Child-Parent Psychotherapy
Intervention for Young Children Exposed to Trauma

Implementation-Level Trainings
Learning Collaboratives
Child-Parent Psychotherapy
Overview
Evolution of a Model
Child-Parent Psychotherapy
Context in Which CPP Evolved

- 1996: Child Trauma Research Program founded at San Francisco General Hospital
- Worked with families who had experienced domestic violence
- Conducted research: Randomized control trial
- Extended Infant-Parent Psychotherapy to children age 3-5
- 2001: Joined the National Child Traumatic Stress Network
- Disseminated CPP via the NCTSN Learning Collaborative model
CPP: Population served

- Child-Parent Psychotherapy (CPP) is an intervention model for children aged 0-5 who have experienced (or are experiencing)
  - traumatic events and/or
  - mental health,
  - attachment, and/or
  - behavioral problems.
CPP: Theoretical Integrations

- Developmentally informed
- Attachment focus
- Trauma-based
- Psychoanalytic theory
- Social learning processes
- Cognitive-behavioral strategies
- Culturally attuned

(Lieberman & Ghosh Ippen, & Van Horn, 2015)
Assumptions in CPP

• Young children remember their experiences
• Traumatic experiences are encoded in the brain and body (so young children can remember traumatic experiences that occurred before they had words to recall them)
• Caregivers are the best people to help children make meaning of their experiences
• It is good to process and talk about your past experiences
• Young children communicate through behavior and play
• It is good to express your feelings

(Ghosh Ippen, 2012)
CPP: Treatment Sessions

- Therapeutic sessions include the child and parent or primary caregiver.

- Therapeutic sessions are held weekly and, typically, take place over a year.

- A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child’s mental health.
CPP: Targets of Intervention

- Targets of intervention include
  - caregivers’ and children’s maladaptive representations of themselves and each other
  - interactions and behaviors that interfere with the child’s mental health.
  - For children exposed to trauma, caregiver and child are guided to create a joint narrative of the traumatic event and to identify and address traumatic triggers that generate dysregulated behaviors and affect.
Overarching Treatment Goal

Restore Developmental Progress

• Affect regulation
• Trust in relationships
• Joy in exploration and learning
• Constructive engagement in society

(Lieberman, Ghosh Ippen, Van Horn, 2015)
CPP: 3 Treatment Phases

• Foundational Phase: Assessment & Engagement
• Core Intervention Phase
• Recapitulation and Termination

Lieberman, Ghosh Ippen, & Van Horn, 2015
Treatment Phases

1. Core Intervention
2. Foundational: Assessment & Engagement
3. Termination

Assess & Establish a Trauma Framework
CPP: Evidence Base

- Five randomized control trials have been conducted
Randomized Trial with Families Affected by Domestic Violence

- 75 children age 3-6 years exposed to domestic violence
- Children also experienced other traumas
  - physical abuse (49%)
  - exposure to community violence (46.7%)
  - sexual abuse (14.4%)
- Mothers experienced on average 12-36 stressful life events
- Randomized to CPP or Case Management plus standard community intervention

Lieberman, Van Horn, & Ghosh Ippen, 2005
Lieberman, Ghosh Ippen, & Van Horn, 2006
Randomized Trial with Families Affected by Domestic Violence (Continued)

- Treatment children show greater improvement than comparison group children
  - Traumatic stress symptomatology
  - Diagnosis of Traumatic Stress Disorder
  - Behavior problems
- Treatment mothers show greater improvement
  - Avoidant symptomatology
  - Total PTSD symptomatology
  - General symptomatology
- Improvements in children’s and mother’s symptoms maintained at 6-month follow-up
Randomized Trial with Families Affected by Domestic Violence (Continued)

- For children who experienced 4+ Traumatic and Stressful Life Events (TSE)
  - CPP group showed significantly greater improvement in
    - PTSD and depression symptoms
    - PTSD diagnosis
    - Number of co-occurring diagnoses
    - Behavior problems
- CPP children with <4 risks showed greater improvements in
  - PTSD symptomatology
- Mothers of children with 4+ TSEs in the CPP group showed greater reductions in
  - PTSD symptomatology
  - Depression
- Improvements were maintained for the high risk group at 6-month follow-up

Lieberman, Van Horn, & Ghosh Ippen, 2005
Lieberman, Ghosh Ippen, & Van Horn, 2006
Ghosh Ippen, Harris, Van Horn, & Lieberman, 2011
Randomized Trial with Maltreated Preschoolers

- 122 children approximately 4 years old recruited from welfare roles
- 34% sustained physical or sexual abuse
- 60% experienced more than one form of maltreatment
- 76.2% of children noted to be ethnic minorities
- Four groups
  - Child Parent Psychotherapy
  - Home visiting with skills training for mothers and therapeutic preschool for children
  - “Community Standard”
  - Non-maltreated controls

Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002
Randomized Trial with Maltreated Preschoolers (Cont.)

• After treatment
  • CPP group: fewer negative maternal representations
  • Fewer negative self-representation
  • Greater number of positive expectations of parent-child relationship

Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002
Randomized Trial with Maltreated Infants

• 137 children approximately 1 year old recruited from identified maltreating families

• 66.4% had directly experienced neglect or abuse
• 33.6% living in families where their siblings had experienced abuse or neglect
• 74.6% of children noted to be ethnic minorities
• Four groups
  • Child Parent Psychotherapy
  • Psychoeducational Parenting Intervention
  • “Community Standard”
  • Non-maltreated controls

Cicchetti, Rogosch, & Toth, 2006
Randomized Trial with Maltreated Infants (Continued)

- CPP and PPI had similar efficacy in terms of altering children’s attachment classifications and were both more significantly different from the comparison group.
- Rate of secure attachment (pre to post)
  - CPP 3.1% to 60.7%
  - PPI 0% to 54.5%
- Similar findings for rates of disorganized attachment

Cicchetti, Rogosch, & Toth, 2006
18-Month CPP Learning Collaborative Overview
Historical Roots of CPP

The Importance of Teams
CPP LC Teams

- Typically teams rather than individuals participate in CPP training
- A team ideally consists of
  - Psychologists/Clinicians: Ideally 3 or more
  - Supervisor(s): At least 1, ideally more (3 for future sustainability)
  - Senior leader(s): Ideally at least 1
Team Member Activities and Responsibilities

• Psychologists/Clinicians
  – Provide direct clinical service
  – Offer feedback about how model aligns with current agency
    • Client population
    • Needs
    • Policies and practices
Team Member Activities and Responsibilities

• Supervisors
  – Provide reflective supervision
  – Responsible for coordinating the learning of the team
    • Knowledge of early childhood development
    • Core skills (e.g. trauma screening)
  – Think with team about how trauma work impacts them and potential shifts in agency policies and practices that may support the work and the team
  – Critical for future sustainability within the agency
Team Member Activities and Responsibilities

- Senior Leaders
  - Individuals who are able to effect agency-level changes
  - Able to make changes to align agency and CPP practices and policies
  - Knowledgeable about funding sources and how current billing practices align with CPP practices
  - Attend any aspects of the LC they can
    - Ideally Learning Session 1 to understand CPP
    - Senior leader calls if included as part of this LC
Rationale for Teams

- Reflective supervision is an integral part of CPP
- Therapists benefit from the support of a team as they learn trauma treatment. The team works together to...
  - Prevent and address vicarious traumatization
  - Develop a culture of self care and team care
- Team members support each other in considering how historical, contextual, and socio-cultural factors shape perspective and behavior
- Sustainability
- Particularly important to include multiple supervisors when the goal of participation is sustainability
- See CPP Agency Mentorship Program (C.A.M.P.) video
Team Members

- Clinical team members must be masters or doctoral-level psychotherapists with a degree in a mental health discipline.
- Some trainers may accept MFTIs and Postdoctoral students, but they are not eligible for the roster until they are licensed.
- This training is not considered intensive enough for students (e.g., practicum students and psychology interns) to learn the model.
  - Students typically require more supervision, training, additional didactics, and more direct contact with families to learn the model.
Team Members: Licensure Requirements

- Team members who are not yet licensed must be supervised by a licensed team member who is participating in the LC or who has completed an Implementation-Level CPP training before.

- Should that supervisor leave the agency or end his/her participation in the LC, arrangements must be made to have nonlicensed staff supervised by a licensed supervisor who has been or is being trained in CPP.
Unlicensed Team Members: If Supervisors Leave

- If there are no available licensed CPP supervisors within the agency, there are two options for continuing.
  - **Option 1**: A licensed supervisor who has not yet been trained in CPP may serve as supervisor of record
    - At a minimum, supervisor needs to participate in CPP consult calls with supervisee so as to become aware of the model and understand how CPP may influence supervisee’s clinical work.
    - New supervisor would not be eligible for the CPP roster unless s/he completes a full CPP Implementation Level course.
    - Unless specific exceptions have been made in consultation with the CPP Development Team, participation in consult calls is not counted towards an Implementation Level Course until after a participant attends the Initial CPP didactic training.

Ghosh Ippen, Van Horn, Lieberman, 2016
Unlicensed Team Members: If Supervisors Leave

- **Option 2:** The agency could contract separately with a licensed clinical supervisor who is trained in CPP, resides within that state, and is willing to provide clinical supervision and serve as the supervisor of record.
18-Month CPP Learning Collaborative Training Components
18-Month Learning Collaborative Overview

Learning Session 1
- 3 days (minimum)
- Core CPP didactics

Learning Session 2
- 2 days (minimum)
- Competency building
- Case-based
- Participant driven

Learning Session 3
- 2 days minimum
- Competency building
- Case-based
- Participant driven

End of Training

Ghosh Ippen, Van Horn, Lieberman, 2016
18-Month CPP LC Overview

- Learning supported by 8 required learning components
  1. Didactics (18 hour minimum)
  2. Read CPP manual
  3. Conduct CPP • 2 cases for Supervisor Participants; 4 cases for Clinician Participants
  4. Reflective CPP supervision within the agency
  5. Ongoing consultation calls
  6. Case presentation
  7. Intensive CPP competency building workshops
  8. Fidelity monitoring
1. Participate in Core CPP Didactics
   - 18-hours of didactics
   - Typically conducted through a 3-day training
   - May be broken into smaller segments
2. Read the Manuals


CPP LC Components: Provide CPP

3. Work with Families Using CPP

- Clinician Participants: At least 4 cases in the 18-month period
- Supervisor Participants: At least 2 cases in the 18-month period
- At least two cases must be treated for at least 16 sessions
  - At least 1 of these must have started from the beginning and included the foundational phase
  - Both must have included dyadic sessions
- For Clinician Participants, the other two families must be seen for at least 4 face-to-face sessions in any treatment phase
CPP LC Components: Provide CPP

3. Work with Families Using CPP (continued)

- For each family
  - Child is under age 6 (at intake)
  - Child has experienced at least one trauma (may include separation from a primary caregiver)
  - For those working with at least 4 families, for one case, one exception can be granted
    - child who is age 6
    - pregnant mother or baby under age 18 months where the caregiver’s trauma history is the primary reason for referral

Ghosh Ippen, Van Horn, Lieberman, 2016
3. Work with Families Using CPP (continued)

• Requirement typically completed during the course of the 18-month LC
• May grant an extension provided that:
  – The participant treated at least one case for at least 16 sessions during the LC
  – The person has completed most of the other components of the LC
  – The person continues in CPP supervision (minimum twice monthly) at their agency with a supervisor trained in CPP until they complete this requirement
  – This requirement is completed within 3 years of finishing an LC
4. Participate in Reflective CPP Supervision

• Consistent space where clinicians and supervisors can reflect on their CPP work within their own agencies
• Discuss
  – Impact of trauma on the provider
  – Alignment of CPP and agency procedures
  – Support for learning core CPP competencies (e.g. screening for trauma)
• Team members contribute different perspectives and expertise
• Develop a culture of team learning
• Enhances sustainability
4. Participate in Reflective CPP Supervision (continued)

- Agency supervisors provide CPP supervision
  - Individual or group
  - Ideally once a week
  - Minimum 2x per month (on weeks when there is no consultation call)

- Supervisors may be learning CPP at the same time as clinicians

- Agency supervisors also benefit from reflective consultation and ideally should reflect with either their teams or with another CPP supervisor
5. Participate on CPP Consultation Calls

- Case-based learning
- Share your interventions (what you did and said), not just family history
- Not expected to be doing CPP yet
- Consultation on the model not just on the “case”
- Highlight strengths
- Conceptualize the case using CPP
- Look at where the work is reflective of CPP
- Look at divergences from CPP
- Explore alternative ways to intervene
CPP LC Components: CPP Consult Calls

5. Participate on CPP Consultation Calls
   • Attend Consultation Calls
     – 70% of calls
     – Minimum 33 calls held (attend at least 23 calls)
     – Consultants will make every effort to provide a minimum of 33 calls
     – Expected to take vacations for self-care
6. CPP Case Presentation

• Present at least twice during ongoing CPP consult calls unless group size does not permit this

• Complete case presentation template & provide clinical material for reflection 48 hours before presenting
7. Participate in Intensive CPP Competency Building Workshops

- **Learning Session 2**
  - Typically 2-days (12 hours minimum)
  - Approximately 6 months after the core CPP didactic training (Session 1)
- **Learning Session 3**
  - Typically 2-days (12 hours minimum)
  - Approximately 12 months after the core CPP didactic training (Session 1)
CPP LC Components: CPP Competency Workshops

7. Participate in Intensive CPP Competency Building Workshops (continued)

• Content tailored to the needs of participants
• Case-based learning
• Multiple case presentations
• Active dialogue and practice
8. Fidelity Monitoring

- Two fidelity clients
  - Ideally one high challenge and one low challenge
  - If a fidelity case ends prior to completing 16 sessions, begin fidelity monitoring with another case
  - Review measures for each phase with a supervisor or colleague
- As required by your LC Trainer
  - Complete supervision fidelity
  - Complete consultation fidelity
18-Month Learning Collaborative Components

Learning Session 1
- Senior Leader Involvement
- Begin Working with Families
- Begin Using Fidelity Measures
- CPP Supervision in Agency
- Consult Calls

Learning Session 2
- Track Fidelity

Learning Session 3

Standard CPP Learning Collaborative Path → End of Training

Ghosh Ippen, Van Horn, Lieberman, 2016
Optional but Highly Recommended Training Components
Optional but Highly Recommended Components

1. Support during pre-work phase
   • Think about the LC application procedure
   • Identify agency teams that are most likely to sustain the model and to serve families in need
   • Think about any knowledge gaps that may need to be addressed
     – Knowledge of infants, toddlers, and preschoolers
     – Relationship assessment
     – Sociocultural considerations
     – Trauma-informed systems
     – Interfacing with specific systems

Ghosh Ippen, Van Horn, Lieberman, 2016
Optional but Highly Recommended Components

2. Supervisor Call
   - Held only with supervisors
   - Supervisors present supervision cases and discuss CPP supervision
   - Typically once a month (schedule determined with trainer)
   - Particularly helpful when supervisors are learning at the same time as supervisees
   - Support future sustainability
Optional but Highly Recommended Components

2. Senior Leader Call
   - Recommended particularly for large systems
   - Typically one call every quarter or every 6 months (schedule determined with trainer)
   - Think together about:
     - Any challenges aligning CPP and systems’ policies and procedures
     - Match for client population
     - Ways to support learning
     - Sustainability

Ghosh Ippen, Van Horn, Lieberman, 2016
Optional but Highly Recommended Components

4. Foundational Trainings

• Offered by some CPP Trainers to help participants gain knowledge core to CPP

• Different CPP trainers have different areas of expertise
Optional but Highly Recommended Components

4. Foundational Trainings (continued)
• Potential topics
  – Child development
  – Reflective supervision
  – Caregiver-child relationship assessment
  – Partnering with specific systems (child welfare, courts) – Early childhood trauma
  – Trauma-informed systems
  – Diversity-informed practice
  – Engagement
Do we certify in CPP?

What do CPP and the insanity workout have in common?
Results May Vary Based On . . .

Start Point

Goals

Effort
We Do Not Certify, But We Do Roster

• Maintain a list of therapists who have completed an Implementation-Level CPP course
• Share this list via websites

- Name
- Contact Information
- Brief Bio
- Insurance
- Languages Spoken
- Photo (optional)