

## Child-Parent Psychotherapy (CPP)

Child-Parent Psychotherapy (CPP) is an intervention for children from birth through age 5 who have experienced at least one traumatic event (e.g., maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and, as a result, are experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD). The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning.

The type of trauma experienced and the child's age or developmental status determine the structure of CPP sessions. For example, with infants, the child is present, but treatment focuses on helping the parent to understand how the child's and parent's experience may affect the child's functioning and development. With older children, including toddlers, the child is a more active participant in treatment, and treatment often includes play as a vehicle for facilitating communication between the child and parent. When the parent has a history of trauma that interferes with his or her response to the child, the therapist (a master's- or doctoral-level psychologist, a master's-level social worker or counselor, or a supervised trainee) helps the parent understand how this history can affect perceptions of and interactions with the child and helps the parent interact with the child in new, developmentally appropriate ways. In studies reviewed for this summary, mother-child dyads participated in weekly sessions for approximately 1 year with therapists who principally used a CPP treatment manual (Don't Hit My Mommy!).

### Descriptive Information

<b>Areas of Interest</b>	Mental health promotion Mental health treatment
<b>Outcomes</b>	<b>Review Date: June 2010</b> 1: Child PTSD symptoms 2: Child behavior problems 3: Children's representational models 4: Attachment security 5: Maternal PTSD symptoms 6: Maternal mental health symptoms other than PTSD symptoms
<b>Outcome Categories</b>	Family/relationships Mental health Social functioning Trauma/injuries
<b>Ages</b>	0-5 (Early childhood) 18-25 (Young adult) 26-55 (Adult)
<b>Genders</b>	Male Female
<b>Races/Ethnicities</b>	Asian Black or African American Hispanic or Latino White Race/ethnicity unspecified
<b>Settings</b>	Home Other community settings
<b>Geographic</b>	Urban

<b>Locations</b>	Suburban Rural and/or frontier
<b>Implementation History</b>	<p>CPP was developed in the 1980s through an adaptation of the infant-parent psychotherapy model, which was developed in the 1970s by Selma Fraiberg and colleagues. The first efficacy trial of CPP began in 1985. The Child Trauma Research Program began disseminating CPP through the National Child Traumatic Stress Network (NCTSN) in 2002. Since then, approximately 143 sites have implemented the intervention. Five randomized controlled trials have been conducted, and the findings from these studies have been published. In addition, reports have been written on the evaluation of dissemination efforts, including the dissemination of CPP within the NCTSN.</p> <p>Since 1996, more than 527 individuals have received training in CPP. Approximately 10 additional individuals per year have received CPP training through internships and fellowships with the Child Trauma Research Program, and other internships and fellowships in CPP are available through the Child Witness to Violence Program; the Tulane University Infant Team; the Louisiana State University Child Violence Exposure Program; and the Mount Hope Family Center, University of Rochester.</p>
<b>NIH Funding/CER Studies</b>	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: Yes
<b>Adaptations</b>	The program has been adapted for use in a randomized trial involving Latino immigrant mothers and their infants.
<b>Adverse Effects</b>	No adverse effects, concerns, or unintended consequences were identified by the developer.
<b>IOM Prevention Categories</b>	Selective Indicated

## Quality of Research

**Review Date: June 2010**

### Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

#### Study 1

[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 and Adolescent Psychiatry\*, 45\(8\), 913-918. !\[\]\(a870788d6ed9b8fd294b7654a8c8526b\_img.jpg\)](#)

[Lieberman, A. F., Van Horn, P., & Ghosh Ippen, C. \(2005\). Toward evidence-based treatment: Child-Parent Psychotherapy with preschoolers exposed to marital violence. \*Journal of the American Academy of Child and Adolescent Psychiatry\*, 44\(12\), 1241-1248. !\[\]\(de95854c7ee024cfadc48187bbb781b2\_img.jpg\)](#)

#### Study 2

[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. !\[\]\(6059a5aa8b4ca7bb793408023d6c6e42\_img.jpg\)](#)

#### Study 3

[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\(6\), 1006-1016. !\[\]\(6a9b39b98eb945faa14c645ec99e4eaa\_img.jpg\)](#)

### Supplementary Materials

Lieberman, A. F., Ghosh Ippen, C., & Marans, S. (2008). Psychodynamic treatment of child trauma. In E. B. Foa, T. M. Keane, & M. J. Friedman (Eds.), *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies* (pp. 370-387). New York: Guilford Press.

Lyons, J. (2008). Evidence-based trauma interventions for foster children in Illinois. Presentation to funders and stakeholders, Chicago, IL.

Toth, S., Manly, J. T., Rogosch, F. A., & Cicchetti, D. (n.d.). IPP Intervention Fidelity Checklist.

## Outcomes

### Outcome 1: Child PTSD symptoms

<b>Description of Measures</b>	Child PTSD symptoms were assessed using the Semistructured Interview for Diagnostic Classification DC: 0-3 for Clinicians. This clinician-administered caregiver interview uses a standardized format to systematize the traumatic stress disorder diagnostic criteria of the Diagnostic Classification Manual for Mental Health and Developmental Disorders of Infancy and Early Childhood, Diagnostic Classification: 0-3.
<b>Key Findings</b>	In a study involving preschool children exposed to marital violence, mother-child dyads were randomly assigned to the intervention group or a comparison group, which received case management services plus individual psychotherapy in the community for mother and/or child, at a clinic chosen by the mother. From pre- to posttest, children in the intervention group had a significant decrease in PTSD symptoms relative to those in the comparison group ( $p < .0001$ ). This result had a medium effect size (Cohen's $d = 0.63$ ).
<b>Studies Measuring Outcome</b>	Study 1
<b>Study Designs</b>	Experimental
<b>Quality of Research Rating</b>	3.7 (0.0-4.0 scale)

### Outcome 2: Child behavior problems

<b>Description of Measures</b>	Child behavior problems were assessed using an age-appropriate version of the Child Behavior Checklist (CBCL), a parent-report questionnaire that indicates the extent of maladaptive behavioral and emotional problems in children who are 2-3 years old (CBCL/2-3) and 4-18 years old (CBCL/4-18). The Total Behavior Problems score of the CBCL includes stress-related behaviors (e.g., staring into space, smearing feces, refusing to eat, showing too little fear of getting hurt, destroying his or her own things).
<b>Key Findings</b>	In a study involving preschool children exposed to marital violence, mother-child dyads were randomly assigned to the intervention group or a comparison group, which received case management services plus individual psychotherapy in the community for mother and/or child, at a clinic chosen by the mother. Children in the intervention group had significant decreases in behavior problems relative to those in the comparison group from pre- to posttest ( $p < .05$ ) and from pretest to 6-month follow-up ( $p < .05$ ). The effect sizes were small (Cohen's $d = 0.24$ and $0.41$ , respectively).
<b>Studies Measuring Outcome</b>	Study 1
<b>Study Designs</b>	Experimental
<b>Quality of Research Rating</b>	3.3 (0.0-4.0 scale)

### Outcome 3: Children's representational models

<b>Description of Measures</b>	<p>Children's representational models were assessed using the MacArthur Story Stem Battery. This narrative instrument for children ages 3-7 uses a standardized set of narrative beginnings ("story stems") to elicit the child's state of mind about family relationships, parental availability, and conflict situations through age-relevant situations (e.g., spilling juice, parental arguing, a monster under the bed, a scraped knee, a scary dog, parental departure and return).</p> <p>Eleven narrative story stems were administered to children at baseline and at the postintervention evaluation by research assistants who were trained in the procedure and were blind to the study condition coding of the stories. Narratives were coded using the MacArthur Narrative Coding Manual --Rochester Revision, which involves a presence-absence method of coding content, including story themes, emotional tone, controllingness, and representation of parent. The following items were evaluated:</p> <ul style="list-style-type: none"><li>• Adaptive maternal representation, a composite score of the following maternal representations: positive mother (the maternal figure is described or portrayed as protective,</li></ul>
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	<p>affectionate, providing care, warm, or helpful) and disciplining mother (the maternal figure is described or portrayed as an authority figure who disciplines the child)</p> <ul style="list-style-type: none"> <li>• Maladaptive maternal representation, a composite score of the following maternal representations: negative mother (the maternal figure is described or portrayed as punitive, harsh, ineffectual, or rejecting), controlling mother (the maternal figure is described or portrayed as controlling the child's behavior, independent of disciplining actions), and incongruent mother (the maternal figure is described or portrayed as dealing with the child-related situations in an opposite or inconsistent manner)</li> <li>• Child self-representation, which was coded for the following self-representations: positive (a child figure is described or portrayed as empathic or helpful, prideful, or feeling good about self), negative (a child figure is described or portrayed as aggressive toward self or other, experiencing feelings of shame or self-blame), and false (a child figure is described or portrayed as overly compliant or reports inappropriate positive feelings)</li> </ul> <p>In addition, the children's mother-child relationship expectations, as given in the children's narratives, were assessed using a modified version of Bickham and Fiese's Global Relationship Expectation Scale. Research assistants rated relationship dimensions on a 5-point scale ranging from very low (participants described or portrayed the mother-child relationship as dissatisfying, unpredictable, and/or dangerous) to very high (participants described or portrayed the mother-child relationship as fulfilling, safe, rewarding, and reliable).</p>
<b>Key Findings</b>	<p>In a study of preschool children maltreated by their families, mother-child dyads were randomly assigned to the intervention group, the psychoeducational home visitation (PHV) group, or the community standard (CS) group. Mother-child dyads from nonmaltreating (NC) families served as a comparison and had access to standard services and resources for child and family functioning provided through the local department of social services. From baseline to the postintervention evaluation:</p> <ul style="list-style-type: none"> <li>• Children in the intervention group had a significant decline in maladaptive maternal representations compared with children in the NC group (<math>p &lt; .05</math>). Children in the intervention group also had a decline in maladaptive maternal representations compared with children in the CS group, but the result was not statistically significant.</li> <li>• Children in the intervention group had a significant reduction in negative self-representations compared with children in the PHV (<math>p &lt; .01</math>), CS (<math>p &lt; .01</math>), and NC (<math>p &lt; .05</math>) groups.</li> <li>• The mother-child relationship expectations of children in the intervention group became significantly more positive compared with the expectations of children in the NC group (<math>p &lt; .05</math>). The mother-child relationship expectations of children in the intervention group also became more positive compared with children in the PHV group, but the result was not statistically significant.</li> <li>• No significant between-group differences were found for adaptive maternal representations and false self-representations.</li> </ul>
<b>Studies Measuring Outcome</b>	Study 2
<b>Study Designs</b>	Experimental
<b>Quality of Research Rating</b>	3.8 (0.0-4.0 scale)

#### Outcome 4: Attachment security

<b>Description of Measures</b>	<p>Attachment security was measured using Strange Situation, which was conducted with mothers and their toddlers to assess the toddler's attachment relationship with the mother. In this assessment, the child was observed playing while caregivers and strangers entered and left the room, recreating the flow of familiar and unfamiliar presences in most children's lives. The situations varied in stressfulness, and the child's responses were videotaped. Two raters separately coded all videotaped sessions, and the raters were unaware of the diagnostic and group statuses of individual mother-child dyads. On the basis of their behaviors, the children were categorized as insecure or secure.</p>
<b>Key Findings</b>	<p>In a study of mothers who had experienced major depressive disorder (MDD) since their child's birth, mother-child dyads were randomized to the intervention group or the MDD comparison group, which received other forms of mental health treatment (including psychotherapy and the use of antidepressants and other medication). Mothers with no current MDD or history of MDD and their toddlers were recruited for a nondepressed control group, which received no therapy or treatment. From baseline to the postintervention assessment, the percentage of children whose category changed from insecure to secure was significantly higher for the intervention group (54.3%) than</p>

the MDD comparison group (7.4%) ( $p < .001$ ) and the nondepressed control group (14.3%) ( $p < .001$ ). No significant difference was found between the MDD comparison group and the nondepressed control group in attachment security.

<b>Studies Measuring Outcome</b>	Study 3
<b>Study Designs</b>	Experimental
<b>Quality of Research Rating</b>	3.9 (0.0-4.0 scale)

#### Outcome 5: Maternal PTSD symptoms

<b>Description of Measures</b>	Maternal PTSD symptoms were assessed using the Clinician-Administered PTSD Scale. This semistructured interview assesses core PTSD symptoms and yields intensity and frequency scores for symptoms, including reexperiencing, avoidance, and hyperarousal symptoms, as well as a total score for PTSD symptoms.
<b>Key Findings</b>	In a study involving preschool children exposed to marital violence, mother-child dyads were randomly assigned to the intervention group or a comparison group, which received case management services plus individual psychotherapy in the community for mother and/or child, at a clinic chosen by the mother. From pre- to posttest, mothers in the intervention group had significant reductions in avoidance symptoms relative to those in the comparison group ( $p < .05$ ). This result had a medium effect size (Cohen's $d = 0.50$ ). No significant differences were found from pre- to posttest between mothers in the two groups in regard to total PTSD symptoms or reexperiencing or hyperarousal symptoms.
<b>Studies Measuring Outcome</b>	Study 1
<b>Study Designs</b>	Experimental
<b>Quality of Research Rating</b>	3.7 (0.0-4.0 scale)

#### Outcome 6: Maternal mental health symptoms other than PTSD symptoms

<b>Description of Measures</b>	Maternal mental health symptoms were assessed using the Symptom Checklist-90-Revised (SCL-90-R). This 90-item self-report checklist measures current psychiatric symptoms in nine dimensions: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The Global Severity Index of the SCL-90-R, the average of all 90 items, indicates current distress and was used to assess maternal functioning.
<b>Key Findings</b>	In a study involving preschool children exposed to marital violence, mother-child dyads were randomly assigned to the intervention group or a comparison group, which received case management services plus individual psychotherapy in the community for mother and/or child, at a clinic chosen by the mother. From pre- to posttest, mothers in the intervention group had a decrease in mental health symptoms relative to those in the comparison group, but the result was not significant. From pretest to 6-month follow-up, mothers in the intervention group had a significant decrease in mental health symptoms relative to those in the comparison group ( $p < .05$ ). This result had a small effect size (Cohen's $d = 0.38$ ).
<b>Studies Measuring Outcome</b>	Study 1
<b>Study Designs</b>	Experimental
<b>Quality of Research Rating</b>	3.3 (0.0-4.0 scale)

### Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
<b>Study 1</b>	0-5 (Early childhood) 18-25 (Young adult)	52% Female 48% Male	41.3% Race/ethnicity unspecified 28% Hispanic or Latino

	26-55 (Adult)		14.7% Black or African American 9.3% White 6.7% Asian
<b>Study 2</b>	0-5 (Early childhood) 18-25 (Young adult) 26-55 (Adult)	55.7% Male 44.3% Female	76.2% Race/ethnicity unspecified 23.8% White
<b>Study 3</b>	0-5 (Early childhood) 18-25 (Young adult) 26-55 (Adult)	52.8% Male 47.2% Female	92.9% White 7.1% Race/ethnicity unspecified

### Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see [Quality of Research](#).

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating
<b>1: Child PTSD symptoms</b>	4.0	4.0	2.5	4.0	4.0	3.5	<b>3.7</b>
<b>2: Child behavior problems</b>	4.0	4.0	2.5	3.5	2.5	3.5	<b>3.3</b>
<b>3: Children's representational models</b>	4.0	4.0	3.0	4.0	3.5	4.0	<b>3.8</b>
<b>4: Attachment security</b>	4.0	4.0	3.5	4.0	4.0	4.0	<b>3.9</b>
<b>5: Maternal PTSD symptoms</b>	4.0	4.0	2.5	4.0	4.0	3.5	<b>3.7</b>
<b>6: Maternal mental health symptoms other than PTSD symptoms</b>	4.0	4.0	2.5	3.5	2.5	3.5	<b>3.3</b>

### Study Strengths

The studies included measures that are widely used and supported by the literature and have good psychometric properties. The intervention was manualized, and all therapists were trained in the delivery of the intervention. Sessions were monitored weekly and videotaped monthly to assess implementation fidelity, and therapists used an adherence checklist. Differential attrition (i.e., differences between dropped and retained subjects) was evaluated appropriately, and the analyses accounted for missing data. Data analysis methods were thorough and appropriate.

### Study Weaknesses

Although fidelity was monitored, it was not measured systematically, and no standard fidelity instruments or measurements were used. In one of the studies, the small sample size and high attrition at the 6-month follow-up raise concerns about potential confounds for two outcomes: child problem behaviors and maternal mental health symptoms other than PTSD.

## Readiness for Dissemination

**Review Date: June 2010**

### Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Child-Parent Psychotherapy Learning Collaborative. (2008). Faculty agenda learning sessions one to three.

Child-Parent Psychotherapy Learning Collaborative. (n.d.). Improving capacity for early childhood mental health providers and trauma intervention application.

Child-Parent Psychotherapy Supervision Checklist

Child-Parent Psychotherapy Training Checklist

Habib, M., Schneider, A., Knoverek, A., Van Horn, P., Hastings, J., Kisiel, C., et al. (2008). Partnerships that work: Applications of trauma-focused interventions for children and adolescents. Poster presented at the 24th annual meeting of the International Society for Traumatic Stress Studies, Chicago, IL.

ICF Macro & the NCTSI Cross-site Evaluation Team. (2009). AIFI summary report: Child-Parent Psychotherapy. Cross-site evaluation of the National Child Traumatic Stress Initiative. Atlanta, GA: Author.

Lieberman, A. F., & Van Horn, P. (2005). Don't hit my mommy!: A manual for Child-Parent Psychotherapy with young witnesses of family violence. Washington, DC: ZERO TO THREE.

Lieberman, A. F., & Van Horn, P. (2008). Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment. New York: Guilford Press.

Lieberman, A. F., & Van Horn, P. (n.d.). Using Child-Parent Psychotherapy to treat young children exposed to trauma [PowerPoint slides].

Lyons, J. (2008). Evidence-based trauma interventions for foster children in Illinois. Presentation to funders and stakeholders, Chicago, IL.

Program Web site, <http://childtrauma.ucsf.edu/>

Toth, S., Manly, J. T., Rogosch, F. A., & Cicchetti, D. (n.d.). IPP Intervention Fidelity Checklist.

Van Horn, P., & Lieberman, A. F. (n.d.). Child Parent Psychotherapy: A manual for trainers.

### Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see [Readiness for Dissemination](#).

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
3.4	4.0	3.5	<b>3.6</b>

### Dissemination Strengths

Implementation materials are current and professionally produced, and they include case illustrations to highlight clinical themes, assessments and interpretations of clinical data, treatment planning guidance, and information on intervention strategies. Core components of the therapeutic practices are clearly delineated and described. CPP's theoretical foundations, as well as information on the knowledge areas and skill sets required for therapists, are detailed and easy to understand. Highly developed training and support resources are available for new and current therapists, supervisors, and trainers of practitioners, including a scripted training manual and training videos for trainers and case vignettes for therapists. Quality assurance and outcome measurement are emphasized as key components of implementation. Standardized assessment instruments assist the therapist in structuring CPP's highly individualized interventions. Multiple forms and processes support quality of care and fidelity to CPP's core components.

### Dissemination Weaknesses

The training manual lacks details regarding the elements essential for model implementation and the necessary requirements of therapist certification. The administration of standardized instruments is recommended as part of the initial assessment, but little information is provided for ongoing measurements of parent and child progress throughout treatment or as part of supervision related to quality assurance and fidelity. Similarly, discussion on supervision related to quality assurance and fidelity does not include details on measuring

the accomplishment of goals listed in the case plan.

## Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Psychotherapy With Infants and Young Children: Repairing the Effects of Stress and Trauma on Early Attachment (manual)	\$35.79 for hardcover, \$28 for paperback, or \$21.95 for Kindle edition	Yes
Don't Hit My Mommy!: A Manual for Child-Parent Psychotherapy With Young Witnesses of Family Violence	\$24.95 each	Yes
1-year full-time internship at specialized NCTSN sites (includes intensive didactic training, clinical practice, and weekly supervision by multiple supervisors)	Free	Yes (one training option is required)
1.5-year training through the NCTSN Learning Collaborative Model (includes three 2- to 3-day workshops for therapists, a half-day training for supervisors, and bimonthly phone consultation)	Free, except for travel expenses	Yes (one training option is required)
1.5-year training for a learning community (i.e., multiple agencies sharing the cost of training) or an individual agency (includes three 2- to 3-day workshops for therapists, a half-day training for supervisors, and bimonthly clinical consultation in person, by phone, or by video chat)	\$1,500-\$3,000 per day of training (depending on trainer experience) for up to 30 participants, plus travel expenses	Yes (one training option is required)
Additional phone, email, or in-person consultation	\$150-\$350 per hour (depending on trainer experience), plus travel expenses if necessary	No
Intervention fidelity checklist, training checklist, and supervision checklist	Free	No

## Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

[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. !\[\]\(fa6f3af6bfa46c5d4a2d362681095beb\_img.jpg\)](#)

[Cicchetti, D., Rogosch, F. A., & Toth, S. L. \(2006\). Fostering secure attachment in infants in maltreating families through preventive interventions. \*Development and Psychopathology\*, 18\(3\), 623-649. !\[\]\(17acf1afa8cdf0b67c53d4865a5ed469\_img.jpg\)](#)

[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 and Human Development\*, 1\(1\), 34-66. !\[\]\(e8fb589d58dad1692debababa5e928b6\_img.jpg\)](#)

Habib, M., Schneider, A., Knoverek, A., Van Horn, P., Hastings, J., Kisiel, C., et al. (2008). Partnerships that work: Applications of trauma -focused interventions for children and adolescents. Poster presented at the 24th annual meeting of the International Society for Traumatic Stress Studies, Chicago, IL.

[Lieberman, A. F., Weston, D. R., & Pawl, J. H. \(1991\). Preventive intervention and outcome with anxiously attached dyads. \*Child Development\*, 62\(1\), 199-209. !\[\]\(e1c624d4757f08486e89482c18364c17\_img.jpg\)](#)

Lyons, J. (2008). Evidence-based trauma interventions for foster children in Illinois. Presentation to funders and stakeholders, Chicago, IL.

## Contact Information

**To learn more about implementation or research, contact:**

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Consider these [Questions to Ask](#) (PDF, 54KB) as you explore the possible use of this intervention.

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