CPP: Child-Parent Psychotherapy

CULTURE-SPECIFIC INFORMATION

Engagement

For which specific cultural group*(s) (i.e., SES, religion, race, ethnicity, gender, immigrants/refugees, disabled, homeless, LGBTQ, rural/urban areas)* **is this treatment tailored? If none, please respond "not specifically tailored."**

The model is broadly tailored. The basic theoretical principles and core goals of CPP are thought to apply across diverse groups. The treatment has been used extensively with a wide range of minority groups: Latino (Mexican, Central, and South American), African-American, and Asian (Chinese). Clinical and research data, including four randomized trials conducted with predominantly ethnic minority samples, document the efficacy of this approach with culturally diverse groups.

Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.

Interventions are tailored to the specific family and their context. Culture is considered to be an important aspect of context.

The following publications detail ways that cultural issues are integrated into CPP:
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Ghosh Ippen & Lewis, 2011; Lieberman, 1990; Lewis & Ghosh Ippen, 2004; Ghosh Ippen, 2009; Klatzkin, Lieberman, & Van Horn, 2012.

Are there culture-specific engagement strategies *(e.g., addressing trust)* **that are included in the intervention?**

CPP involves a flexible approach. Clinicians are encouraged to tailor engagement strategies depending on the needs and background of the family. Specific strategies include, but are not limited to, providing outreach and intake services in English and Spanish, providing case management to reduce barriers to treatment, engaging in dialogue about cultural beliefs related to participating in treatment, and providing CPP in the family's native language.

Language Issues

How does the treatment address children and families of different language groups?

Clinicians make every attempt to see families in their native language. The treatment is regularly conducted in English, Spanish, Cantonese, and Mandarin. This has been accomplished through the hiring of bilingual, bicultural staff and by training bilingual, bicultural providers in community clinics. For example, at the Child-Trauma Research Project (CTRP), where the treatment was developed, 75% of the staff are bilingual and speak both Spanish and English. CTRP also trained Cantonese and Mandarin speaking community mental health clinicians to provide CPP at clinics in San Francisco that serve monolingual Chinese speaking clients. CPP does not use many printed materials. If handouts or forms are used (e.g., consent and release of information forms and assessment tools) they are translated into the family's language.

If interpreters are used, what is their training in child trauma?

Interpreters are not used.

Any other special considerations regarding language and interpreters?

Every attempt is made to see children and families in their native language. On occasion, there has been a family that speaks a rare language, and there are no available clinicians that speak that particular language. If no other referral can be made, treatment is conducted in English.

Symptom Expression	**Is there research or clinical evidence to suggest that the populations served manifest trauma symptoms in differential ways? If so, are there differences in the ways that symptoms are assessed for the various populations?** Young children manifest trauma symptoms differently from adults and older children. The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised (DC:0-3R) contains various diagnostic classifications for young children and serves as a more valid system for children under age 6 compared to DSM-IV. The Early Trauma Treatment Network, ETTN, of the NCTSN is currently engaged in studies to examine trauma symptoms in young children. ETTN members have conducted several studies that examine cultural differences in caregivers and young children's symptom expression, including a study that was presented at the 115th annual meeting of the American Psychological Association. That particular study explored the ethnic differences in Posttraumatic Stress Disorder (PTSD) and related symptomatology among women who have experienced traumatic events. In addition studies, the ETTN has also released publications in this area that are listed below. Scheeringa, Peebles, Cook & Zeanah, 2001; Scheeringa, Zeanah, Myers & Putnam, 2003. **If there are differences in symptom expression, in what ways does the theoretical conceptual framework of this treatment address culturally specific symptoms?** Specific details regarding symptom expression and treatment in young children and in ethnically diverse groups are provided in the following CPP-related publications: Lieberman & Van Horn, 2005; Lieberman, Compton, Van Horn & Ghosh Ippen, 2003; Lewis & Ghosh Ippen, 2004; Lieberman & Van Horn, 2004.
Assessment	**In addition to any differences noted above, are there any differences in assessment measures used across cultural groups? If so, please indicate which measures are used for which cultural groups. Are there normative data available for the populations for which they are being used?** Overall there is a dearth of measures for young children. Few measures exist whose psychometrics have been examined with ethnically diverse groups. Empirical research on CPP has been conducted using the same measures for all ethnic groups. When studies have involved Latinos, all assessment measures have either been available from the publishers in Spanish (e.g., Child Behavior Checklist [CBCL], Trauma Symptom Checklist for Young Children [TSCYC], Parenting Stress Index [PSI], Davidson Trauma Scale) or were translated and back-translated by a group of Spanish speaking clinicians. Norms are available for some measures (e.g., CBCL, PSI, TSCYC), but they often do not involve an ethnically diverse sample. Information regarding some of the specific measures used in CPP studies are available on the NCTSN Measures Review Database (NCTSN.org/measures). The reviews (click the assets tab for the full PDF) provide details regarding the use with diverse cultural groups. As of June, 2007 reviews can be found for the following child measures: Trauma Symptom Checklist for Young Children; Infant Toddler Social and Posttraumatic Stress Disorder Semi-Structured Interview and Observational Record, and Parenting Stress Index. In addition, reviews of the following measures used to assess parents are included: Beck Depression Inventory, Beck Anxiety Inventory.

Assessment continued	**If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** Randomized control trials have examined pre to post-test reductions in symptoms and improvements in functioning. Studies show that relative to comparison groups, CPP children and mothers show greater improvements. Clinically, data are examined in the following ways. First many of these measures have clinical cutoffs. Clinicians can examine whether a child moves from being above the cutoff to below. Second, change on individual items with clinical relevance (e.g., enuresis, aggression towards others) is examined. **What, if any, culturally specific issues arise when utilizing these assessment measures?** Clinicians make every attempt to ensure that measures are understandable. Assessments are conducted in an interview format, so if an individual does not understand, the clinician can help explain the item.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** Cultural issues have been specifically addressed throughout various writings about the treatment, including the treatment manual (Lieberman & Van Horn, 2005) and guidelines for the treatment of traumatic bereavement in infancy and early childhood (Lieberman et al., 2003). There have also been two culture-focused publications that detail ways that cultural issues are integrated into CPP (Lieberman, 1990; Lewis & Ghosh Ippen, 2004). **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)*. The basic principles of CPP are thought to apply broadly to different cultural groups. Reflective supervision and training are used to individually tailor the treatment to the family, given their cultural background, trauma history, and context. **Has differential drop out been examined for this treatment? Is there any evidence to suggest differential drop out across cultural groups? If so, what are the findings?** No, but the developers are interested in examining this. A randomized controlled trial consisting of 100% Latino immigrant mothers reported an attrition rate of 18% (Lieberman, Weston & Pawl, 1991). Attrition rates for other studies involving predominantly ethnic minority samples are 14.3% (Lieberman, Van Horn & Ghosh Ippen, 2005) and 19.4% (Toth et al., 2002). Another trial involving 74% ethnic minorities reported that prior to engagement the attrition rate was 39.6% for the CPP group and 51% for the comparison group, which received a psychoeducational parenting intervention (PPI). Following engagement, the overall attrition rate was 21.7%. The community standard showed an attrition rate of 42.9% and there were no differences in attrition for the CPP or PPI groups (Cicchetti et al., 2006).

Intervention Delivery Method/ Transportability & Outreach

If applicable, how does this treatment address specific cultural risk factors *(i.e., increased susceptibility to other traumas)***?**

This treatment is intended for multiply-traumatized populations. In a randomized trial of preschoolers exposed to domestic violence (Lieberman, Van Horn, & Ghosh Ippen, 2005), caregivers reported experiencing on average 12 stressful life events. Data collected as part of the NCTSN show that on average children have experienced 4 traumatic events. The treatment focuses on reconnecting your children to caregivers and helping caregivers understand how trauma has disrupted their relationship and their child's development. By focusing on the caregiver-child relationship, the treatment targets a universal risk factor. Treatment also encourages caregivers to engage in culturally consistent parenting practices that are appropriate given their context. Culture-specific issues such as immigration trauma and family separation due to immigration are addressed in this treatment. Case management to help families deal with problems of daily living is an integral component of treatment.

Is this a clinic-based treatment or is the treatment transportable *(e.g., into home, community)***? If the treatment is transportable, how is it adapted into the new setting? Is it still efficacious?**

CPP was originally developed as a home-visiting model. It can and has been implemented in the home, clinic, and school settings as well as in a variety of other settings, such as play grounds, hospitals, etc. Data from randomized trials are based on both home and clinic implementation of treatment.

Are there cultural barriers to accessing this treatment *(i.e., treatment length, family involvement, stigma, etc.)***?**

While the treatment is conducted in a way that attempts to minimize barriers, there are certain cultural issues that can arise. Stigma is always a cultural barrier. For example, some families do not want to be thought of as "crazy." Also, in some families that have experienced domestic violence, fathers may not want the family to participate in treatment. Although CPP is an intensive treatment with a long duration (50 sessions), this does not appear to be a barrier. When consumers provide feedback about treatment, the most common complaint is that it is too short.

Are there logistical barriers to accessing this treatment for specific cultural groups *(i.e., transportation issues, cost of treatment, etc.)***?**

For some families, including immigrant families, there are real life constraints to accessing this treatment. For example, some families need to cancel sessions because they must work to survive and the type of work (e.g., babysitting or house cleaning) often means needing to work at a moments notice. Generally, attempts are made to accommodate these issues. Occasionally there are clinic barriers to providing an intensive treatment of this type. The developers are aware that the treatment is expensive to implement; however, they believe that the treatment is cost-effective in the long run based on the extensive research that has been done underscoring the detrimental effects of trauma on the rapidly developing brains of young children.

Intervention Delivery Method/ Transportability & Outreach continued	**Are these barriers addressed in the intervention and how?** Reflective supervision and reflective practice are key components of this flexible intervention. Through these mechanisms, clinicians and supervisors work to identify what (if any) barriers exist and how interventions should be crafted to meet a family's individual needs. **What is the role of the community in treatment** *(e.g., local groups such as faith-based organizations, community groups, youth and/or parent organizations, first responders, schools)***?** A portion of the intervention is spent focusing on issues related to case-management. As such, clinicians will partner with the community and connect families to services on a case by case basis. Partnerships have been developed with domestic violence shelters, battered women organizations, the court system, restraining order clinics, day care providers and preschools.
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** As part of the ETTN's NCTSN SAMHSA grant, the treatment developers are putting together a diversity training manual. Currently all CPP trainees are provided training using this manual. The manual contains a framework for identifying conflicts related to difference. The manual also contains vignettes related to diversity conflicts. They are meant to encourage reflection and dialogue regarding potential differences and how they influence intervention. This discussion is continued during reflective supervision and case conferences. The diversity training model and key theoretical models related to working with culturally diverse families are presented in the following chapter: Ghosh Ippen, (in press). **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** While this varies based on the individual supervisor and clinician, supervisors encourage open discussion of cultural issues. During reflective supervision, cultural issues are discussed on a case by case basis (i.e., if the case demands it). **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** See above. Again, cultural issues are generally addressed on a case by case basis. **Has this guidance been provided in the writings on this treatment?** The diversity training manual and a book chapter in press (see above) will provide guidance on these topics in the near future. **Any other special considerations regarding training?** At least five recent national trainings on CPP have been focused on integrating issues of diversity into this treatment and on working with culturally diverse families.

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