American Psychological Association
The Community for Psychologists in Independent Practice

Practice Innovations

ISSN: 2377-889X

2020, Vol. 5, No. 1, 65–80
http://dx.doi.org/10.1037/pri0000109

Integrating Parents With Trauma Histories Into Child Trauma Treatment: Establishing Core Components

Laurel J. Kiser
University of Maryland

Alisa B. Miller
Boston Children's Hospital/Harvard Medical School, Boston, Massachusetts

Megan A. Mooney
National Child Traumatic Stress Network, Houston, Texas

Rebecca Vivrette
University of Maryland School of Medicine

Sara R. Davis
Kennedy Krieger Institute, Baltimore, Maryland

To identify core components of parent/caregiver integration into evidence based child trauma treatment models, specifically those parents/caregivers who have experienced trauma themselves. The Parent/Caregiver Trauma and Healing Coordinating Group (PCTHCG) of the National Child Traumatic Stress Network examined existing scholarly literature, gathered input from clinical experts and parent partners, and assessed child trauma treatments. Eleven core components were identified through pooled sources of the available literature, clinical and parent/caregiver partner expertise, and information from existing evidence-based child trauma treatment models. Core components identified: engagement of parent/caregiver, assessment, parenting, coregulation, attachment, relationship repair, support of parent/caregiver, emotional coaching, addressing parent/caregiver trauma history and symptoms, and parent/caregiver appraisal and meaning making. To further validate these core components, the PCTHCG invited child trauma treatment model developers ($N = 11$) to indicate the presence of these components in their models and describe how their models attend to parent/caregiver trauma. Subsequently, a Core Components of Trauma Informed Child Treatment Models Related to Parent/Caregiver Trauma Grid (Core Components Grid) was developed. Despite general consensus that it is beneficial, few studies thoroughly explore the impact of parent/caregiver inclusion, specifically those who have experi-

Laurel J. Kiser, Family Informed Trauma Treatment (FITT) Center, University of Maryland; Alisa B. Miller, Department of Psychiatry, Boston Children's Hospital/Harvard Medical School, Boston, Massachusetts; Megan A. Mooney, National Child Traumatic Stress Network, Houston, Texas; Rebecca Vivrette, FITT Center, University of Maryland; Sara R. Davis, Center for Child and Family Traumatic Stress, Kennedy Krieger Institute, Baltimore, Maryland.

The authors are grateful for the contributions of the National Child Traumatic Stress Network Parent/Caregiver Trauma and Healing Coordinating Group (PCTHCG) for their efforts in development of The Core Components of Trauma Informed Child Treatment Models Related to Parent/Caregiver Trauma. We also appreciate the generous sharing of information, strategies, techniques and research from model developers including Margaret Blaustein, Judith Cohen, Kathryn Collins, Carrie Epstein, Julian Ford, Sarah Gardner, Abigail Gerwirtz, Chandra Ghosh-Ippen, Hilary Hahn, Richard Kagan, Kristine Kinniburgh, Laurel J. Kiser, Alicia Lieberman, Anthony Mannarino, Steven Marans, Michael Scheeringa, and Frederick H. Strieder.

Sara R. Davis and Megan A. Mooney serves as a steward for SFCR and received $1,000 annually for her work supporting the implementation and sustainability of the model. Laurel J. Kiser is the developer of Strengthening Family Coping Resources (SFCR) and receives funding from grants, royalties, and implementation/training contracts related to this intervention.

Correspondence concerning this article should be addressed to Alisa B. Miller, Department of Psychiatry, Boston Childrens Hospital, 300 Longwood Avenue, Mail stop BCH 3199, Boston, MA 02115. E-mail: alisa.miller@childrens.harvard.edu

enced trauma, in their child's trauma treatment. There is a significant need for future studies on the impact and mechanisms of parent/caregiver trauma and the integration into child trauma treatment. The Core Components Grid is intended to move the field forward toward a more structured examination of parent/caregivers who have experienced trauma and their inclusion in their child's trauma treatment.

Clinical Impact Statement

Parents' own exposures and reactions related to trauma may impact access to and engagement in care and the clinical outcomes for children who have also experienced trauma. This article presents a framework, the Core Components of Trauma Informed Child Treatment Models Related to Parent/Caregiver Trauma Grid, identifying 11 core components of child trauma treatment that consider how parents who have their own trauma histories should be integrated into their children's trauma services. It is intended to illuminate clinical strategies and highlight child treatment models that attend to a parent/caregiver's history of trauma.

Keywords: parent trauma, caregiver trauma, child trauma treatment, clinical strategies

Supplemental materials: http://dx.doi.org/10.1037/pri0000109.supp

Family stress models provide a strong theorectical basis and empirical evidence for the mediational role of parental caregivers'[1] reactions to and functioning related to traumatic experiences on their children's own responses to trauma (Cobham & McDermott, 2014; Cross et al., 2018; Gewirtz, DeGarmo, & Zamir, 2018; Hiller et al., 2018; Kiser & Black, 2005; Lambert, Holzer, & Hasbun, 2014). These models describe how exposure to stress and trauma experienced by parents negatively influences their well-being, with detrimental impacts on their parenting capacities and ultimately increases their children's risk for poor outcomes. This holds true across culturally and socioeconomically diverse samples of parents and children and includes a variety of types of trauma including medical accidents, natural disasters, military trauma, abuse, neglect and family and community violence (Cobham & McDermott, 2014; Cross et al., 2018; Hiller et al., 2018).

Family stress models support the numerous calls in recent years to include parents in treatment of trauma in children, to have integrated trauma treatment for both parents and children, and to develop trauma-focused interventions to help with parenting skills and strategies (Cohen, Hien, & Batchelder, 2008; Cross et al., 2018; Thakar, Coffino, & Lieberman, 2013; Tutus & Goldbeck, 2016). However, there is minimal study of the inclusion of, the strategies used, and potential benefits of parental participation[2] in trauma-focused treatment of children and adolescents and particularly when parents have their own trauma histories. This article seeks to raise the standard of care for youth who have been traumatized by elucidating how parents with their own trauma histories are being included in their children's trauma treatment with a focus on how these treatments address parents' response to their child's trauma and also to their own trauma experiences including parental symptoms of distress. Furthermore, this article examines evidence for integrating parents into treatment collected by child trauma treatment model developers, highlighting clinical implications and outlining directions for future research.

Many studies have demonstrated that parents' own experiences of trauma impact their well-being which in turn affects their parenting skills and their perceptions of their chil-

[1] Parental caregivers include biological parents, grandparents, foster parents, and/or others in a parenting role with the child (henceforth referred to as "parents" for convenience).

[2] For purposes of this article, parental participation in child trauma treatments refers to more than just attendance. It encompasses parents' provision of support for their children, understanding how their own experiences of and reactions to trauma influence their parenting, and assisting in their own healing.

dren. For example, Cross et al. (2018) found that a maternal history of trauma was positively associated with potential for child abuse, parental distress, and reports of having a difficult child. Similarly, a study by Cohen et al. (2008) found that cumulative maternal trauma was a significant predictor of abuse potential, psychological aggression, and use of physical discipline. A systemic review of the impact of parental posttraumatic stress symptoms (PTSS) on parenting suggested that there is sufficient evidence of impaired functioning across multiple domains of parenting (Christie, Hamilton-Giachritsis, Alves-Costa, Tomlinson, & Halligan, 2019).

Additional research has demonstrated that parents' responses to traumatic experiences may impact their children and family functioning (Cobham & McDermott, 2014; Hiller et al., 2018; Van Ee, Kleber, & Jongmans, 2016). In a review of studies examining the influence of parent functioning on child posttraumatic stress disorder (PTSD), all but one found a significant association between less adaptive parent and child functioning following trauma exposure (Scheeringa & Zeanah, 2001). Specifically, parental avoidance, rejection, and induced guilt and anxiety toward the child were predictive of increased risk for poor child emotional and behavioral functioning. A recent study completed by Thakar et al. (2013) found that maternal depression and dysfunctional parent–child interactions were associated with children's adaptation (including both internalizing and externalizing behaviors) in the aftermath of traumatic events. Cobham and McDermott (2014) found that children of parents who reported changes in parenting style after a natural disaster (e.g., increased protectiveness and caution, avoidance of talking/thinking about the event) were at risk for development of PTSD symptoms.

Specifically, research suggests that maternal PTSD is positively associated with a wide range of psychological difficulties in their children (Cross et al., 2018; Lambert et al., 2014). Lambert et al. (2014) conducted a meta-analysis of studies on the correlation between parents' PTSD symptom severity and children's psychological status. Results yielded a moderate overall effect size ($r = .35$). Tutus and Goldbeck (2016) found that many of the parents in a clinical sample of children with PTSD had their own traumatic experiences and related PTSS and depression. These parents often had dysfunctional thoughts about their child's traumatic experiences that the authors hypothesized could be a barrier to the child's recovery from PTSD. Snyder and colleagues (2016) found that for military-connected parents, PTSD symptoms may be related to more parental coercive behaviors and poor emotion regulation as well as less positive engagement, which were in turn related to their children's internalizing and externalizing behaviors. Lastly, Hiller, et al. (2018) found that parents' negative appraisals or encouraging avoidant coping behaviors in the aftermath of accidental or medical traumas were related to greater PTSS and coping in their children several months later. In sum, research suggests that children may be negatively impacted in a variety of ways by their parents' own experiences of trauma and the subsequent effects on their mental health and parenting practices.

Disrupting the impact of trauma across generations is a significant long-term advantage of including parents in a child's trauma treatment. Family risk models highlight the role of parental symptoms and distress and the toll they take on parenting as key mediators of intergenerational transmission of trauma (Smith, Cross, Winkler, Jovanovic, & Bradley, 2014). "Typically framed as the intergenerational transmission of trauma (Dekel & Goldblatt, 2008) or secondary traumatization (Rosenheck & Nathan, 1985), the underlying premise is that trauma-related symptoms are passed to children either directly, through talking about events, or as a consequence of living with a traumatized parent" (Lambert et al., 2014, p. 9). Kiser (2015) further explains that traumatic circumstances create complicated shifts in relationships and roles affecting the functioning of parenting subsystems. Clinical implications of these frameworks point to a need for enhanced parent involvement (i.e., self-regulation, attention to parental distress/symptoms) in child trauma treatment in order to break the transactional patterns that support intergenerational trauma. Particularly in the case of child trauma, services should aim to be intergenerational and family focused in their approach. In addition to enhanced safety and quality, intergenerational family focused care

reduces health care costs by streamlining services and investing in prevention (Guevara, Mandell, Danagoulian, Reyner, & Pati, 2013).

Addressing Parental Trauma in Trauma Treatment Models for Children

Given that parents' own exposures and reactions in the aftermath of trauma impact access to and engagement in care and the clinical outcomes for children who have experienced trauma, child trauma interventions need to consider specific strategies for addressing parental concerns. To explore how parents are included in child trauma treatment models, the Parent/Caregiver Trauma and Healing Coordinating Group (PCTHCG)[3] examined existing scholarly literature, gathered input from clinical experts and parent partners, and assessed evidenced-based child trauma treatments, resulting in development of *The Core Components of Trauma Informed Child Treatment Models Related to Parent/Caregiver Trauma* (subsequently referred to as the Core Components Grid; see Table 1). The Core Components Grid includes 11 core components (plus an "other" category for the inclusion of additional components identified by a treatment model; see Table 1). To validate these components, the PCTHCG invited developers of child trauma treatment models ($N = 11$) to indicate the presence and describe how their models attend to parent trauma (see online supplemental material for name and brief description of child trauma treatment models). Finally, small group in person discussions held by the PCTHCG with model developers, clinicians, and parent partners at two annual National Child Traumatic Stress Network (NCTSN) conferences focused on the importance of attending to parent trauma, therapeutic strategies for addressing parent trauma, and implementation/model fidelity issues.

To further define how child trauma treatment models attend to parents' experience of trauma, model developers submitted information outlining at least two strategies included in their models across all 11 identified core components.[4] Table 1 summarizes the themes/strategies identified for each core component. Of note, the inclusion of parents in child trauma treatment varies across models. At least one strategy for each core component was identified by a majority of models (64%, 7 out of 11 models). Developers indicated when a core component was not addressed or prescribed within their model; six components (assessment, attachment, relationship repair, addressing parent trauma history, addressing parent symptoms, parental appraisal and meaning making) were not included in all models. Two model developers reported that their models (ADAPT and PPT) do not include the core component "addressing parent symptoms." Although these two models do not directly attend to parent symptoms, ADAPT suggests that parents learn skills such as emotion regulation that help parents to work more actively on their own symptoms and PPT stated that parental symptoms can be addressed in parent only sessions on a case-by-case basis. Four developers indicated an "other" core component addressed by their model: post-traumatic growth (SFCR and TARGET), united parenting (ADAPT) and enhancing caregiver-child interactive cycles (RLH).

Effectiveness of Addressing Parent Trauma in Child Trauma Treatment

Although it was promising to discover that most child trauma treatment models include strategies to attend to parent trauma, the PCTHCG also wanted to determine what evidence existed of the effectiveness of this approach across three different areas: 1) parent symptoms and levels of distress; 2) parenting and family functioning; and 3) child outcomes. Model developers were asked to submit pub-

[3] The PCTHCG is an expert group of clinicians, researchers, treatment developers, and parent partners within the National Child Traumatic Stress Network (NCTSN).

[4] Names of Treatment Models (in alphabetical order) and Model Developers who Completed the Core Components Grid include After Deployment, Adapting Parenting Tools (ADAPT; Gewirtz); Attachment, Regulation and Competency (ARC; Blaustein/Kinniburgh); Child and Family Traumatic Stress Intervention (CFTSI; Marans/Epstein/Hahn); Child Parent Psychotherapy (CPP; Lieberman/Ghosh); FamilyLive (Gardner); Preschool PTSD Treatment Model (PPT; Scheeringa); Real Life Heroes (RLH; Kagan); Strengthening Families Coping Resources (SFCR; Kiser); Trauma Adapted Family Connections (TA-FC; Collins/Strieder); Trauma Affect Regulation: Guide for Education and Therapy (TARGET; Ford); Trauma Focused Cognitive Behavioral Therapy (TF-CBT; Mannarino/Cohen).

lished research and unpublished data exploring the effects of inclusion.[5]

Parent Symptoms and Levels of Distress

Parents who participate in child trauma treatment often present with a variety of clinical problems including emotional distress related to their child's trauma experience(s) or their own history of trauma, depressive symptoms, and PTSD. Of the 11 models, eight developers responded to the query regarding strategies and seven of those provided data related to change in parental symptoms of distress when parents participated in their child's treatment. Across models there is emerging evidence of the positive impact of parent participation as prescribed in each model on parental symptoms of PTSD, depression, and general indicators of emotional distress. A study of ADAPT (Gewirtz), a parent training model for military families, demonstrated reductions in mothers' PTSD symptoms. These symptom reductions occurred over 24 months' time (DeGarmo & Gewirtz, 2018).

A recent study of CFTSI (Marans/Epstein) examined reduction in trauma symptoms for parents whose children were referred following sexual or physical abuse and received CFTSI ($N = 640$ caregiver-child dyads; Hahn, Putnam, Epstein, Marans, & Putnam, 2019). Across 10 community treatment sites an innovative multisite metanalytic approach was used to evaluate pooled and site-specific therapeutic effect sizes for parents and children. CFTSI was associated with clinically meaningful improvements in PTSS for 62% of participating parents who had started CFTSI with clinical levels of PTSS as measured by the Post Traumatic Checklist–Civilian Version (PCL-C). The overall mean PCL-C change in paired, prepost PCL-C scores was close to a clinically meaningful change of 10 or higher.

Research on CPP (Lieberman/Ghosh) shows that maternal symptoms improve significantly more when the mother is included in the treatment, and this improvement continues to increase after the end of treatment. Specifically, data from five randomized-controlled trials (RCT) demonstrate reductions in maternal symptomatology including symptoms of PTSD and depression (Ghosh Ippen, Harris, Van Horn, & Lieberman, 2011), global symptoms (Lieberman, Ghosh Ippen, & Van Horn, 2006), and avoidant symptoms (Lieberman, Van Horn, & Ippen, 2005). Data from effectiveness studies also suggest that CPP results in changes for parents. An effectiveness study including 199 families found significant reductions in parent PTSD of a magnitude greater than .5 *SD* (Hagan et al., 2017).

In a study of PPT (Scheeringa), symptoms of maternal major depressive disorder (MDD) and PTSD were assessed with a diagnostic interview (Scheeringa, personal communication of unpublished data). The number of maternal MDD symptoms significantly decreased from a mean of 4.3 symptoms pretreatment to 2.4 symptoms posttreatment ($p < .05$). The number of maternal PTSD symptoms were 9.3 pretreatment and 8.3 posttreatment, but this was not a statistically significant change.

Recently collected data on parents who participated in SFCR (Kiser) multifamily groups (SFCR MFG; $N = 56$) demonstrate significant reductions in self-reported symptoms of PTSD and psychological symptoms. Results of paired *t* tests for prepost assessment indicated statistically significant reductions in PTSD symptoms on the PCL-5 Total Scale ($t = -3.39$; $df = 52$; $p < .01$; ES $= -0.47$) and overall parent psychological symptoms as measured by the Brief Symptom Inventory-18 Total Scale ($t = -3.74$; $df = 55$; $p < .001$; ES $= -0.50$), and on subscales of anxiety ($t = -3.48$; $df = 54$; $p < .001$; ES $= -0.47$), depression ($t = -3.32$; $df = 55$; $p < .01$; ES $= -0.44$), and somatization ($t = -2.93$; $df = 55$; $p < .005$; ES $= -0.39$) (Feldman, Trauben, Medoff, & Kiser, 2018).

In a study of TA-FC (Collins/Strieder), parents reported significant prepost reductions for trauma symptomatology and depressive symptoms. Trauma symptoms fell to below the clinical cutoff while depression remained above the cutoff score. Significant positive changes were noted on subscales of the RAND caregiver self-report measure including physical functioning, role limitations due to physical health, social functioning, emotional well-being, pain, and, general health (Collins, Freeman, Strieder, Reinicker, & Baldwin, 2015).

[5] Published research is summarized while unpublished results are presented in detail.

Table 1
Core Components of Child Trauma Treatment Models Related to Parent Experience of Trauma, Corresponding Common Themes/Strategies Identified Across Treatment Models, and General Strategies for Clinicians to Consider When Working With the Parents/Caregivers of a Traumatized Child for Each Core Component

Core component	Common Themes/Strategies Identified Across Treatment Models to Attend to Parent/Caregiver Experience of Trauma	General Strategies for Clinicians to Consider when Working with the Parents/Caregivers of a Traumatized Child
Engagement of Parent	Strategies for engagement of parents included: 1. Providing psychoeducation about trauma, the impact of trauma, the therapeutic process 2. Empowering parents/caregivers and believing in their capabilities to be an agent of change	• At treatment outset, explicitly discuss with parents the importance of parental involvement in child treatment, and obtain agreement to participate. • Use strengths based engagement strategies as outlined by Gopalan and colleagues (2010) such as: 1. Reviewing and addressing potential barriers to treatment at the outset of treatment and throughout treatment 2. Helping families identify specific practical concerns and problem solve to address these concerns to demonstrate the usefulness of treatment
Assessment	Strategies for assessment of parents included: 1. Initial assessment of parent's history of trauma, PTSD, depression, current stressors 2. Ongoing assessment of impact of parental PTSD/depression on parenting and ability to participate in treatment, therapeutic skills gained as well as cultural and familial strengths, attainment of goals	• Educate parents about how a child's trauma can impact the parent and how they feel and function • Include, when possible, formal or informal assessment of parents' own functioning. • Provide rationale and psychoeducation about why assessment of parents' own functioning is important – how gaining a better picture of parents' current functioning can help the therapist to tailor interventions, provide support as needed, and help support the parents in enhancing self-reflection on how they respond to their child's needs.
Parenting	Strategies for attending to parenting included: 1. Focusing on parents' ability to regulate their own emotions, increase awareness and build appropriate responses 2. Emphasizing and teaching about the importance of routine and rituals	• Teach concepts like labeled praise and have parents practice in-session • Model skills with the child first with parents' observing • Model skills with the parent pretending to be the child. • Have parents practice skills in session with their child • Provide in session coaching • Give suggestions/support to parents as needed

Table 1 (*continued*)

Core component	Common Themes/Strategies Identified Across Treatment Models to Attend to Parent/Caregiver Experience of Trauma	General Strategies for Clinicians to Consider when Working with the Parents/Caregivers of a Traumatized Child
Co-regulation	Strategies for co-regulation included: 1. Building awareness of emotion, affect and reaction through skill building exercises like relaxation, mindfulness, breathing 2. Focusing on the dyad as prominent, both the child and parent and their co-ability to raise awareness and teach skills to one another	• Teach parents to regulate their own emotions • Practice strategies such as deep breathing and progressive muscle relaxation to parents and children in-session • Teach regulation strategies to children first and have them practice by teaching parents in session • Encourage parents to practice with children at home • Assign dyadic activities such as: 1. Engaging parent and child in a "support" conversation to resolve a conflict as practice for dealing with negative affect 2. Have parent and child share a happy story or memory to engage around positive affect
Attachment	Strategies on increasing attachment included: 1. Providing psychoeducation about safety and security in relationships, holding conjoint sessions in an effort to bolster connection between parent and child 2. Encouraging and planning with parents/caregivers how to engage in fun activities	• Engage parent and child in team work such as having them work together as a team against you -the clinician on an activity (e.g., a game, a puzzle, a tower of cards, etc.). • As parent and child work together towards a common goal (to defeat the you -the clinician) highlight the new ways they are communicating. • Engage parent and child in crafts activities that do not have a "right" way to do them • Schedule weekly or monthly parent/child "dates" outside of session • Highlight positive moments or interactions during session to magnify secure attachment behaviors (e.g., "you both are really enjoying this game together")

(*table continues*)

Table 1 (*continued*)

Core component	Common Themes/Strategies Identified Across Treatment Models to Attend to Parent/Caregiver Experience of Trauma	General Strategies for Clinicians to Consider when Working with the Parents/Caregivers of a Traumatized Child
Relationship repair	Strategies for relationship repair included: 1. Working to understand expectations of relationships 2. Encouraging discussion about perceptions of others and how a history of trauma may be playing a role in interactions	• Provide psychoeducation on basic communication skills • Teach reflective listening • Practice these skills in session through games, moving from discussing/hearing silly benign topics to more personal topics • Support positive interactions and play between parent and child • Encourage parent and child to practice skills at home daily to re-establish physical and emotional safety in the relationship. • Talk about and process traumatic or stressful events that have happened • Plan with parent for future safety, and encourage parent not to avoid these topics, as a means to instill a sense of safety in the relationship
Support of parent	Strategies to support parents included: 1. Providing emotional support within the treatment context and therapeutic relationship like engaging in empathic listening and parental praise, recognition of parent and family strength, aligning with and providing support for parent's goals 2. Helping parent to identify additional sources of support	• Link parent to community resources • Use the United Way's helpline (211 everywhere) to find resources by geographic location. • Incorporate parents into "feelings check-in" at the beginning or end of each session to help model affective expression and create a routine around self-monitoring
Emotional Coaching	Strategies for emotion coaching included: 1. Helping a parent understand where negative affect is coming from, if its connected to past trauma and the unintended negative cycle that can be created 2. Teaching concrete skills like mindfulness, active listening, and relaxation to parents	• Assign dyadic activities such as teaching both parent and child skills such as labeling emotions and attunement through psychoeducation, clinician coaching and modeling. • Have parents practice reading a children's book or watching shows/cartoons/videos and then: 1. discuss characters' feelings with children. 2. Practice asking questions about why characters may feel a certain way and is there anything that could change that feeling? • Play feelings charades where the parent and child have to guess what feeling the other is "acting out."
Addressing parent trauma history	Strategies for addressing parent trauma history included: 1. Proactively reviewing a parent's trauma history through construction of timelines or personal histories 2. Exploring current triggers and how those impact the parent's reactions to his/her child and other areas of his/her life/person	• Intentionally engage in/schedule parent-only sessions to discuss perceptions of treatment and progress • Review skills • Assess parental needs

Table 1 (*continued*)

Core component	Common Themes/Strategies Identified Across Treatment Models to Attend to Parent/Caregiver Experience of Trauma	General Strategies for Clinicians to Consider when Working with the Parents/Caregivers of a Traumatized Child
Addressing parent symptoms	Strategies for addressing parent symptoms included: 1. Referring the parent/caregiver for individual trauma-informed therapy 2. Teaching coping skills like journaling	• Assess parental needs at onset and throughout treatment • Teach coping skills on an as-needed basis • Refer for individual therapy if warranted
Parental Appraisal and Meaning Making	Strategies for attending to appraisal and meaning making included: 1. Encouraging understanding one's own values 2. Using Socratic questioning with parents to expand understanding of the context of child/own behavior and meaning behind behaviors	• Talk with parents at the outset of treatment about their goals for treatment • Continue to discuss goals throughout the course of treatment • Prepare for termination, review assessments that demonstrate change and discuss changes in parent and child functioning that are evident in daily life, and develop family goals for the future
Other	An example of an identified "other" component is posttraumatic growth (PTG); strategies for attending to PTG included: • Systematically helping parents identify their core values and goals as a parent/caregiver and a person • Helping parents apply core values/goals to enhance their sense of efficacy	• Introduce the concepts of values and goals to parents • Help parents identify their core values and goals both as a parent and a person • Monitor parents progress in identifying and applying core values/goals

Note. This non-exhaustive list of strategies to consider is intended to provide guidance to clinicians. A comprehensive list of strategies attentive to the individual child and family/treatment model (e.g., age, developmental stage, trauma type, theoretical orientation, etc.) is beyond the scope of this work. More information about specific strategies per model is available in the *Core Components Grid by Treatment Model* available from the corresponding author.

Parents participating in TF-CBT (Mannarino/Cohen) with their child typically make significant improvement in clinical domains. For example, in a TF-CBT RCT with preschool children, parents had significant reductions in their emotional distress related to their child's sexual abuse and this outcome was maintained at 6- and 12-month follow-up (Cohen & Mannarino, 1996; Cohen & Mannarino, 1996a). Moreover, reductions in parental distress and increases in parental support correlated significantly with clinical improvements in their children. In treatment outcome studies with older children (ages 7–14), it has been consistently demonstrated that parents who participate in treatment with their children experience significant reductions in depressive and PTSD symptoms and that these gains are maintained for at least one year (Cohen & Mannarino, 1998; Cohen, Deblinger, Mannarino, & Steer, 2004; Deblinger, Mannarino, Cohen, & Steer, 2006; Mannarino, Cohen, Deblinger, & Steer, 2007). Other studies have demonstrated that parents' own symptoms of depression as well as their emotional reactions to their child's trauma decrease over the course of TF-CBT provided to them and their children (Holt, Jensen, & Wentzel-Larsen, 2014; Tutus, Keller, Sachser, Pfeiffer, & Goldbeck, 2017).

Parenting (Stress, Efficacy, Parent-Child Relations) and Family Functioning

Multiple models emphasize parent support as a key component in trauma-focused treatment. Through these support strategies, child trauma treatment models intend to reduce parenting stress and four models reported data demonstrating such effects. Several ARC (Blaustein & Kinneburgh) implementation projects showed significant changes in parenting stress on the part of both mothers and fathers from pre- to posttreatment and at a 6-month follow up (Hodgdon, Blaustein, Kinniburgh, Peterson, & Spinazzola, 2016). Significant reductions were observed in mother reported total stress, mother reported parent distress, mother reported parent–child dysfunction, father reported perception of difficult child, and mother reported perception of difficult child. Additionally, RCT data show that CPP results in reductions of maternal stress related to the child (Toth, Sturge-Apple, Rogosch, & Cicchetti, 2015). In studies of SFCR, parents' participation in multifamily group sessions resulted in parents reporting significant reductions in their children's behavior problems and significantly decreased parenting stress (Kiser et al., 2015). Decreases in observed parenting stress have also been found for TA-FC; data indicate significant decreases in total parenting stress, parental distress, and perceptions of difficult child (Collins, personal communication of unpublished data).

Two models reported positive shifts in parental sense of efficacy following treatment. ADAPT improves parenting efficacy (6 months) which results in reductions in parental PTSD, depression, and suicidality at 12 months (Gewirtz, DeGarmo, & Zamir, 2018). Additionally, ADAPT improved mothers' emotion coaching, but not fathers', at 6 months post baseline (Zhang et al., under review). Similarly, TA-FC parents showed significant increases between intake and closing in parenting efficacy (Collins, personal communication of unpublished data).

Child trauma treatment models often use conjoint child and parent sessions or family sessions with the primary objective of strengthening or repairing the parent–child relationship. CPP RCT data show improvements in the mother-child relationship and in the way children perceive mothers, including improved attachment security (Cicchetti, Toth, & Rogosch, 1999; Stronach, Toth, Rogosch, & Cicchetti, 2013; Toth, Rogosch, Manly, & Cicchetti, 2006), fewer maladaptive child maternal representations (Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002), and greater observed partnership between mothers and children (Lieberman, Weston, & Pawl, 1991). Data also suggests that mutual attributions and perceptions become more empathic. In a TA-FC study a significant decrease in the number of items indicating need for intervention was reported based on responses to the Caregiver-Child Interaction Scale from the Family Assessment Form (Collins et al., 2015). In the RCT of TF-CBT with preschoolers, mentioned above, there were significant increases in parental support of their child and these gains were maintained at follow-up (Cohen & Mannarino, 1996; Cohen & Mannarino, 1996a).

Four models reported on studies demonstrating improvements in family functioning. In a RCT comparing families in two alternative in-

tervention groups, ARC intervention families demonstrated significant gains on three measures of family functioning: lower levels of family conflict over 12 months, reduced reports of daily family stress, and lower reports of daily problems. All three groups demonstrated reductions in reported child victimization from baseline. Improvement in adjustment was particularly demonstrated in ARC families with higher combined child and adult adverse childhood experiences (Kinniburgh, Blaustein, Blodgett, & Schibel, 2012). In another study of ARC GROW, an adaptation of ARC, results indicated that the average score for providers' perception of Families' Functioning and Resiliency was significantly higher (better) at follow-up compared to baseline. This study also found significantly higher scores at follow-up compared to baseline on a subscale of Nurturing and Attachment (Bodian et al., 2017). Data from SFCR MFG prepost studies demonstrated significant increases in the mobilization of family resources on the Family Crisis Oriented Personal Evaluation Scales ($N = 141$; $t = 2.43$; $p < .05$) and significantly healthier family functioning on prepost measures (Feldman et al., 2018; Kiser et al., 2015). Significant increases have also been observed for perceived family resources for families participating in TA-FC (Collins et al., 2015). TARGET, delivered as an in-home child and parent (individual and conjoint) therapy, has been evaluated in two randomized effectiveness studies with foster and adoptive families. Anecdotally, parents, children and providers described TARGET as providing skills that helped reduce family conflicts (Ford, personal communiction).

Child Outcomes

Three models have data demonstrating that parental participation in their children's treatment is linked with positive child outcomes. Studies of ADAPT demonstrate improvements in observed parenting at 12 months, which are associated with reductions in child internalizing and externalizing using parent, child, and teacher reports and also predict reductions in youth substance use at 24 months (Gewirtz et al., in prep; Gewirtz et al., 2018). Additionally, improvements in parenting efficacy led to improved children's social skills at 12 months (Piehler, Ausherbauer, Gewirtz, & Gliske, 2018). Data from CPP effectiveness studies suggest that reductions in parent symptoms are associated with reductions in child avoidance and hyperarousal (Hagan et al., 2017). TF-CBT data indicate that including parents results in decreased behavioral problems and depressive symptoms in children (Deblinger, Lippmann, & Steer, 1996; Yasinski et al., 2016). Yasinski et al. (2016) found that children showed decreased internalizing and externalizing behaviors when their parent was able to approach trauma-related material, make constructive meaning of the trauma, and shift their own perspectives and emotional responses during the trauma narrative phase of TF-CBT.

Clinical Implications

The presence and wellbeing of parents could be considered imperative to children's ability to respond with resilience in the face of traumatic exposures (Herbers, Cutuli, Monn, Narayan, & Masten, 2014). Recognizing the critical role that parents can play in helping their children heal from traumatic exposures and adapt to difficult conditions, it is important to identify intervention methods that provide parents with multiple opportunities to fulfill this role. The Core Components Grid provides a tool for unpacking the therapeutic strategies needed by providers.

Across all 11 child trauma treatment models included in the grid, engagement of the parent was identified as an essential component of treatment. Parents who struggle with their own trauma and who may have had previous negative experiences with mental health or other service systems must be engaged and partnered with in order to establish the buy-in required for progress in their children's trauma treatment (Madsen, 2009). Strengths based engagement strategies may help parents understand the impact trauma has on parenting, marking a shift away from the perception that there is something wrong with them or their parenting, to the recognition that trauma can disrupt adaptive parenting and self-regulation (Gopalan et al., 2010). From this standpoint, parents will likely be more invested in treatment, creating greater potential to improve child, parent, and family functioning.

Effective inclusion of parents in trauma-focused treatment models for children would

necessitate not only assessing the child's symptoms of PTSS but also those of the parent as well as family dynamics and functioning. Most of the treatment models in the Core Components Grid include an assessment of parent trauma histories, PTSD symptoms, and/or family functioning. However, the model developers also noted that they did not necessarily attend to parent symptoms as a component of treatment, rather they described monitoring and addressing parent symptoms only if they appear to be interfering with treatment. Furthermore, many of the models have shown reductions in reported levels of parental distress even when this is not a specific treatment goal. Multiple models demonstrate improvements in measures of family functioning and parenting stress which may or may not be directly addressed within the treatment itself.

Developmental, attachment theory and family systems theories highlight the critical role that parents play in a child's survival, development, his or her overall social, emotional well-being as well as providing consistency and structure to the family. Parents also have the role of responding to and taking actions to cope with crises faced by the child and family. These roles may be compromised by a parent's own experience of trauma and/or PTSS symptomatology creating psychological barriers to constructive parental involvement in child trauma treatment including: poor adult self-regulation, unstable interpersonal relationships, disorganization in daily life and family patterns, negative parental attributions toward the child, lack of confidence in ability to positively affect child's behavior and lack of capacity to form and sustain a recovery-oriented narrative (Collins et al., 2011). Use of the strategies suggested in the Core Components Grid may provide the needed resources and supports for parents and providers to address these barriers. This may happen by helping parents take better care of themselves as well as develop more accurate and helpful cognitions about the meaning of intergenerational trauma. Parents may develop positive behavior management, self-regulation strategies and co-regulation skills. In addition, they may learn to interpret their children's behavior and emotions differently and be able to have overt discussions about trauma and process the impact of trauma on their parenting and parent–child relationships. Addressing parental trauma may bolster parents' capacities to provide stability, predictability and structure allowing treatment to move away from crisis-oriented and episodic services.

Directions for Future Research

Despite the known benefits, there remains a critical need for additional research on moderators of child trauma treatment response, including parent involvement. Findings to date have been mixed, and the necessity for parental involvement in child trauma treatment continues to be debated (e.g., Leenarts, Diehle, Doreleijers, Jansma, & Lindauer, 2013). This article delineated an innovative approach for unpacking and understanding the field of practice and research on parent involvement.

Although the studies described in this article comprise an important first step to understanding the impact of parent inclusion in child trauma treatment, the models that participated in the Grid project were primarily designed to address child trauma, and similarly, investigations on model efficacy and effectiveness focused principally on improvement in child symptoms and functioning. When included, parent symptoms and functioning were often conceptualized as secondary outcomes or exploratory analyses (e.g., DeGarmo & Gewirtz, 2018; Hahn et al., under review; Holt, Jensen, & Wentzel-Larsen, 2014; Tutus et al., 2017). A notable exception to this was studies of TF-CBT in which changes in parental functioning were a primary outcome (Cohen & Mannarino, 1996; Cohen & Mannarino, 1996a; Cohen & Mannarino, 1998; Cohen et al., 2004; Deblinger et al., 2006; Mannarino et al., 2007). Thus, many of the studies were limited by small sample sizes, simplistic data analysis models, or other methodological flaws. There are numerous implications of these limitations for future research on attending to parent trauma in child treatment models.

Many of the clinical implications of parent integration into child trauma treatment can be addressed empirically, yet there is a dearth of evidence-based information on the impact of parent involvement on child trauma treatment outcome trajectories. For example, the field knows little about the differential impact of parent integration into child trauma treatment across child and parent characteristics. A recent review of child trauma treatment models iden-

tified several "at risk" groups that may be particularly amenable to the benefits of parental involvement: very young children; children with externalizing problems; parents with significant mental health concerns or unhelpful trauma-related beliefs; and parents who perpetrated (see Dorsey et al., 2017). Due to methodological limitations noted earlier, existing studies have not been able to adequately shed light on these questions.

Issues such as whether child trauma interventions extend invitations for parent participation or incorporate specific core components addressing parental trauma history and symptoms in their manualized approach also need to be explored. This is pertinent to a number of questions related to dose-response and timing of parental involvement in treatment (e.g., during skill building phases of treatment vs. during trauma processing or narrative exposure). For example, is there a minimal and an optimal level of parent participation in treatment that leads to symptom reduction for parents and improvements in their ability to actively support their child's recovery? Do these levels of participation result in differential response to treatment among children? Future investigations should use more robust samples to conduct moderator and mediator analyses.

As reported in a recent review by Dorsey et al. (2017), there are few studies that have explored whether benefits to parent integration into treatment may be related to either: (a) reduction in parent mental health symptoms, and/or (b) improvements in parent cognitions, attitudes, and response to the child's trauma exposure(s), and findings have been mixed across different childhood psychiatric disorders and syndromes. Understanding the mechanisms by which parent involvement might impact child response to treatment is critical to evidence-based intervention delivery and cross-systems collaboration. While reducing parent symptoms might lend itself to referral and coordination with adult-serving systems and treatment providers, altering parent cognitions, attitudes, and response to child trauma would likely be better addressed through integrated, child-focused trauma treatment. Future directions for research should focus on determining what sort of specific therapeutic activities of child trauma treatments result in the significant reductions noted in parental stress and PTSS and to whether there are specific components critical to achieving positive child outcomes.

In conclusion many of the studies of parent involvement in child trauma treatment have been limited by small sample sizes or other methodological issues that complicate what is known about the benefits of parental involvement, for whom, and for which treatment modalities. Nevertheless, the level of evidence points to the inclusion of parents in treatment as empirically supported and should be the goal for child trauma treatment providers serving families with intergenerational trauma histories, and these services should be coordinated and integrated across systems to more holistically serve families in ways that reduce burden and maximize benefit.

References

Blaustein, M. E., & Kinniburgh, K. M. (2017). Attachment, self-regulation, and competency (ARC). In M. A. Landolt, M. Cloitre, & U. Schnyder (Eds.), *Evidence-based treatments for trauma related disorders in children and adolescents* (pp. 299–319). Cham, Switzerland: Springer. http://dx.doi.org/10.1007/978-3-319-46138-0_14

Bodian, R., Barto, B., Bartlett, B., Griffin, G., Norona, C. R., Spinazzola, J., & Fraser, J. G. (2017). *Massachusetts Child Trauma Project final report* (pp. 164–167). Boston: Massachusetts Department of Children and Families.

Christie, H., Hamilton-Giachritsis, C., Alves-Costa, F., Tomlinson, M., & Halligan, S. L. (2019). The impact of parental posttraumatic stress disorder on parenting: A systematic review. *European Journal of Psychotraumatology*. Advance online publication. http://dx.doi.org/10.1080/20008198.2018.1550345

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,* 34–66. http://dx.doi.org/10.1080/14616739900134021

Cobham, V. E., & McDermott, B. (2014). Perceived parenting change and child posttraumatic stress following a natural disaster. *Journal of Child and Adolescent Psychopharmacology, 24,* 18–23. http://dx.doi.org/10.1089/cap.2013.0051

Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry, 43,* 393–

402. http://dx.doi.org/10.1097/00004583-200404000-00005

Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry, 35,* 42–50. http://dx.doi.org/10.1097/00004583-199601000-00011

Cohen, J. A., & Mannarino, A. P. (1996a). Factors that mediate treatment outcome of sexually abused preschool children. *Journal of the American Academy of Child & Adolescent Psychiatry, 35,* 1402–1410. http://dx.doi.org/10.1097/00004583-199610000-00028

Cohen, J. A., & Mannarino, A. P. (1998). Factors that mediate treatment outcome of sexually abused preschool children: Six- and 12-month follow-up. *Journal of the American Academy of Child & Adolescent Psychiatry, 37,* 44–51. http://dx.doi.org/10.1097/00004583-199801000-00016

Cohen, L. R., Hien, D. A., & Batchelder, S. (2008). The impact of cumulative maternal trauma and diagnosis on parenting behavior. *Child Maltreatment, 13,* 27–38. http://dx.doi.org/10.1177/1077559507310045

Collins, K. S., Freeman, P., Strieder, F. H., Reinicker, P., & Baldwin, C. (2015). A pilot study of reducing developmental and complex trauma symptomatology with families to prevent child abuse and neglect. *Journal of Public Child Welfare, 9,* 506–527. http://dx.doi.org/10.1080/15548732.2015.1098582

Collins, K. S., Strieder, F. H., DePanfilis, D., Tabor, M., Freeman, P. A., Linde, L., & Greenberg, P. (2011). Trauma adapted family connections: Reducing developmental and complex trauma symptomatology to prevent child abuse and neglect. *Child Welfare, 90,* 29–47.

Cross, D., Vance, L. A., Kim, Y. J., Ruchard, A. L., Fox, N., Jovanovic, T., & Bradley, B. (2018). Trauma exposure, PTSD, and parenting in a community sample of low-income, predominantly African American mothers and children. *Psychological Trauma: Theory, Research, Practice and Policy, 10,* 327–335. http://dx.doi.org/10.1037/tra0000264

Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment, 1,* 310–321. http://dx.doi.org/10.1177/1077559596001004003

Deblinger, E., Mannarino, A. P., Cohen, J. A., & Steer, R. A. (2006). A follow-up study of a multisite, randomized, controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry, 45,* 1474–1484. http://dx.doi.org/10.1097/01.chi.0000240839.56114.bb

DeGarmo, D. S., & Gewirtz, A. H. (2018). A Recovery Capital and Stress-Buffering Model for Postdeployed Military Parents. *Frontiers in Psychology, 9,* 1832. http://dx.doi.org/10.3389/fpsyg.2018.01832

Dekel, R., & Goldblatt, H. (2008). Is there intergenerational transmission of trauma? The case of combat veterans' children. *American Journal of Orthopsychiatry, 78,* 281–289. http://dx.doi.org/10.1037/a0013955

Dorsey, S., McLaughlin, K. A., Kerns, S. E. U., Harrison, J. P., Lambert, H. K., Briggs, E. C., . . . Amaya-Jackson, L. (2017). Evidence-base update for psychosocial treatments for children and adolescents exposed to traumatic events. *Journal of Clinical Child and Adolescent Psychology, 46,* 303–330. http://dx.doi.org/10.1080/15374416.2016.1220309

Feldman, H. T., Trauben, E., Medoff, D., & Kiser, L. J. (2018). *Evaluation of efficacy and markers for positive outcomes in a trauma-focused multifamily group. Poster presentation at Medical School Research Day*. Baltimore: University of Maryland.

Gewirtz, A. H., DeGarmo, D. S., & Zamir, O. (2018). After deployment, adaptive parenting tools: One year outcomes of an evidence-based parenting program for military families. *Prevention Science, 19,* 589–599. http://dx.doi.org/10.1007/s11121-017-0839-4

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,* 504–513. http://dx.doi.org/10.1016/j.chiabu.2011.03.009

Gopalan, G., Goldstein, L., Klingenstein, K., Sicher, C., Blake, C., & McKay, M. M. (2010). Engaging families into child mental health treatment: Updates and special considerations. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 19,* 182–196.

Guevara, J., Mandell, D., Danagoulian, S., Reyner, J., & Pati, S. (2013). Parental depressive symptoms and children's school attendance and emergency department use: A nationally representative study. *Maternal & Child Health Journal, 17,* 1130–1137. http://dx.doi.org/10.1007/s10995-012-1109-5

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,* 690–697. http://dx.doi.org/10.1002/jts.22240

Hahn, H., Putnam, K., Epstein, C., Marans, S., & Putnam, F. (2019). Child and family traumatic stress intervention (CFTSI) reduces parental posttraumatic stress symptoms: A multi-site meta-

analysis (MSMA). *Child Abuse & Neglect, 92,* 106–115. http://dx.doi.org/10.1016/j.chiabu.2019.03.010

Herbers, J. E., Cutuli, J. J., Monn, A. R., Narayan, A. J., & Masten, A. S. (2014). Trauma, adversity, and parent-child relationships among young children experiencing homelessness. *Journal of Abnormal Child Psychology, 42,* 1167–1174. http://dx.doi.org/10.1007/s10802-014-9868-7

Hiller, R. M., Meiser-Stedman, R., Lobo, S., Creswell, C., Fearon, P., Ehlers, A., . . . Halligan, S. L. (2018). A longitudinal investigation of the role of parental responses in predicting children's posttraumatic distress. *Journal of Child Psychology and Psychiatry, 59,* 781–789. http://dx.doi.org/10.1111/jcpp.12846

Hodgdon, H., Blaustein, M., Kinniburgh, K., Peterson, M., & Spinazzola, J. (2016). Application of the ARC Model with adopted children: Supporting resiliency and family well being. *Journal of Child & Adolescent Trauma, 9,* 43–53. http://dx.doi.org/10.1007/s40653-015-0050-3

Holt, T., Jensen, T., & Wentzel-Larsen, T. (2014). The change and the mediating role of parental emotional reactions and depression in the treatment of traumatized youth: Results from a randomized controlled study. *Child and Adolescent Psychiatry and Mental Health, 8,* 11. http://dx.doi.org/10.1186/1753-2000-8-11

Kagan, R. (2014). *Real Life Heroes: Practitioner's Manual*. New York, NY: Routledge.

Kinniburgh, K., Blaustein, M., Blodgett, C., & Schibel, Y. (2012). *Adaptation of the ARC Framework as a Parent Home Visiting Intervention*. Spokane, WA: WSU Area Health Education Center.

Kiser, L. J. (2015). *Strengthening Family Coping Resources: Intervention for Families Impacted by Trauma*. New York, NY: Routledge.

Kiser, L. J., Backer, P. M., Winkles, J., & Medoff, D. (2015). Strengthening Family Coping Resources (SFCR): Practice-based evidence for a promising trauma intervention. *Couple and Family Psychology, 4,* 49–59. http://dx.doi.org/10.1037/cfp0000034

Kiser, L. J., & Black, M. A. (2005). Family processes in the midst of urban poverty. *Aggression and Violent Behavior, 10,* 715–750. http://dx.doi.org/10.1016/j.avb.2005.02.003

Lambert, J. E., Holzer, J., & Hasbun, A. (2014). Association between parents' PTSD severity and children's psychological distress: A meta-analysis. *Journal of Traumatic Stress, 27,* 9–17. http://dx.doi.org/10.1002/jts.21891

Leenarts, L. E., Diehle, J., Doreleijers, T. A., Jansma, E. P., & Lindauer, R. J. (2013). Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: A systematic review. *European Child & Adolescent Psychiatry, 22,* 269–283. http://dx.doi.org/10.1007/s00787-012-0367-5

Lieberman, A. F. (2004). *Child-Parent Psychotherapy: A Relationship-Based Approach to the Treatment of Mental Health Disorders in Infancy and Early Childhood*. Retrieved from https://www.researchgate.net/publication/232591927_Child-Parent_Psychotherapy_A_Relationship-Based_Approach_to_the_Treatment_of_Mental_Health_Disorders_in_Infancy_and_Early_Childhood

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,* 913–918. http://dx.doi.org/10.1097/01.chi.0000222784.03735.92

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,* 1241–1248. http://dx.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,* 199–209. http://dx.doi.org/10.2307/1130715

Madsen, W. C. (2009). Collaborative helping: A practice framework for family-centered services. *Family Process, 48,* 103–116. http://dx.doi.org/10.1111/j.1545-5300.2009.01270.x

Mannarino, A. P., Cohen, J. A., Deblinger, E., & Steer, R. (2007). Self-reported depression in mothers of children who have experienced sexual abuse. *Journal of Psychopathology and Behavioral Assessment, 29,* 203–210. http://dx.doi.org/10.1007/s10862-006-9036-7

The National Child Traumatic Stress Network. (2008). "CFTSI: Child and Family Traumatic Stress Intervention." *Trauma-Informed Interventions: General Information Intervention Template*. Los Angeles, CA. Author.

Piehler, T. F., Ausherbauer, K., Gewirtz, A., & Gliske, K. (2018). Improving child peer adjustment in military families through parent training: The mediational role of parental locus of control. *The Journal of Early Adolescence, 38,* 1322–1343. http://dx.doi.org/10.1177/0272431616678990

Rosenheck, R., & Nathan, P. (1985). Secondary traumatization in children of Vietnam veterans. *Hospital & Community Psychiatry, 36,* 538–539. http://dx.doi.org/10.1176/ps.36.5.538

Scheeringa, M. S., & Zeanah, C. H. (2001). A relational perspective on PTSD in early childhood. *Journal of Traumatic Stress, 14,* 799–815. http://dx.doi.org/10.1023/A:1013002507972

Scheeringa, M. S., Salloum, A., Arnberger, R. A., Weems, C. F., Amaya-Jackson, L., & Cohen, J. A.

(2007). Feasibility and effectiveness of cognitive-behavioral therapy for posttraumatic stress disorder in preschool children: Two case reports. *Journal of Traumatic Stress, 20,* 631–636. http://dx.doi.org/10.1002/jts.20232

Smith, A. L., Cross, D., Winkler, J., Jovanovic, T., & Bradley, B. (2014). Emotional dysregulation and negative affect mediate the relationship between maternal history of child maltreatment and maternal child abuse potential. *Journal of Family Violence, 29,* 483–494. http://dx.doi.org/10.1007/s10896-014-9606-5

Snyder, J., Gewirtz, A., Schrepferman, L., Gird, S. R., Quattlebaum, J., Pauldine, M. R., . . . Hayes, C. (2016). Parent-child relationship quality and family transmission of parent posttraumatic stress disorder symptoms and child externalizing and internalizing symptoms following fathers' exposure to combat trauma. *Development and Psychopathology, 28*(4pt1), 947–969. http://dx.doi.org/10.1017/S095457941600064X

Stronach, E. P., Toth, S. L., Rogosch, F., & Cicchetti, D. (2013). Preventive interventions and sustained attachment security in maltreated children. *Development and Psychopathology, 25*(4pt1), 919–930. http://dx.doi.org/10.1017/S0954579413000278

Thakar, D., Coffino, B., & Lieberman, A. F. (2013). Maternal symptomatology and parent-child relationship functioning in a diverse sample of young children exposed to trauma. *Journal of Traumatic Stress, 26,* 217–224. http://dx.doi.org/10.1002/jts.21799

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,* 877–908. http://dx.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,* 1006–1016. http://dx.doi.org/10.1037/0022-006X.74.6.1006

Toth, S. L., Sturge-Apple, M. L., Rogosch, F. A., & Cicchetti, D. (2015). Mechanisms of change: Testing how preventative interventions impact psychological and physiological stress functioning in mothers in neglectful families. *Development and Psychopathology, 27,* 1661–1674.

Tutus, D., & Goldbeck, L. (2016). Posttraumatic symptoms and cognitions in parents of children and adolescents with PTSD. *European Child & Adolescent Psychiatry, 25,* 997–1005. http://dx.doi.org/10.1007/s00787-016-0821-x

Tutus, D., Keller, F., Sachser, C., Pfeiffer, E., & Goldbeck, L. (2017). Change in Parental Depressive Symptoms in Trauma-Focused Cognitive-Behavioral Therapy: Results from a Randomized Controlled Trial. *Journal of Child and Adolescent Psychopharmacology, 27,* 200–205. http://dx.doi.org/10.1089/cap.2016.0136

van Ee, E., Kleber, R. J., & Jongmans, M. J. (2016). Relational patterns between caregivers with PTSD and their nonexposed children: A review. *Trauma, Violence, & Abuse, 17,* 186–203. http://dx.doi.org/10.1177/1524838015584355

Yasinski, C., Hayes, A. M., Ready, C. B., Cummings, J. A., Berman, I. S., McCauley, T., . . . Deblinger, E. (2016). In-session caregiver behavior predicts symptom change in youth receiving Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). *Journal of Consulting and Clinical Psychology, 84,* 1066–1077. http://dx.doi.org/10.1037/ccp0000147.supp

Received October 22, 2019
Revision received January 16, 2020
Accepted January 19, 2020 ■