CPC-CBT: Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse

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 treatment incorporates elements as described below to respond to the needs of many groups.

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

Some of our efforts toward enhancing the cultural competence/relevance of our model and enhancing our ability to engage clients of all cultural backgrounds have been based on consumer feedback and are notable. With regard to the relevance of interventions, it is notable that other interventions utilizing similar CBT strategies have found no differential treatment effects based on ethnicity. Research has also suggested that African-Americans and other minority populations may be more amenable to structured therapy approaches that seem more like a class than therapy. As such, we are cognizant of how we describe our therapy when introducing it to families via the telephone prior to the initial assessment and during subsequent sessions. The treatment included a number of aspects that, while not necessarily culture-specific, may have increased the relevance of the treatment protocol to the families served and engaged them in the treatment process. For example, the therapists established collaborative working relationships with families. A primary goal was to empower our parents to feel as though they were an effective agent of change in their environments, particularly with regard to their children's behavior. They also initiated discussions and demonstrated respect for families' cultural beliefs and traditions (i.e., cultural, ethnic, religious, gender, etc.) and worked with families to determine how some new skills might fit into their preexisting environment and how others might not work. Other families presented with specific goals in mind for their families and their children, some of which were related to their cultural beliefs, traditions, and backgrounds. By establishing a collaborative relationship with them, listening to them educate us about their beliefs and goals and discussing what the treatment offers that may help them achieve those goals, families appeared to become more engaged in the treatment process. In sum, engagement strategies are tailored to each family regardless of culture.

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

Compounded by other culturally-relevant factors, many children and families who are referred for child physical abuse may be distrustful and reluctant to participate in treatment and be open about abusive experiences to systems due to the discriminatory and oppressive practices directed towards them by these very systems (Fontes, 1993), as well as their fears of being judged and persecuted by treatment providers. We establish collaborative working relationships to determine how we can work with families to find available options to attain their goals.

Engagement continued	We also empathize and align with parents in a non-judgmental fashion while keeping the delicate balance of holding them accountable for their abusive behavior(s). We also utilize a motivational procedure/consequence review (Donohue, Van Hasselt, et al., 1998) to motivate parents and engage them in the treatment process.
Language Issues	**How does the treatment address children and families of different language groups?** We have incorporated Spanish-language parenting books (Whitham, 2002, 2003) into the treatment. We have also translated many of our handouts into Spanish and the protocol has been utilized with families who speak Spanish only who were not involved in the treatment studies. **If interpreters are used, what is their training in child trauma?** N/A **Any other special considerations regarding language and interpreters?** N/A
Symptom Expression	**If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** N/A
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?** We have carefully selected assessment measures that were normed on diverse populations. We use the same measures across cultural groups. Some of the measures have been translated into Spanish and others are published in Spanish. **If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** Normative data for diverse populations exists for some of the assessment measures. We are cautious about interpreting measures not normed on Spanish-speaking populations and often examine only the individual items. **What, if any, culturally specific issues arise when utilizing these assessment measures?** N/A
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** None to date.