NC CHILD TREATMENT PROGRAM | CENTER FOR CHILD & FAMILY HEALTH

**North Carolina Child Treatment Program (NC CTP)**
**Evidence-Based Treatment (EBT) Service Delivery Time Model Series**

# Clinical Service Delivery Time Model for Child-Parent Psychotherapy (CPP)

Case-level Time Estimate

## CPP Time Model Tool

The *NC CTP Clinical Service Delivery Time Model (CPP)* tool was developed to support service utilization data collection, aggregation, and analysis at the level of the client-caregiver dyad, caseload, and agency. Additionally, it may be used to: establish agency-level service capacity; monitor intervention-specific processes and cost; and develop a *cost model* that reflects CPP clinical delivery requirements.

CPP service utilization estimates and data should be interpreted with caution, under the guidance of a CPP clinical expert, when applied to: clinical network development and contracting; establishment of service delivery payment rates; utilization management; and clinical performance monitoring. This template should not be used to facilitate training, treatment, fidelity monitoring, and/or clinical supervision, as these standards are established by the CPP model developers (www.childparentpsychotherapy.com).

The *NC CTP Clinical Service Delivery Time Model (CPP)* defines a "typical" case as one in which CPP is delivered in an outpatient setting, to a client-caregiver dyad presenting with moderate clinical complexity, in the primary language of both the client and caregiver. Service delivery is described in terms of: a) total number of clinical encounters (in-session treatment); b) total clinical encounter time (hours); and c) total out-of-session clinical support activity time (hours). Case-level service utilization data may fall outside the "typical" range, yet remain acceptable clinically, due to case complexity and implementation-related factors.

NC CTP populated the *NC CTP Clinical Service Delivery Time Model (CPP)* tool with case-level *estimates* to provide guidance regarding the development and sustainment of an outpatient CPP program. Estimates are based on the peer-reviewed literature, CPP trainer experience, and service utilization data from a cohort of clients associated with NC CTP clinical trainees and graduates.

## CPP Service Delivery Overview

- CPP is a dyadic trauma treatment model for young children that includes three phases: Foundational Phase (Assessment and Engagement), Core Intervention Phase, and Recapitulation and Termination Phase.
- CPP delivery typically includes a client and at least one primary caregiver. In select circumstances, the primary caregiver may be identified as the client (target of intervention).
- Clinical encounter participation varies based on treatment phase. The majority of clinical encounters are conducted individually with the caregiver during the Foundational Phase, and the majority of clinical encounters are conducted with client-caregiver dyad during Core Intervention Phase and Recapitulation and Termination Phase.
- Clinical encounters (treatment sessions) are typically conducted on a weekly basis; less frequent sessions may adversely impact the achievement of targeted clinical outcomes. In select circumstances, a client-caregiver dyad and/or caregiver may participate in more than one clinical encounter during a single week.
- A clinical encounter is typically 60 minutes in duration; however, treatment sessions may exceed 60 minutes and remain appropriate clinically.
- A typical course of community-based CPP includes an estimated: a) 34 hours of total in-session activities; and b) 42.4 hours of total out-of-session activities (72 minutes for every 60-minute clinical encounter).
- In select circumstances, two primary caregivers may be unable or unwilling to participate in CPP together, necessitating two separate courses of treatment with a single client.
- Treatment content and intensity, clinician fidelity, and clinical outcomes may vary across a CPP caseload due to child-, caregiver-, family-, clinician-, agency-, and systems-level factors.

***Table One: CPP Total Treatment Time Estimate Summary*** *(Case-level)*

| **Clinical Activities** (Case-level) | | **Treatment Time** | |
|---|---|---|---|
| | | Typical Case [a] (Hours) | Typical Range [b] (Hours) |
| **Total In-Session Activities** | | **34.0** | **21.0 - 56.0** |
| CPP-specific activities [c] | (Table Two) | 33.0 | 21.0 – 55.0 |
| General clinical activities [d] | (Table Two) | 1.0 | 0.0 – 1.0 |
| **Total Out-of-Session Activities** [e] | (Table Three) | **42.4** | **22.7 – 74.1** |
| **Total Treatment Time** | (In-Session + Out-of-Session) | **76.4** | **43.7 – 130.1** |
| **Ratio** [f] | (In-Session) : (Out-of-Session) | **(1.0) : (1.2)** 60 min : 72 min | **(1.0 : 1.1) – (1.0 : 1.3)** |

[a] "Typical case" includes CPP delivery in a community-based setting, to a client presenting with moderate clinical complexity, in the primary language of both client and caregiver.

[b] Service utilization data may fall outside the "typical" range, yet remain clinically acceptable, due to case complexity and implementation-related factors.

[c] CPP-specific activities are defined per the CPP manuals [1, 2] and Fidelity Toolkit[3, 4].

[d] General clinical activities are conducted in-session and include: client intake, additional clinical assessment, treatment and discharge planning, case coordination/communication, crisis management, and other general clinical activities.

[e] Conducted by treating clinician and include: client intake, additional clinical assessment, treatment and discharge planning, case coordination/communication, crisis management, clinical supervision/peer fidelity support/expert consultation, and other general support activities. Out-of-session activities are critical to successful TF-CBT implementation and improved clinical outcomes.

[f] A typical course of treatment includes an estimated 72 minutes of clinical support activity time (out-of-session) for every 60-minute encounter (treatment session).

***Table Two: CPP Clinical Activities Estimates*** *(In-Session Activities)*

| **In-Session Activities** [a] (Case-level) | Clinical Encounters **(# Sessions)** | | | Total Treatment Time [b] **(Hours)** | | |
|---|---|---|---|---|---|---|
| | Typical Case | Typical Range | | Typical Case | Typical Range | |
| | | Minimum | Maximum | | Minimum | Maximum |
| **CPP-specific Activities** [c] | | | | | | |
| Foundational Phase: Assessment and Engagement | 7 | 4 | 14 | 7.0 | 4.0 | 14.0 |
| Foundational Phase: Feedback | 1 | 1 | 2 | 1.0 | 1.0 | 2.0 |
| Core Intervention Phase: Introducing the Child to CPP | 1 | 1 | 1 | 1.0 | 1.0 | 1.0 |
| Core Intervention Phase | 16 | 10 | 24 | 16.0 | 10.0 | 24.0 |
| CPP interval assessment during Core Intervention Phase[d] | 2 | 0 | 4 | 2.0 | 0.0 | 4.0 |
| Recapitulation and Termination Phase | 6 | 5 | 10 | 6.0 | 5.0 | 10.0 |
| ***Subtotal*** | **33** | **21** | **55** | **33.0** | **21.0** | **55.0** |
| **General Clinical Activities (In-Session)** | | | | | | |
| Client intake[e] | 1 | 0 | 1 | 1.0 | 0.0 | 1.0 |
| Other general clinical activities | -- | -- | -- | -- | -- | -- |
| **TOTAL IN-SESSION ACTIVITIES** | **34** | **21** | **56** | **34.0** | **21.0** | **56.0** |

[a] Includes general and CPP-specific clinical activities delivered during a clinical encounter (treatment session); multiple activities may be delivered during a single clinical encounter.

[b] Assumes clinical encounters are 60 minutes in duration; duration may vary based on clinical considerations.

[c] Defined by the CPP manuals[1, 2] and Fidelity Toolkit[3, 4]. Includes: case coordination/communication and crisis management; typically delivered by treating clinician. Highly variable across clients.

[d] Standardized assessment measures are typically re-administered at the twelfth (12) Core Intervention session, and every 12 sessions thereafter. Timing of interval assessment administration may vary based on clinical need.

[e] Includes consent and other agency-specific documentation and activities.

***Table Three: CPP Clinical Support Activities Estimates*** *(Out-of-Session Activities)*

| **Out-of-Session Activities** [a] (Case-level) | | **Time per Activity** | | |
|---|---|---|---|---|
| | | Typical Case (Hours) | Typical Range (Hours) | |
| | | | Minimum | Maximum |
| Case Support Activities (out-of-session) | Client intake [b] | 0.5 | 0.0 | 1.0 |
| | Clinical assessment + case conceptualization [c] | 3.0 | 1.0 | 5.0 |
| | Treatment planning + documentation [d] | 0.5 | 0.5 | 1.0 |
| | Session preparation [e] | 2.8 | 1.8 | 4.7 |
| | Session documentation + fidelity monitoring [f] | 8.5 | 5.3 | 14.0 |
| | Discharge planning + documentation [g] | 0.5 | 0.0 | 1.0 |
| | Case coordination/ communication [h] | 17.0 | 10.5 | 28.0 |
| | Crisis management [i] | 4.0 | 0.0 | 10.0 |
| CPP Fidelity Support Activities (out-of-session) | Periodic clinician fidelity self-monitoring [j] | 2.8 | 1.8 | 4.7 |
| | Reflective supervision/ peer fidelity support/ expert consultation [k] | 2.8 | 1.8 | 4.7 |
| General Support Activities (out-of-session) | Insurance + billing support | -- | -- | -- |
| | Court preparation + testimony | -- | -- | -- |
| | Clinician travel for treatment session | -- | -- | -- |
| | Clinician travel for case coordination | -- | -- | -- |
| Other Activities (out-of-session) | Other activities | -- | -- | -- |
| **TOTAL OUT-OF-SESSION ACTIVITIES** | | **42.4** | **22.7** | **74.1** |

[a] Conducted out-of-session by a treating clinician; critical to successful CPP implementation and improved clinical outcomes.

[b] Includes: referral review; caregiver engagement and scheduling; clinical screening; consent process; and other clinical activities and documentation.

[c] Includes: scoring and interpretation of clinical assessment measures; collateral contact; record review; case conceptualization; documentation of assessment process and findings; and treatment recommendations.

[d] Includes: documentation of treatment goals and recommendations; and consideration of potential treatment barriers.

[e] Assumes five (5) minutes per clinical encounter; includes clinical note review and preparation of materials/activities.

[f] Assumes fifteen (15) minutes per clinical encounter (treatment session); includes session-level documentation and CPP procedural fidelity forms. Procedural fidelity is monitored by treating clinician, using a structured tool, at clinical encounter level.

[g] Includes out-of-session development of recommendations for remaining treatment or service needs.

[h] Assumes thirty (30) minutes per clinical encounter (treatment session); includes routine out-of-session: treatment/multidisciplinary team participation; collateral contact; service coordination and monitoring; provision of consultation to non-clinical professionals; and caregiver contact.

[i] Includes urgent or emergent out-of-session case coordination and communication. Highly variable across clients.

[j] In addition to session-level fidelity monitoring, treating clinicians complete periodic fidelity monitoring as defined by the CPP Fidelity Toolkit[3, 4]. Assumes five (5) minutes per session (clinical encounter).

[k] A treating clinician should participate in case-specific: a) reflective supervision provided by a trained supervisor; b) fidelity-driven peer case support; and/or (c) expert consultation. Frequency depends upon caseload size, case complexity, supervision structure, agency requirements, and other factors. Assumes five (5) minutes per session (clinical encounter).

## Agency-level CPP Program: Additional Resource Requirements

The following implementation requirements should be considered when determining the resource allocation necessary to develop and sustain an outpatient CPP program:

**Clinician Training and National Rostering**

To become and/or remain nationally rostered, a clinician must complete all training and rostering requirements, as outlined by the CPP National Therapist Rostering Program (www.childparentpsychotherapy.com).

The cost associated with participation in a CPP training program is variable.

**Post-Training Reflective Supervision**

While maintaining an active caseload, CPP clinicians should participate in a minimum of two hours per month of CPP reflective supervision provided by a trained CPP supervisor or peer. CPP reflective supervision may be conducted in a group or individual format, using the CPP fidelity toolkit[3, 4]. Additionally, the clinician should self-monitor fidelity across their caseload throughout treatment delivery.

When allocating resources to support supervision or peer case review, consider: caseload size and complexity; CPP fidelity requirements; supervision structure; agency requirements; and other factors.

**Clinical Assessment Measures**

CPP requires the administration of standardized clinical measures (pre-treatment, during treatment, and post-treatment) to assess multiple client and caregiver domains, including: trauma history, posttraumatic stress symptoms, mental health symptoms and functioning, child development, physical safety, child-caregiver interaction, parenting, and family ecology.

The cost associated with purchase or licensing of standardized clinical assessment measures should be considered when allocating resources to support an agency CPP program.

**Clinical Materials**

CPP delivery requires a clinical toy kit and other clinical materials during each clinical encounter; cost is variable.

**Clinician Travel**

A CPP clinician may participate in activities that require travel, including home-based treatment delivery and clinical support activities (out-of-session).

When allocating resources to support an agency CPP program, consideration should be given to clinician travel time, as well as direct travel expenses.

## North Carolina Child Treatment Program
## Evidence-Based Treatment (EBT) Service Delivery Time Model Series

# Clinical Service Delivery Time Model for Child-Parent Psychotherapy (CPP)

Model Overview, Research Base, and Outcomes

## Section One: CPP Overview

**Model Developers**

- Alicia F. Lieberman, Ph.D.,
  Child Trauma Research Program,
  UCSF-Zuckerberg San Francisco General Hospital and Trauma Center
- Patricia Van Horn, J.D., Ph.D.

**Dissemination Director**

- Chandra Ghosh Ippen, Ph.D.,
  Child Trauma Research Program,
  UCSF-Zuckerberg San Francisco General Hospital and Trauma Center

**Treatment Protocols (Manuals)**

- Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2015). *Don't hit my mommy!: A manual for child-parent psychotherapy with young witnesses of family violence* (2nd ed.). Washington, DC: Zero to Three.[1]
- Lieberman, A. F., & Van, H. P. (2008). *Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment*. New York, NY: Guilford Press[2]

**Model Description**

CPP is an evidence-based, dyadic mental health treatment for children experiencing symptoms following a wide range of traumatic experiences or exposures; additionally, the model may be used to address client-caregiver attachment difficulties. CPP incorporates multiple treatment strategies, including: family assessment and engagement; safety planning; care coordination; psychoeducation about child development and behavior; provision of reflective, non-directive developmental guidance; support of dyadic physiological and affective co-regulation; and trauma processing.

**Treatment Theory**

CPP is based on attachment, psychoanalytic, and developmental psychopathology theories.

**Target Population**

CPP is indicated for children birth through five years of age who are symptomatic following traumatic experiences and exposures and/or are experiencing significant difficulties in the child-parent relationship. Treatment delivery may be tailored based on the developmental age, rather than chronological age, of a client with intellectual and/or developmental disabilities.

CPP may also be indicated for caregivers exhibiting significant stress or dysfunction due to trauma, interpersonal violence, mental health disorders, substance use, or physical health challenges.

**Targeted Clinical Outcomes**
CPP was developed to promote child and caregiver: physical and psychological safety and stabilization; attachment security; affective and physiological regulation; trauma processing and symptom reduction; and healthy development and functioning.

**Treatment Participants**
CPP typically includes a client (child) and at least one primary caregiver; however, in select circumstances, the primary caregiver may be identified as the client (target of intervention).

Clinical session participation varies based on CPP treatment phase. During the Foundational Phase, the majority of clinical encounters are conducted individually with the caregiver. During the Core Intervention Phase and Recapitulation and Termination Phase, the majority of clinical encounters are conducted with the client-caregiver dyad. In rare clinical circumstances, a clinician may conduct client-only sessions.

**Treatment Delivery Professionals**
CPP is delivered by a licensed mental health clinician who is actively engaged in training with an endorsed trainer, or has successfully completed all CPP training requirements, as defined by the model developers (www.childparentpsychotherapy.com).

**Service Setting and Type**
CPP may be delivered in an outpatient clinic, home, residential, or other community setting. Additionally, CPP may be offered through a variety of service delivery models, including: telehealth, outpatient, enhanced outpatient, intensive in-home, and others.

**Treatment Delivery and Intensity**
- CPP clinical encounters (treatment sessions) are typically conducted on a weekly basis; less frequent sessions may adversely impact the achievement of targeted clinical outcomes. In select circumstances, a client-caregiver dyad and/or caregiver may participate in more than one clinical encounter during a single week.
- A clinical encounter is typically 60 minutes in duration; however, treatment sessions may exceed 60 minutes and remain appropriate clinically.
- A typical course of community-based CPP includes an estimated: a) 34 hours of total in-session activities; and b) 42.4 hours of total out-of-session activities (72 minutes out-of-session time for every 60-minute clinical encounter).
- In select circumstances, two primary caregivers may be unable or unwilling to participate in CPP together, necessitating two separate courses of treatment with a single client.

**Reflective Supervision**
While maintaining an active caseload, CPP clinicians should participate in a minimum of two hours per month of CPP reflective supervision provided by a trained supervisor or peer. CPP reflective supervision may be conducted in a group or individual format, using the CPP fidelity toolkit[3, 4]. Additionally, the clinician should self-monitor fidelity across their caseload throughout treatment delivery.

**Factors Impacting Treatment Delivery and Outcomes**
Treatment content and intensity, clinician fidelity, and clinical outcomes may vary across a CPP caseload due to child-, caregiver-, family-, clinician-, agency-, and systems-level factors.

## Section Two: Child-Parent Psychotherapy (CPP) Clinical Inclusion and Exclusion Criteria

| | Inclusion Criteria | Exclusion Criteria |
|---|---|---|
| **Child (client)** | ○ Pre-natal to six years of age<br>○ Clinical indication:<br>▪ Exposure to a traumatic event or experience [a]<br>▪ Symptoms that impact functioning; and/or<br>▪ Concerns regarding attachment relationship with primary caregiver<br>○ Available to participate in treatment sessions, as clinically indicated | ○ Unable to participate in scheduled treatment sessions [b] |
| **Caregiver** [c] | ○ Concerns regarding attachment relationship with child<br>○ Available to participate in regularly scheduled treatment sessions [b] | ○ Perpetrator of sexual abuse<br>○ Has active psychosis, cognitive impairment, or thought disorder that precludes participation<br>○ Unable to participate in regularly scheduled treatment sessions [b] |

[a] A traumatic experience or exposure is defined as a frightening, dangerous, and/or violent event that poses a threat to a child's life or bodily integrity *and/or* witnessing of a traumatic event that threatens the life or physical security of a loved one. For young children, loss of a primary attachment figure is considered a traumatic event.

[b] Clinical encounters (treatment sessions) are typically conducted on a weekly basis; less frequent sessions may adversely impact the achievement of clinical goals.

[c] In select circumstances, a primary caregiver may be identified as the client, or target of intervention.

## Section Three: CPP Clinical Assessment Strategy

Case-level CPP clinical assessment should be individualized and include:

- Administration, scoring, and interpretation of standardized clinical assessment measures;
- Comprehensive, trauma-informed clinical interview with client, if developmentally appropriate, and caregiver;
- Clinical observation;
- Collateral contacts;
- Record review;
- Case conceptualization;
- Documentation of the assessment process, findings, and conclusions;
- Provision of feedback.

Clinical assessment is conducted during the Foundational Phase and the Recapitulation and Termination Phase. Assessment may also be conducted during the Core Intervention Phase, generally around the completion of the twelfth (12) Core Intervention session, and approximately every twelfth session thereafter.

**CPP Clinical Assessment Measure Domains** (Per Treatment Phase)

| | | **CPP Treatment Phase** | | |
|---|---|---|---|---|
| | | Foundational (Assessment and Engagement) | Core Intervention | Recapitulation and Termination |
| **Assess Child** | Required | ○ Child-caregiver relationship quality<br>○ Trauma history<br>○ Posttraumatic stress symptoms<br>○ Internalizing symptoms<br>○ Externalizing symptoms<br>○ Developmental functioning<br>○ Physical health<br>○ Physical safety<br>○ Family biopsychosocial history | ○ Child-caregiver relationship quality<br>○ Trauma history<br>○ Posttraumatic stress symptoms<br>○ Internalizing symptoms<br>○ Externalizing symptoms<br>○ Physical safety | ○ Child-caregiver relationship quality<br>○ Trauma history<br>○ Posttraumatic stress symptoms<br>○ Internalizing symptoms<br>○ Externalizing symptoms<br>○ Physical safety |
| | Recommended | ○ Other domains, as indicated | ○ Developmental functioning<br>○ Physical health<br>○ Family biopsychosocial history<br>○ Other domains, as indicated | ○ Developmental functioning<br>○ Physical health<br>○ Family biopsychosocial history<br>○ Other domains, as indicated |
| **Assess Caregiver** | Required | ○ Caregiver trauma history<br>○ Caregiver posttraumatic stress symptoms<br>○ Caregiver mental health symptoms<br>○ Caregiver adaptive functioning<br>○ Parenting strategies and stress<br>○ Physical safety<br>○ Family biopsychosocial history | ○ Caregiver trauma history<br>○ Caregiver posttraumatic stress symptoms<br>○ Caregiver mental health symptoms<br>○ Parenting strategies and stress<br>○ Physical safety | ○ Caregiver trauma history<br>○ Caregiver posttraumatic stress symptoms<br>○ Caregiver mental health symptoms<br>○ Parenting strategies and stress<br>○ Physical safety |
| | Recommended | ○ Caregiver physical health<br>○ Caregiver substance use<br>○ Other domains, as indicated | ○ Caregiver adaptive functioning<br>○ Caregiver physical health<br>○ Caregiver substance use<br>○ Family ecology<br>○ Other domains, as indicated | ○ Caregiver adaptive functioning<br>○ Caregiver physical health<br>○ Caregiver substance use<br>○ Family ecology<br>○ Other domains, as indicated |

## Section Four: CPP Service Delivery Checklist

The *NC CTP Clinical Service Delivery Checklist (CPP)* was developed to support the collection, aggregation, and analysis of service utilization data within an outpatient CPP program. The *Checklist* describes core clinical and fidelity requirements for the delivery of CPP, per standards established through the CPP manuals[1, 2] and the CPP Fidelity Toolkit[3, 4]. *Checklist* adaptation may be required to support service utilization analysis within other service delivery models or treatment environments.

The *Checklist* should not be used to facilitate training, treatment, fidelity monitoring, or clinical supervision. Rather, the CPP manuals[1, 2] and the CPP Fidelity Toolkit[3, 4] should be used for this purpose.

| **Foundational Phase (Assessment and Engagement)** | |
|---|---|
| **Clinical Activities** | **Fidelity Assessment** |
| 1. Conduct and document weekly sessions, individually or jointly, with each participating caregiver to:<br><br>a. Assess:<br>○ Referral issues and presenting concerns<br>○ Child trauma history; posttraumatic stress symptoms; internalizing and externalizing symptoms; developmental functioning; physical health; and physical safety.<br>○ Caregiver trauma history; posttraumatic stress symptoms; mental health symptoms; adaptive functioning; parenting strategies and stress; and physical safety<br>○ Family biopsychosocial history<br>○ Child-caregiver relationship quality<br>b. Provide psychoeducation about trauma and its impact<br>c. Describe CPP rationale, treatment parameters, clinical assessment, and targeted clinical outcomes<br>d. Address CPP clinical objectives, including:<br>○ Establish therapeutic relationship<br>○ Promote physical safety, psychological safety, and ecological stabilization<br>○ Enhance dyadic emotional reciprocity<br>○ Enhance affective and physiological co-regulatory capacity<br>○ Normalize client and caregiver response regarding traumatic event<br>○ Promote client and caregiver ability to address trauma reminders<br>○ Facilitate client and caregiver ability to make meaning of traumatic experience (CPP trauma narration)<br>○ Promote normative client development<br><br>2. Conduct and document the client-caregiver Observation Session(s), individually, with each participating caregiver, to assess:<br>a. Child-caregiver relationship quality<br>b. Child developmental functioning<br>c. Parenting strategies and stress<br><br>3. Conduct and document the Assessment Feedback Session, individually or jointly, with each participating caregiver to:<br>a. Elicit caregiver perception regarding assessment process<br>b. Provide feedback regarding assessment findings and case conceptualization<br>c. Introduce the CPP Core Intervention Phase<br>d. Assess safety risks associated with child participation in treatment<br>e. Develop plan to introduce CPP to client<br><br>4. Provide recommendations and referrals for child, caregiver, and family members<br>Conduct out-of-session case support activities, as clinically indicated<br><br>5. For treatment termination prior to full CPP course, conduct and document clinically indicated activities | 1. Self-assess and document adherence to CPP fidelity standards following each clinical encounter per *Procedural Fidelity: Assessment and Engagement* metric<br><br>2. Self-assess and document adherence to CPP fidelity standards following the Feedback Session per:<br>a. *Procedural Fidelity: Feedback Session* metric<br>b. *CPP Core Intervention Fidelity: Case Conceptualization and Content for Foundational Phase)* metric<br><br>3. Self-assess and document adherence to CPP fidelity standards upon completion of Foundational Phase, per the *CPP Core Intervention Fidelity* metric, for Foundation Phase specifically addressing:<br>a. Reflective Practice fidelity<br>b. Emotional Process fidelity<br>c. Dyadic-Relational fidelity<br>d. Trauma Framework fidelity<br>e. Procedural fidelity<br>f. Case Conceptualization and Content (CPP objectives) fidelity<br><br>4. For treatment termination prior to full course of CPP, self-assess and document adherence to CPP fidelity standards following each clinical encounter per *Procedural Fidelity: Planned Termination* metric<br><br>5. Participate in routine, case-specific reflective supervision |

*NC CTP CPP Service Delivery Checklist Continued*

| Core Intervention Phase | |
|---|---|
| **Clinical Activities** | **Fidelity Assessment** |
| 1. Conduct and document the *Introducing Client to CPP* Session with the client-caregiver dyad<br><br>2. Conduct and document weekly sessions with the client-caregiver dyad to address CPP clinical objectives, including:<br>a. Enhance therapeutic relationship<br>b. Promote physical safety, emotional safety, and ecological stabilization<br>c. Enhance dyadic emotional reciprocity<br>d. Enhance affective and physiological co-regulatory capacity<br>e. Enhance caregiver ability to respond to client behavioral cues<br>f. Normalize client and caregiver response regarding traumatic event<br>g. Promote client and caregiver ability to address trauma reminders<br>h. Facilitate client and caregiver ability to make meaning of traumatic experience (CPP trauma narration)<br>i. Promote client normative development<br><br>3. Provide recommendations and referrals for child, caregiver, and family members<br><br>4. Conduct out-of-session case support activities, as clinically indicated<br><br>5. Conduct and document assessment around completion of the twelfth (12) Core Intervention session, and approximately every twelfth session thereafter<br><br>6. For treatment termination prior to full CPP course, conduct and document clinically indicated activities | 1. Self-assess adherence to CPP fidelity standards following each clinical encounter per the *CPP Core Intervention Fidelity: Case Conceptualization and Content (CPP objectives)* metric, and document adherence approximately every 12 sessions<br><br>2. Self-assess and document adherence to CPP fidelity standards following the session in which the child is introduced to CPP per the *Procedural Fidelity: Introducing the Child to CPP* metric<br><br>3. Self-assess and document adherence to CPP fidelity standards upon completion of approximately every twelve (12) Core Intervention sessions per the *CPP Core Intervention Fidelity* metric, specifically addressing:<br>a. Reflective Practice fidelity<br>b. Emotional Process fidelity<br>c. Dyadic-Relational fidelity<br>d. Trauma Framework fidelity<br>e. Procedural fidelity<br>f. Case Conceptualization and Content (CPP objectives) fidelity<br><br>4. For treatment termination prior to full course of CPP, self-assess and document adherence to CPP fidelity standards following each clinical encounter per *Procedural Fidelity: Planned Termination* metric<br><br>5. Participate in routine, case-specific reflective supervision |

*NC CTP CPP Service Delivery Checklist Continued*

| Recapitulation and Termination Phase | |
|---|---|
| **Clinical Activities** | **Fidelity Assessment** |
| 1. Conduct and document weekly sessions, individually or jointly, with each participating caregiver to:<br>a. Introduce the Recapitulation and Termination Phase<br>b. Assess:<br>○ Progress towards achievement of targeted clinical outcomes<br>○ Child trauma history; posttraumatic stress symptoms; internalizing and externalizing symptoms; and physical safety<br>○ Caregiver trauma history; posttraumatic stress symptoms; mental health symptoms; parenting strategies and stress; and physical safety<br>○ Family biopsychosocial status<br>○ Child-caregiver relationship quality<br>c. Provide feedback regarding assessment findings and current case conceptualization<br><br>2. Conduct and document weekly sessions with the client-caregiver dyad to:<br>a. Prepare for treatment termination<br>b. Review the client-caregiver dyad Family Story (CPP trauma narration)<br>c. Address CPP clinical objectives, including:<br>○ Sustain therapeutic relationship<br>○ Promote physical safety, emotional safety, and ecological stabilization<br>○ Enhance dyadic emotional reciprocity<br>○ Enhance affective and physiological co-regulatory capacity<br>○ Enhance caregiver ability to respond to client behavioral cues<br>○ Normalize client and caregiver response regarding traumatic event<br>○ Promote client and caregiver ability to address trauma reminders<br>○ Facilitate client and caregiver ability to make meaning of traumatic experience (CPP trauma narration)<br>○ Promote client normative development<br><br>3. Provide recommendations and referrals for child, caregiver, and family members<br><br>4. Conduct out-of-session case support activities, as clinically indicated<br><br>5. For treatment termination prior to full CPP course, conduct and document clinically indicated activities | 1. Self-assess and document adherence to CPP fidelity standards following each clinical encounter per:<br>a. *Procedural Fidelity: Planned Termination* metric<br>b. *CPP Core Intervention Fidelity: Case Conceptualization and Content (CPP objectives)* metric<br><br>2. Self-assess and document adherence to CPP fidelity standards upon completion of the Recapitulation and Termination Phase per the CPP Core Intervention Fidelity metric for Termination Phase specifically addressing:<br>a. Reflective Practice fidelity<br>b. Emotional Process fidelity<br>c. Dyadic-Relational fidelity<br>d. Trauma Framework fidelity<br>e. Procedural fidelity<br>f. Case Conceptualization and Content (CPP objectives) fidelity<br><br>3. Participate in routine, case-specific reflective supervision |

## Section Five: CPP Research Base

*NC CTP* faculty conducts an annual literature review of the Child-Parent Psychotherapy (CPP) research base, with a particular emphasis on populations studied and treatment outcomes for the CPP model and/or model adaptations. A paper is eligible for inclusion if, minimally, the study: 1) is published in a peer-reviewed journal, 2) incorporates a pre-post evaluation design that includes at least one group of children and families, and 3) represents an original randomized efficacy trial (RCT), quasi-experimental study, single-group pretest-posttest design study, pilot study, systematic review, or meta-analysis. Studies are excluded entirely from the CPP Research Base section if they do not meet all three inclusion criteria. A specific outcome is included in this review if a statistically- and/or clinically-significant main effect was found over time for that outcome.

Detailed information about study rationale, methodology, and other content may be accessed directly via the cited research article.

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**Populations Studied**

- Pregnant women and infants exposed to intimate partner violence (IPV) [5]
- Anxiously attached infants of Latina immigrant moms [6]
- Infants exposed to maltreatment[7-9]
- Young children exposed to maltreatment[10, 11]
- Young children of depressed mothers[12-15]
- Young children exposed to domestic violence[16, 17]
- Young children exposed to interpersonal trauma[18, 19]
- Young children who experienced at least four traumatic and stressful life events, including domestic violence[20]
- Young children in a wraparound foster care program[21]
- Young children exposed to different and/or multiple types of trauma [22]
- Diverse ethnic and racial populations, including African American, Asian, Caucasian, Hispanic/Latinx, multiracial, and/or other groups[5-11, 16-18, 20, 21]

## Section Six: CPP Treatment Outcomes

| Client Outcomes | |
|---|---|
| **Immediate Post-Treatment Outcome** | **Outcome Sustained Following Treatment** |
| Decrease in PTSD symptoms and PTSD diagnosis[16, 18, 20-22] | At 6 months[20] |
| Decrease in co-occurring diagnoses[20] | At 6 months[20] |
| Decrease in internalizing symptoms[19] | -- |
| Decrease in externalizing symptoms[19] | -- |
| Decrease in behavior problems (combination of internalizing and externalizing symptoms) [16, 19, 20] | At 6 months [16, 20] |
| Decrease in depression symptoms[20] | At 6 months[20] |
| Decrease in behavioral/emotional needs[21] | -- |
| Decrease in risk behaviors[21] | -- |
| Improvement in life domain functioning[21] | -- |
| Improvement in attachment security[7, 11, 12, 14, 15] | At 1 year[11]<br>At 6 years[15] |
| Improvement in strengths[21] | -- |
| Improvement in regulation of cortisol levels (biological regulatory processes)[9] | At 1 year[9] |
| Maintenance of normative gains in cognitive development[13] | -- |
| Decrease in negative self-representations[10] | -- |
| Decrease in maladaptive maternal representations[10] | -- |
| Improvement in mother-child relationship expectations[10] | -- |
| Decrease in avoidance, resistance, and anger towards mother[6] | -- |
| Improvement in mother-toddler reciprocity during reunion following separation[6] | -- |

| Caregiver Outcomes | |
|---|---|
| **Immediate Post-Treatment Outcome** | **Outcome Sustained Following Treatment** |
| Decrease in maternal PTSD symptoms[5, 16, 18-20] | At 6 months[20] |
| Decrease in maternal general psychiatric distress[16, 17] | At 6 months[17] |
| Decrease in maternal child-related stress[8] | -- |
| Decrease in maternal depression symptoms[5, 20] | At 6 months[20] |
| Improvement in maternal empathic responsiveness and initiation with children[6] | -- |
| Decrease in maternal bias towards fearful infant facial cues[19] | -- |
| Improvement in maternal positive child-rearing attitudes[5] | -- |

## North Carolina CPP Treatment Outcomes

The NC Child Treatment Program provides intensive CPP training and clinical coaching to approximately 17-39 (average: 27) licensed clinicians each year. Since 2014, NC CTP has monitored clinical outcomes for a minimum of two clients per clinician-trainee; additionally, select caregiver outcomes are assessed. Per comparison of pre-and post-treatment assessment results:

- The majority of clients demonstrate a statistically significant reduction in PTSD symptoms, social/emotional problems, hyperactivity, and peer problems (per caregiver report).
- The majority of caregivers demonstrate a statistically significant reduction in PTSD symptoms, anxiety, and parental stress (per caregiver self-report).

## Section Seven:
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