NCTSN The National Child Traumatic Stress Network

**Trauma-Informed Interventions:**
**Combined Parent Child Cognitive Behavioral Approach for Children and Families At Risk for Physical Abuse**

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| **Treatment Description** | • **Acronym** (abbreviation) **for intervention:** CPC-CBT<br>**Average length/number of sessions:** CPC-CBT can be offered in individual or group formats to parents and their children. Individual sessions consist of 16 ninety-minute sessions where the therapist meets with the parent and child separately and meets jointly with both the parent and the child. Group sessions consist of 16 two-hour sessions where the therapists meet with the parents and children separately and meet jointly with both the parent and the child. Initially, joint parent and child sessions last about 15 minutes. As treatment progresses, more time is allotted to the parent-child joint sessions based families' needs (based on a 2-hour group-approx. 15 minutes in Sessions 1-6; 30-40 minutes-Sessions 7-11; 60-75 minutes in Sessions 12-16).<br><br>• **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers):* Transportation, babysitting, cultural, and/or religious values and beliefs, particularly as they relate to parenting practices.<br>• **Trauma type** *(primary):* Physical abuse/coercive parenting practices/significant parent-child conflict<br>• **Trauma type** *(secondary):* Children who have experienced sexual abuse and or exposed to domestic violence in addition to the physical abuse are not excluded.<br>• **Additional descriptors** *(not included above):* A cognitive behavioral therapy (CBT) treatment protocol for children and families at risk for physical abuse that incorporates elements from evidence-based CBT models for child sexual abuse (Deblinger & Heflin, 1996; Deblinger, Lippmann, Steer, 1996; Cohen, Deblinger, Mannarino, & Steer, 2004), as well as those targeting families in which physical abuse (Kolko, 1996; Kolko & Swenson, 2002) and domestic violence occur (Runyon, Basilio, Van Hasselt & Hersen, 1998).<br><br>CPC-CBT consists of 16 sessions that aim to empower parents to effectively parent their children in a non-coercive manner, improve parent-child relationships, assist children in healing from their abusive experiences, and enhance the safety of family members. This model helps to reduce the risk of the recurrence of child physical abuse in children and families at-risk for child physical abuse. The treatment consists of three components: (1) Parent Interventions, (2) Child Interventions, and (3) Parent-Child Interventions.<br><br>Some of the topics emphasized in the structured therapy sessions include:<br><br>• The use of engagement strategies (McKay, Stoewe, McCadam, & Gonzales, 1998) and motivational interviewing/consequence review to engage this often challenging population to participate in and comply with treatment<br>• Providing parents with information concerning emotional and behavioral effects on children of corporal punishment and child physical abuse as well as processing the impact on children's relationship with their parents as a result of their parent's use |

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| | of coercive parenting techniques<br>• Providing education about child development and age appropriate expectations for children's behavior<br>• Empowering parents to be effective by working collaboratively with them to develop adaptive coping skills (i.e., anger management, relaxation) to assist them in remaining calm while interacting with their children, to develop non-violent conflict resolution skills, to develop a variety of problem-solving skills related to child rearing, and non-coercive child behavior management skills<br>• Teaching children a variety of positive coping skills, particularly assertiveness and anger management skills training given that children who are exposed to physical violence are much more likely to present with these issues than other trauma populations<br>• Developing a family safety plan that involves learning how to identify when parent-child interactions are escalating and taking a cool down period in order to enhance safety and communication in the family<br>• Over the course of treatment, joint parent-child sessions involve having parents practice implementation of communication skills and behavior management skills with children while the therapists coach them and offer positive reinforcement and corrective feedback to enhance the skills; parents and children rehearse the implementation of the family safety plan; parents and children communicate openly about the abusive experiences between them<br>• During the last phase of treatment when improvements have been reported in parent-child interactions, positive parenting, and children's fear, the child begins to develop a trauma narrative and the parent writes a letter in which they take full responsibility for their abusive behavior and relieve their children of fear and self-blame for the abuse. The trauma narrative and abuse clarification process have been integrated so the parent can directly address some of their children's fears as stated in the trauma narrative in the abuse clarification process |
| **Target Population** | • **Age range:** 4 to 17<br>• **Gender:** ☐ Males ☐ Females ☒Both<br>• **Ethnic/Racial Group** *(include acculturation level/ immigration/refugee history--e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans):* Black/African-American, Caucasian, Latino, and Multiracial. Some individuals enrolled in our study were first and second generation immigrants; all spoke English; they functioned at various levels of acculturation with some remaining very traditional in their beliefs and values. Implemented with families who only speak Spanish outside of our treatment study.<br>• **Other cultural characteristics** *(e.g., SES, religion)*: Diverse SES and religious backgrounds.<br>• **Language(s):** English as a first and second language; Spanish as a first language (not involved in treatment study); Swedish<br>• **Region** (.e.g., rural, urban)**:** Rural and urban as we serve several counties over a diverse geographic region; many from inner city areas<br>• **Other characteristics** (not included above): Targeted to families with a history of physical abuse and inappropriate physical discipline/coercive parenting strategies. Symptoms include PTSD, depression, abuse-related attributions, and externalizing behavior problems in children. Parental anger, child behavior management skills, coercive and/or violent parenting behavior, and parent-child relationships. |
| **Essential** | • **Theoretical basis:** Cognitive behavioral therapy |

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| **Components** | • **Key components:** 1. Child Intervention, 2. Parent Intervention, and 3. Parent-Child Intervention. |
| **Clinical & Anecdotal Evidence** | • **Are you aware of any suggestion/evidence that this treatment may be harmful?** ☐Yes ☒No ☐ Uncertain<br>• **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time).* 2<br>• **This intervention is being used on the basis of anecdotes and personal communications only** (no writings) **that suggest its value with this group.** ☐Yes ☒No<br>• **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***?** ☒Yes ☐No<br>**If YES, please include citation:**<br>• **Has this intervention been presented at scientific meetings?** ☒Yes ☐No<br>**If YES, please include citation(s) from last five presentations:**<br><br>1. E. Deblinger, J. Sherrill, A. Mannarino, J. Cohen, M. Runyon, R. Steer, D. Smith; A. M. Hayes, C. Webb, D. Grasso, J. Cummings, J. Vahlsing (November, 2009). Interventions for youth exposed to trauma/abuse: Understanding change processes. Presented at the 43rd Annual Convention of the Association for the Behavioral and Cognitive Therapies, New York City.<br>2. Runyon, M. K. (April, 2009). Introduction to combined parent-child cognitive-behavioral treatment (CBT) of children and families at-risk for child physical abuse. CARES Institute Fourth Annual Statewide Best Practice Symposium: Optimizing Outcomes in Child Abuse and Neglect: Integrating Passion, Commitment and Best Practices, Stratford, New Jersey.<br>3. Runyon, M. K. (April 20, 2007). Strengthening families by developing healthy outlooks and peaceful home environments. Presented at the 16th National Conference on Child Abuse and Neglect. Portland, Oregon.<br>4. Runyon, M. K. & Behl. L. (October, 2005). Combined parent-child cognitive-behavioral treatment (CBT) of children and families at-risk for child physical abuse. Invited workshop at Joining Forces: the 18th Annual Conference on Child Abuse & Family Violence, Salt Lake City, Utah.<br>5. Runyon, M. K. & Berry, E. J. (March, 2005). Combined parent-child cognitive-behavioral treatment (CBT) of children and families at-risk for child physical abuse. Invited workshop at the 13th Annual Children's Justice Conference, Seattle, Washington.<br><br>• **Are there any general writings which describe the components of the intervention or how to administer it?** ☒Yes ☐No<br>1. Runyon, M. K., Deblinger, E., & Steer, R. A. (in press). Group cognitive behavioral treatment for parents and children at risk for physical: An initial study. *Family and Behavior Therapy.*<br>2. Runyon, M.K., Deblinger, D., & Schroeder, C.M. (2009). Pilot evaluation of outcomes of combined parent-child cognitive-behavioral group therapy for families at risk for child physical abuse. *Cognitive and Behavioral Practice, 16*, 101-118.<br>3. Runyon, M. K., Ryan, E., Kolar, R., & Deblinger, E. (2004). An overview of child physical abuse: Developing an integrated parent-child cognitive-behavioral treatment approach. *Trauma, Violence, & Abuse: A Review Journal, 5*, 65-85.<br>• **Has the intervention been replicated anywhere?** ☒ Yes ☐No<br>**Other countries?** *(please list)* The CARES team, including the developers and senior |

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| | clinicians, has previously offered training and/or ongoing consultation in CPC-CBT to mental health professionals at individual agencies across the United States through SAMHSA and other funding. Currently, we are involved in two larger scale dissemination projects. One project involves the dissemination of CPC-CBT to multiple agencies in three cities across Sweden. A group of Swedish researchers plan to evaluate the outcomes associated with the model being provided by professionals in Sweden. We are also currently training two agencies, TRY at Catholic Charities and TIDES at Gulf Coast Mental Health, in the Gulf Coast region of the United States in CPC-CBT. This training is being conducted in preparation for the first Learning Collaborative (LC) in CPC-CBT in the NCTSN that is scheduled in the Summer of 2010 in the Gulf Coast.<br><br>• **Other clinical and/or anecdotal evidence** *(not included above)*: | |
| **Research Evidence** | **Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)* | **Citation** |
| **Published Case Studies** | | |
| **Pilot Trials/Feasibility Trials** *(w/o control groups)* | N=12 parents and 21 children<br>**By gender:**<br>Children – 13 females, 8 males<br>Parents –<br>**By ethnicity:**<br>Children – 52% African American, 19% Hispanic, 19% Caucasian, 10% Other<br>Parents – 50% African American, 33% Hispanic, 10% Caucasian, 7% Other<br>**By other cultural factors:**<br>Diverse ethnic and religious backgrounds | Runyon, M. K., Deblinger, E., & Schroeder, C. M. (2009). Pilot evaluation of outcome of combined parent-child cognitive behavioral group therapy for families at risk for child physical abuse. *Cognitive and Behavioral Practice, 16,* 101-118. |
| **Clinical Trials** *(w/control groups)* | | |
| **Randomized Controlled Trials** | N=60<br>**By gender:**<br>Children – 32 females, 28 males<br>Parents – 38 females, 6 males<br>**By ethnicity:**<br>72% identified themselves as African American, Hispanic and Other backgrounds, 28% Caucasian<br>**By other cultural factors:**<br>Diverse SES and religious backgrounds; 55% of the participants are economically disadvantaged and the majority are single mothers. | Runyon, M. K., Deblinger, E., & Steer, R. A. (in press). Group cognitive behavioral treatment for parents and children at risk for physical: An initial study. *Family and Behavior Therapy.* |

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| Studies Describing Modifications | | |
| Other Research Evidence | | |
| Outcomes | • What assessments or measures are used as part of the intervention or for research purposes, if any?<br>Child-report Outcome Measures<br>Children's Depression Inventory (CDI-II; Kovacs & Beck, 1982)<br>Parent-Child Conflict Tactics Scale (CTSPA; Straus et al., 1998)<br>UCLA PTSD Reaction Index (Steinberg et al., 2004)<br>Alabama Parenting Questionnaire-Child Report (APQ; Frick, 1991)<br><br>Parent-Report Outcome Measures<br>Alabama Parenting Questionnaire-Parent Self-Report (APQ; Frick, 1991)<br>Parent-Child Conflict Tactics Scale (CTSPA; Straus et al., 1998)<br>Beck Depression Inventory (BDI; Beck et al., 1996)<br>Parental Anger Inventory (PAI; MacMillan et al., 1988)<br>Achenbach Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983)<br><br>• If research studies have been conducted, what were the outcomes?<br>• A pilot study examined pre- to post-treatment changes in parents and children after their participation in 16 sessions of group Combined Parent-Child CBT (Runyon, Deblinger, & Schroeder, 2009). Both parents and children reported significant pre- to post-treatment reductions in the use of physical punishment. Results also demonstrated pre- to post-treatment improvements in parental anger towards their children, consistent parenting, as well as children's post-traumatic stress symptoms and behavioral problems. These promising results were preliminary, based on a small pilot sample, and did not include a comparison group. To address these methodological issues and further examine the utility of this model, a larger controlled comparison was completed.<br>• To compare the relative efficacy of two types of group cognitive-behavioral therapy for treating the traumatized child and at-risk or offending parent in cases of child physical abuse (CPA), 24 children and their parents were treated with Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT) and 26 parents were treated with Parent-Only CBT. Outcome measures assessing children's emotional and behavioral functioning and parents' parenting skills were administered to both parent and child participants before treatment, after 15 sessions of treatment, and 3 months after the completion of treatment. A series of correlated *t* tests and analyses of covariance were used to compare the scores on the outcome measures. The children and parents in the Combined Parent-Child CBT group demonstrated greater improvements in total posttraumatic symptoms and positive parenting skills, respectively, compared to those who participated in the Parent-Only CBT group. The parents in the Parent-Only CBT group reported using less corporal punishment to manage their children's behavior at post-test than the parents in the Combined Parent-Child CBT group. The differential benefits of including the child in treatment are discussed. | |

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| **Implementation Requirements & Readiness** | • **Space, materials or equipment requirements?**<br>• **Supervision requirements** *(e.g., review of taped sessions)***?** Weekly supervision and/or case consultation is required; direct observation of sessions and/or reviewing audio taped sessions is preferred<br>• **To ensure successful implementation, support should be obtained from:** Melissa K. Runyon, Ph.D. and her colleagues at UMDNJ-SOM; CARES Institute, 42 East Laurel Road, Suite 1100, Stratford, NJ 08084 |
| **Training Materials & Requirements** | • **List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** A detailed session-by-session treatment guide and accompanying client handouts are available and can be obtained from Dr. Melissa K. Runyon at runyonmk@umdnj.edu or 856-566-7036.<br>• **How/where is training obtained?** Introductory training generally consists of two to three days of didactic training that includes case examples, role-plays, and demonstrations. Advanced training is offered as a follow-up to the introductory training and is tailored to the needs of those who participated in the introductory training.<br>• **What is the cost of training?** $2,000-$3,000 for didactic training per day plus travel expenses, additional fees for consultation calls.<br>• **Are intervention materials** *(handouts)* **available in other languages?** ☐ Yes ☒ No<br>**If YES, what languages?** All of the materials have been translated into Swedish and many of the handouts have been translated into Spanish.<br>• **Other training materials &/or requirements** *(not included above)*: |
| **Pros & Cons/ Qualitative Impressions** | • **What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** Engagement strategies and motivational interviewing to increase parental compliance; provide transportation and babysitting to remove barriers (not unique to the model); CPC-CBT engages parents in a collaborative process to empower them to effectively parent their children by teaching them positive alternatives to coercive parenting strategies. Additionally, CPC-CBT assists the child in healing from the trauma of the abuse and strengthens the relationship between the parent and child.<br>• **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** Challenges that are not unique to the model, but to the population involve building a referral base, the amount of case management necessary to retain child physical abuse cases in treatment, and engaging parents in the treatment process<br>• **Other qualitative impressions:** Some of our efforts toward enhancing the cultural competence/relevance of our model have been based on consumer feedback and are notable. See CPC-CBT Culture-Specific Fact Sheet |
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