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Child-Parent Psychotherapy

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Brief historic overview

The history of psychotherapy with young children and their caregivers has now been nearly 75 years in the making. A long list of eminent theorists, clinicians, and researchers have contributed to the establishment of dyadic psychotherapy as a respected treatment intervention. The birth of this new form of psychotherapy is rooted in many factors, including a flourishing interest in early determinants of personality organization; cultural practices and historical events that allowed for the study of early childhood separation from primary caregivers; and an expansion of psychoanalytic and child development paradigms.

The pioneer infant-parent intervention was developed by Selma Fraiberg and colleagues, in 1975, in the USA. Evolving alongside psychoanalytic theories on the role of maternal fantasy in the formation of the infant psyche, this model, which became identified with the metaphor “ghosts in the nursery”, illustrated the intergenerational transmission of psychopathology through the parents’ reenactment with their baby of unresolved conflicts from their own childhood. Roughly at the same time, schools of psychodynamic parent-infant treatment were developed in Europe, by Serge Lebovici, Leon Kreisler and Michel Soule in Paris and by Bertram Cramer in Geneva. Since then, the understanding and integration of multiple constructs in early childhood mental health intervention has increased impressively. One of the, although apparently simple, overriding notion achieved is that very young children exist in a relational context. Therefore, the relationship is a core target of therapeutic intervention.

Child-parent psychotherapy (CPP) is a more recent and empirically validated form of dyadic psychotherapy. Key components of CPP have their origin in infant-parent psychotherapy as developed by Fraiberg and colleagues, namely, the underlying psychoanalytic conceptualization of intergenerational trauma transmission and the intervention techniques of developmental guidance, concrete assistance, and insight-oriented interpretation. As research and theory have advanced over time, CPP has integrated additional paradigms, both theoretical (attachment theory, trauma theory, developmental psychology, psychoanalytic theory and developmental psychopathology) and of intervention (derived from social work, social learning theory, and cognitive-behavioural therapy). Most recently, CPP has incorporated an innovative concept: “angels in the nursery”, seeking to recall (or create) benevolent internal models of positive, responsive, and nurturing care.

Description

As a child-centred treatment, CPP prioritizes the goal of a healthy development across all domains. As a relationship-based treatment that locates the mental health of the young child within the relationship with the primary caregiver, the goal of CPP is to strengthen and support that relationship, building qualities of mutuality, reciprocity, communication, and understanding/empathy. CPP fosters security of attachment, the reestablishment of the caregiver as a source of protection and safety, and caregiver-child mutually constructed meanings as opposed to individually held misperceptions about self and other. Additional goals are child cognitive growth, positive conflict-resolution skills, and accurate reality testing.

These aims are pursued through joint child-parent sessions, in which the therapist uses strategies designed to promote an age-appropriate, goal-corrected partnership between parent and child. A variety of intervention modalities are used in response to different clinical needs, such as translating behavioural meanings using play, physical contact, and language; offering unstructured reflective developmental guidance; modelling appropriate protective behaviour; promoting insight-oriented interpretation; addressing traumatic reminders; retrieving benevolent memories; providing emotional support; and offering crisis intervention, case management and concrete assistance. The concept of “ports of entry” refers to the variety of elements in the parent-child relationship system that may be used as the starting point for an intervention. The choice of which “port” to enter is determined by what is happening in the moment, and the clinician’s judgment of what will be most effective in that moment; it is not a singular overall treatment strategy nor a single focus of clinical attention throughout the whole of a given session. Possible ports include the individual behaviour of the child or parent, interactive exchanges between the parent and child, mental representations held by the child of self or of parent, mental representations held by the parent of self or of child, the relationship between the parent and therapist, the relationship between the child and therapist, or the parent-child-therapist relationship.

For these reasons, there are no “typical” CPP cases, and therapeutic strategies are tailored to the specific characteristics of the child and the parents. In general, the match between the therapist’s therapeutic strategies and the parent’s and the child’s receptiveness is the best predictor of treatment outcome. The timing of questions, suggestions, and interpretations is a crucial element in fostering treatment motivation. The therapist needs to cultivate a careful balance between addressing the relevant

clinical issues and remaining tactfully alert to the parent's and child's ability to tolerate and make use of these interventions.

Some unique aspects that confront the infant mental health clinician undertaking dyadic therapy must be pinpointed: accurate identification of symptoms in the context of rapid developmental change and a limited repertoire of behaviours; inference of the young child's subjective experience; assessment of symptoms in light of the ongoing interaction between child development and the caregiving environment; mastery of an expanded range and breadth of competencies (the clinician, ideally, should have knowledge of: infant and early childhood development, including brain development and developmentally salient anxieties; adult development; psychopathology and diagnostic categories ranging from infancy to adulthood; psychodynamic therapy including child-play therapy; attachment theory; trauma theory; and current research regarding parent-child interaction); management of multiple simultaneous actual and transferential relationships (the clinician must be attuned to the parent's transference to the child, the parent's transference to the therapist, the child's transference to the therapist, and the therapist's own countertransferential responses to parent, child, and the parent-child relationship—noting that both transference and countertransference reactions can be of a positive or negative cast); tolerance of intense sensory, affective, and cognitive stimulation in the treatment room (working with both parent and child together means having to simultaneously attend to feeling states, behaviours, interactional patterns, play themes and content, and specific trauma material, as they are presented both individually and in interaction); and knowing when to strategically “not intervene” (for example, in the case of a crying, distressed infant and a parent who is either nonresponsive or hostile, the clinician must maintain self-regulation, remain mindful of countertransferential reactions, recall that the infant's best interests may not be well served if it is the clinician who offers comfort, and determine a course of intervention that promotes repair within the dyad).

Main uses (indications)

CPP is indicated in the presence of factors that affect the dyadic relationship in such a manner that symptoms emerge (or are at risk of emerging) in the infants, toddlers, and pre-schoolers (i.e. birth–5years). These factors include:

- **Traumatic stressors** (e.g. domestic violence, community violence, physical abuse, sexual abuse, neglect, serious medical illness with instrumentation, prolonged or repeated separation from primary attachment figure). For the very young child, any threat (or perception of threat) to the primary caregiver is experienced as a potential

annihilation of the self. Also, whether the traumatic event occurred to the child alone or to the caregiver and child jointly, it is necessary to treat the dyad, as the primary caregiver may either exacerbate or mitigate the child's trauma, which is, in fact, the most important determinant of the child's subsequent adjustment. Additionally, dyadic intervention may be used as a preventive care strategy, in advance of potentially traumatic life stressors that may present a significant risk for psychiatric or developmental disturbance in the infant or young child (e.g. impending death of a parent from a terminal illness, or an imminent separation from a military parent).

- **Constitutional challenges in the child** (e.g. developmental delay, autism spectrum disorder, sensory processing disorder, affect regulation disturbance, prematurity). These circumstances do not necessarily engender problematic reactions in the caregiver, but these can rise. Parental responses such as withdrawal, unrealistic expectations, grief and mourning, overprotection, or hostility can be normative initial reactions but they may also become fixed instead of evolving into a more integrated stance, thereby compromising the optimal development of the individual child and the parent-child relationship. In such situations, dyadic psychotherapeutic intervention is of great benefit. The paradigm of "goodness of fit" (referring to the fit, or lack thereof, between the infant's temperament and the demands of the surrounding environment, including parental temperament) also applies here. In cases of mismatched dyads, dyadic psychotherapy can often improve the developmental trajectory of the caregiver-child relationship.
- **Disturbances in caregiving** (e.g. parental mental illness (including schizophrenia, bipolar disorder, personality disorder, major depression, anxiety disorder, PTSD), parental substance abuse, adolescent parenthood, parental history of trauma). These situations may pose a significant risk to the parent-child relationship given that: 1) caregiver self-regulation is compromised and, therefore, the caregiver's capacity to regulate the child is compromised and 2) caregiver disturbances lend themselves to distortions and misattributions in their perception of the child's feelings, thoughts, and intentions. Maladaptive parenting practices, including externalizing problems (e.g., excessive controlling, punitiveness, self-endangerment and aggression) and internalizing problems, such as emotional constriction and social withdrawal, are also included here.

Efficacy

CPP efficacy has been empirically documented in randomized controlled trials including more than 500 racially/ethnically diverse children in households ranging

from poverty to middle-class backgrounds and populations of maltreated infants, toddlers, and pre-schoolers in the child welfare system and pre-schoolers exposed to an average of five traumatic events. These studies have demonstrated this approach results in reductions in both maternal and child posttraumatic stress symptoms, decreased child diagnosis of traumatic stress disorder, improvements in the mother-child relationship and child quality of attachment, positive shifts in child attributions regarding self, mother, and relationships, as well as improved child cognitive functioning. CPP groups had significantly better outcomes than comparison groups posttreatment and at follow-up 6 months, 1 year, and 9 years later.

Quotes from famous psychotherapists

“A method of child-rearing is not - or should not be - a whim, a fashion or a shibboleth. It should derive from an understanding of the developing child, of his physical and mental equipment at any given stage, and, therefore, his readiness at any given stage to adapt, to learn, to regulate his behaviour according to parental expectations.”

Selma Fraiberg

“Parents and children help each other to grow. In raising their children, parents are also raising themselves. Child rearing gives parents the chance to redo their own childhood and to improve on it.” **Alicia F. Lieberman**

Manuals and Training

CPP has been manualized since 2005, with the publication, “Don't Hit My Mommy: A Manual for Child-Parent Psychotherapy with Children Exposed to Violence”, by Alicia F. Lieberman and Patricia Van Horn. The 2nd edition was updated in 2015 to include new sections on the phases of treatment and CPP fidelity to support implementation.

The CPP Training materials also include two books with clinical case studies:

1. "Psychotherapy with Infants and Young Children: Repairing the Effects of Stress and Trauma on Early Attachment", by Alicia F. Lieberman and Patricia Van Horn, published in 2008. This book describes the conceptual framework underpinning CPP and illustrates complex concepts and intervention modalities using rich case examples.

2. “Losing a Parent to Death in the Early Years: Guidelines for the Treatment of Traumatic Bereavement in Infancy and Early Childhood”, by Alicia F. Lieberman, Patricia Van Horn, Nancy Compton, and Chandra Ghosh Ippen, published in 2003. This book was written shortly after 9-11 in an effort to help more people understand how babies, toddlers, and pre-schoolers respond to loss and ways to support them. Rich clinical vignettes illustrate manifestations of traumatic bereavement and intervention strategies.

However, clinicians are not considered to be certified practitioners until they have received formal CPP training and supervision.

CPP is disseminated mainly in the USA, through the Early Trauma Treatment Network, a centre of the Substance Abuse and Mental Health Services Administration (SAMHSA) National Child Traumatic Stress Network (NCTSN) that involves the collaboration of four university-based programs: University of California, San Francisco Child Trauma Research Program as lead program; Child Witness to Violence at Boston Medical Centre; Child Violence Exposure Program at Louisiana State University Health Sciences Centre; and the Infant Team at Tulane University School of Medicine.

The training of clinicians in CPP is conducted within the NCTSN learning collaborative model, which combines didactic teaching with competence training through case-focused consultation for 18 months. Trainings incorporate the following areas: (1) foundational knowledge of early childhood development; (2) specialized trauma knowledge; (3) knowledge and competencies specific to the learners' roles; (4) ongoing practice; (5) evaluation of professional practice; (6) engaging supervisors and key administrators to develop leadership; (7) interdisciplinary training to address intersystem fragmentation; and (8) consultation and support to promote sustainability.

In addition to learning collaboratives, CPP is taught through internships and fellowships for master's, doctoral, and postdoctoral students.

International outreach includes implementation-level trainings in Australia, Colombia, Israel, and the Scandinavian countries.

Further information is available on the Child Parent Psychotherapy official website (<http://childparentpsychotherapy.com/providers/training/>).

Links to Societies

<http://childparentpsychotherapy.com/>

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