of trauma	○	○	○	○	○
I believe that play is an important factor in trauma work with young children	○	○	○	○	○
I understand how symptoms of posttraumatic stress disorder are expressed in young children.	○	○	○	○	○
I am familiar with Child Parent Psychotherapy and how it is used.	○	○	○	○	○
I understand the Triangle of Explanations.	○	○	○	○	○

I know resources to refer to caregivers with trauma-exposed children.	○	○	○	○	○
I know what certifications are necessary to become a certified CPP provider.	○	○	○	○	○
I am interested in becoming certified in Child Parent Psychotherapy.	○	○	○	○	○

We appreciate your participation!

Post-Training Survey

Post-Training Survey – *CPP Informational Training*

A Post-Test Assessment for the "Child Parent Psychotherapy in Community Mental Health Agencies" informative training for mental health counselors. This assessment is meant to assess your knowledge of child parent psychotherapy and trauma exposure in young children following the training and to provide us feedback regarding the training experience. Asterisk indicates required.

Please fill out the following questions on the scale provided. *

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I am familiar with the prevalence of trauma	○	○	○	○	○
I believe that play is an important factor in trauma work with young children	○	○	○	○	○
I understand how symptoms of posttraumatic stress disorder are expressed in young children.	○	○	○	○	○
I am familiar with Child Parent Psychotherapy and how it is used.	○	○	○	○	○
I understand the Triangle of Explanations.	○	○	○	○	○

I know resources to refer to caregivers with trauma-exposed children.	○	○	○	○	○
I know what certifications are necessary to become a certified CPP provider.	○	○	○	○	○
I am interested in becoming certified in Child Parent Psychotherapy.	○	○	○	○	○

Please rate your satisfaction with this presentation on the scale provided. *

	Extremely satisfied	Satisfied	Neutral	Unsatisfied	Extremely unsatisfied
Presentation	☐	☐	☐	☐	☐
Information Provided	☐	☐	☐	☐	☐
Resources	☐	☐	☐	☐	☐
Applicability	☐	☐	☐	☐	☐

What are your takeaways from this presentation?

Any feedback for us?

We appreciate your participation!