Child-Parent Psychotherapy

Review: Foundations for Life, July 2016

Note on provider involvement: This provider has agreed to EIF's terms of reference, and the assessment has been conducted and published with the full cooperation of the programme provider.

Child-Parent Psychotherapy (CPP) is a psychoanalytic intervention targeting mothers and preschool children (aged three to five) who may have experienced trauma or abuse (eg domestic violence), or are otherwise at risk of an insecure attachment and/or other behavioural and emotional problems.

Specifically, CPP aims to improve children's representations of their relationship with their parent and reduce maternal and child symptoms of psychopathology.

Mothers and their child attend weekly sessions for a period of 12 months or longer. The sessions are delivered by practitioners with a Masters (or higher) qualification in psychology or social work. During each session, the practitioner uses empathic, non-didactic support to help the mother reflect on her childhood experiences and differentiate them from her current relationship with her child.

Parent sessions are interspersed with sessions involving the child where the mother, therapist and child jointly engage in structured play aimed at eliciting trauma-related feelings and behaviours. This allows the therapist to help the mother and child develop a joint narrative around the traumatic events and bring them to their resolution. Mothers also receive support in appropriate discipline and an increased awareness of their child's moods and emotional states.

Please note that this Guidebook page describes the evidence for a specific programme that makes use of psychotherapy. It does not describe the evidence for psychotherapy with children as a broader practice.

Evidence rating: **3+**

Cost rating: **NA**

EIF Programme Assessment

Child-Parent Psychotherapy has evidence of a **short-term positive impact** on child outcomes from at least one rigorous evaluation.

Evidence rating: **3+**

What does the evidence rating mean?

Level 3 indicates **evidence of efficacy**. This means the programme can be described as evidence-based: it has evidence from at least one rigorously conducted RCT or QED demonstrating a statistically significant positive impact on at least one child outcome.

This programme does not receive a rating of 4 as it has not yet replicated its results in another rigorously conducted study, where at least one study indicates long-term impacts, and at least one uses measures independent of study participants.

What does the plus mean?

The plus rating indicates that this programme has evidence from at least one level 3 study, along with evidence from other studies rated 2 or better.

Cost rating

NA indicates that the information required to generate a cost rating is not available at this time.

Cost rating: **NA**

Child outcomes

According to the best available evidence for this programme's impact, it can achieve the following positive outcomes for children:

Supporting children's mental health and wellbeing

Improved representations of the mother-child relationship

Based on study 1

Improved expectations of the mother-child relationship

Based on study 1

Reduced traumatic stress disorder symptoms

Based on study 2

2.29-point improvement on the semistructured interview for diagnostic classification

Improvement index: **+24**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 74% and worse outcomes than 26% of their peers, if they had received the intervention.

Immediately after the intervention

Preventing crime, violence and antisocial behaviour

Improved child behaviour

Based on study 2

2.38-point improvement on the Child Behaviour Checklist

Improvement index: **+9**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 59% and worse outcomes than 41% of their peers, if they had received the intervention.

Immediately after the intervention

4-point improvement on the Child Behaviour Checklist

Improvement index: **+16**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 66% and worse outcomes than 34% of their peers, if they had received the intervention.

6 months later

This programme also has evidence of supporting positive outcomes for couples, parents or families that may be relevant to a commissioning decision. Please see the 'About the evidence' section for more detail.

Key programme characteristics

Who is it for?

The best available evidence for this programme relates to the following age-groups:

- Preschool

How is it delivered?

The best available evidence for this programme relates to implementation through these delivery models:

- Individual

Where is it delivered?

The best available evidence for this programme relates to its implementation in these settings:

- Home
- Out-patient health setting

The programme may also be delivered in these settings:

- Home
- Children's centre or early-years setting
- Primary school
- Secondary school
- Sixth-form or FE college
- Community centre
- In-patient health setting
- Out-patient health setting

How is it targeted?

The best available evidence for this programme relates to its implementation as:

- Targeted indicated

Where has it been implemented?

United Kingdom, United States

UK provision

This programme has been implemented in the UK.

UK evaluation

This programme's best evidence does not include evaluation conducted in the UK.

Spotlight sets

EIF includes this programme in the following Spotlight sets:

- programmes for children with recognised or possible special education needs

About the programme

What happens during delivery?

How is it delivered?

- CPP is delivered in 32 sessions of approximately 1 to 1.5 hours' duration each by one clinical practitioner with QCF-7/8 qualifications (and 92 hours of programme training).

What happens during the intervention?

- CPP is delivered by a practitioner with a Masters (or higher) qualification in psychology or social work. Mothers and their child attend weekly sessions for a period of 12 months or longer.
- During each session, the practitioner uses empathic, non-didactic support to help the mother reflect on her childhood experiences and differentiate them from her current relationship with her child.
- Parent sessions are interspersed with sessions involving the child, where the mother, therapist and child jointly engage in structured play aimed at eliciting trauma related feelings and behaviours. This allows the therapist to help the mother and child develop a joint narrative around the traumatic events and bring them to their resolution.
- Mothers also receive support in appropriate discipline and an increased awareness of their child's moods and emotional states.

What are the implementation requirements?

Who can deliver it?

- The practitioner who delivers this programme is a Masters level clinical practitioner with NFQ-9/10 qualification.

What are the training requirements?

- The practitioners have 92 hours of programme training (seven days' face-to-face training with 36 hours of phone consultation). Booster training of practitioners is recommended.

How are the practitioners supervised?

- Practitioners are supervised by one host-agency supervisor with NFQ-level 9/10, who provides clinical, skills and case-management supervision.

What are the systems for maintaining fidelity?

Not available

Is there a licensing requirement?

There is no licence required to run this programme.

How does it work? (Theory of Change)

How does it work?

- Positive and sensitive parent/child interactions increase the likelihood of a secure parent/child attachment relationship.
- Parents experiencing multiple hardships and/or an insecure attachment relationship in their own childhood are less likely to develop positive representations of their child, reducing their ability to respond sensitively and appropriately to their child’s behaviour.
- Parents receive therapeutic support to improve their ability to form positive representations of their child and provide an appropriately nurturing and sensitive caregiving environment.
- In the short term, parents develop positive representations of their child, their sensitivity increases and the child experiences greater attachment security.
- In the longer term, children will develop positive expectations of themselves and others, demonstrate improved mental health and be at a reduced risk of child maltreatment.

Intended outcomes

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About the evidence

CPP's most rigorous evidence comes from two RCTs, both of which were conducted in the USA.

These studies identified statistically significant positive impact on a number of child and parent outcomes.

This programme has evidence from at least one rigorously conducted RCT along with evidence from an additional comparison group study. Consequently, the programme receives a 3+ rating overall.

Study 1

Citation:	Toth et al (2002)
Design:	RCT
Country:	United States
Sample:	155 mother-child (aged four) pairs, 112 where there was a known incident of child maltreatment
Timing:	Approximately 1 and 3 years after baseline evaluation

Child outcomes:

- Improved representations of the mother-child relationship
- Improved expectations of the mother-child relationship

Other outcomes:

- None measured

Study rating: 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*, 877-908.

Available athttp://europepmc.org/abstract/med/12549708

Study design and sample

The first study is an RCT.

This study involved random assignment of families to CPP treatment, psychoeducational home visiting intervention (PHV), and community standard (CS) control condition.

This study was conducted in the US, with a sample of 155 mothers and their preschoolers. During baseline, the children were approximately 4 years of age (M = 48.18 months, SD = 6.88). The majority of children in all groups were from minority ethnicities while the majority of the mothers in all groups were not married.

Measures

Children's maternal and self-representations and expectations of the mother-child relationship were measured using narrative story-stems selected from the MacArthur Story Stem Battery (MSSB) and the Attachment Story Completion Task (ASCT) (diagnostic interview).

Intelligence was measured using the abbreviated version of the Wechsler Preschool and Primary Scale of Intelligence (WPPSI-R) (achievement test)

Findings

This study identified statistically significant positive impact on a number of child outcomes.

This includes:

- Improved representations of the mother-child relationship
- Improved expectations of the mother-child relationship

The conclusions that can be drawn from this study are limited by methodological issues pertaining to a lack of intention-to-treat analysis, hence why a higher rating is not achieved.

Study 2

Citation:	Lieberman et al (2005); Lieberman et al (2006); Ghosh et al (2011)
Design:	RCT
Country:	United States
Sample:	75 mother-child (aged three to five) pairs who have witnessed trauma or domestic violence
Timing:	Post-test; 6 month follow-up

Child outcomes:

- Reduced traumatic stress disorder symptoms
- Improved child behaviour

Other outcomes:

- Reduced symptoms of PTSD Reduced symptoms of PTSD (maintained for high-risk group at six-month follow-up) Reduced depressive symptoms (maintained for high-risk group at six-month follow-up)

Study rating: 3

Lieberman, A.F., van Horn, P., & Ghosh Ippen, C. (2005). Toward evidence-based treatment: Child-parent psychotherapy *Psychiatry, 44,* 1241-1248.

Lieberman, A.F., Ghosh Ippen, C., & van Horn, P. (2006). Child-parent psychotherapy: 6-month follow-up of a randomized

Ghosh Ippen, C., Harris, W.W., Van Horn, P. l., & Lieberman, A.F. (2011). Traumatic and stressful events in early childhoc

Available athttp://www.jaacap.com/article/S0890-8567(09)62235-8/fulltext?refuid=S0890-8567(10)00082-1&refissn=0890

http://www.sciencedirect.com/science/article/pii/S0145213411001499

Study design and sample

The second study is a rigorously conducted RCT.

This study involved random assignment of families to a CPP treatment group and families to a case management plus indi

This study was conducted in the US, with a sample of 65 children and their mothers. The children were between 3 to 5 yea

Further, 41% of the families had incomes below the federal poverty level.

Measures

Child trauma symptomatology was measured using the Semistructured Interview for Diagnostic Classification DC: 0-3 for t

Child Behaviour Checklist (CBCL) score (parent report).

Maternal reexperiencing, avoidance, and hyperarousal symptoms were measured using the Clinician-Administered PTSD

Symptoms Checklist-90 Revised (SCL-R-90) (parent report)

Findings

This study identified statistically significant positive impact on a number of child and parent outcomes.

Child outcomes include:

- Reduced PTSD symptoms
- Improved behaviour

Guidebook

The EIF Guidebook provides information about early intervention programmes that have at least preliminary evidence of achieving positive outcomes for children. It provides information based on EIF's assessment of the strength of evidence for a programme's effectiveness, and on detail about programmes shared with us by those who design, run and deliver them.

The Guidebook serves an important starting point for commissioners to find out more about effective early interventions, and for programme providers to find out more about what good evidence of impact looks like and how it can be captured. As just one of our key resources for commissioners and practitioners, the Guidebook is an essential part of EIF's work to support the development of and investment in effective early intervention programmes.

Our assessment of the evidence for a programme's effectiveness can inform and support certain parts of a commissioning decision, but it is not a substitute for professional judgment. Evidence about what has worked in the past offers no guarantee that an approach will work in all circumstances. Crucially, the Guidebook is not a market comparison website: ratings and other information should not be interpreted as a specific recommendation, kite mark or endorsement for any programme.

How to read the Guidebook

EIF evidence standards

About the EIF Guidebook

EIF

The Early Intervention Foundation (EIF) is an independent charity and a member of the What Works network. We support the use of effective early intervention for children, young people and their families: identifying signals of risk, and responding with effective interventions to improve outcomes, reduce hardship and save the public money in the long term.

We work by generating evidence and knowledge of what works in our field, putting this information in the hands of commissioners, practitioners and policymakers, and supporting the adoption of the evidence in local areas and relevant sectors.

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