## CPC-CBT: General Information

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

<table>
<thead>
<tr>
<th><strong>Treatment Description</strong></th>
<th><strong>Acronym (abbreviation) for intervention:</strong> CPC-CBT</th>
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<tr>
<td><strong>Average length/number of sessions:</strong></td>
<td>Parents and children attend weekly two hour group sessions over a 16-week period. Parent and child interventions are conducted concurrently for the first 75 minutes of the session by four group therapists while the second 45 minutes involves the integrated joint parent-child sessions.</td>
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<tr>
<td><strong>Aspects of culture or group experiences that are addressed (e.g., faith/spiritual component, transportation barriers):</strong></td>
<td>Transportation, babysitting, cultural and/or religious values and beliefs, particularly as they relate to parenting practices</td>
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<tr>
<td><strong>Trauma type (primary):</strong></td>
<td>Physical abuse/harsh parenting practices</td>
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<tr>
<td><strong>Trauma type (secondary):</strong></td>
<td>Sexual abuse and domestic violence</td>
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<tr>
<td><strong>Additional descriptors (not included above):</strong></td>
<td>A cognitive behavioral therapy (CBT) treatment protocol for children and families at risk for physical abuse that incorporates elements from empirically supported CBT models for sexually abused children as well as those targeting families in which physical abuse and domestic violence occur.</td>
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<td>It includes three goals:</td>
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<td></td>
<td>1. Reduce the recurrence of child physical abuse by helping parents learn nonviolent disciplining and anger-control strategies, assisting them in altering faulty beliefs about who is responsible for the abuse, and challenging unrealistic expectations and misattributions about the causality of their children’s behavior;</td>
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<td></td>
<td>2. Decrease children’s emotional distress by assisting them in processing their abusive experiences and developing adaptive coping skills; and</td>
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<tr>
<td></td>
<td>3. Increase positive parent-child interactions that are necessary for beneficial developmental outcomes for children.</td>
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### Target Population

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<th><strong>Age range:</strong></th>
<th>14 to 17</th>
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<tbody>
<tr>
<td><strong>Gender:</strong></td>
<td>☐ Males ☐ Females ☒ Both</td>
</tr>
<tr>
<td><strong>Ethnic/Racial Group (include acculturation level/immigration/refugee history—e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans):</strong></td>
<td>Hispanic, Black/African-American, Caucasian, 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.</td>
</tr>
<tr>
<td><strong>Other cultural characteristics (e.g., SES, religion):</strong></td>
<td>Diverse SES and religious backgrounds</td>
</tr>
<tr>
<td><strong>Language(s):</strong></td>
<td>English as a first and second language; Spanish as a first language (not involved in treatment study)</td>
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</table>
**CPC-CBT: Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse**

### Target Population continued

**Region (e.g., rural, urban):** Rural and urban as we serve 7 counties over a diverse geographic region; many do hail from inner city areas

**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 relationship.

### Essential Components

**Theoretical basis:** Cognitive-behavioral


### Clinical & Anecdotal Evidence

- **Are you aware of any suggestion/evidence that this treatment may be harmful?**
  - ☐ Yes ☒ No ☐ Uncertain

- **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).**
  - 1

- **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 See attached paragraph

- **Are there any anecdotes describing satisfaction with treatment, drop-out rates (e.g., quarterly/annual reports)?**
  - ☒ Yes ☐ No

  **If YES, please include citation:**
  Overall, there is a 33% drop-out rate for those families who are offered treatment through our treatment study. Of the families who actually attend the first two treatment sessions which involve motivational interviewing, only 8% drop-out. The treatment model was developed in conjunction with client’s feedback on satisfaction surveys. Initially, clients requested more culturally relevant materials. As such, we incorporated a number of elements (see Qualitative Impressions section below). Participants in Dr. Runyon’s treatment development study also reported that the model assisted them in the following areas: helped them feel less alone (81%), gain their child’s cooperation (87.5%), children’s behavior improved (88%), improve their parent-child relationship and helped them more effectively manage their anger (94%). Parents whose children were involved in treatment identified the skills they learned as the most helpful aspect of the group.

- **Has this intervention been presented at scientific meetings?**
  - ☐ Yes ☒ No

  **If YES, please include citation(s) from last five presentations:**
  Accepted for presentation at a scientific meeting in Oregon in April, 2007

- **Are there any general writings which describe the components of the intervention or how to administer it?**
  - ☒ Yes ☐ No
### General Information

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

**Clinical & Anecdotal Evidence continued**

If YES, please include citation:
Runyon, Deblinger, Ryan & Thakkar-Kolar, 2004

Has the intervention been replicated anywhere?  
☑ Yes ☐ No

Other countries? (please list) We are providing ongoing consultation to two sites in New Jersey who are using the model with their clients. We just initiated consultation calls with an agency at Duke University who plans to implement the model.

Other clinical and/or anecdotal evidence (not included above): We are in the process of organizing training for dissemination of the treatment program in Sweden at multiple agencies; they are presently arranging to translate the treatment manual into Swedish.

#### Research Evidence

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<th>Sample Size (N) and Breakdown (by gender, ethnicity, other cultural factors)</th>
<th>Citation</th>
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</table>
| **Pilot Trials/Feasibility Trials (w/o control groups)** | N=9 parents and 16 children  
**By gender:**  
9 females, 7 males  
**By ethnicity:**  
25% Caucasian, 37% African-American, 25% Hispanic, 13% other  
**By other cultural factors:**  
diverse ethnic and religious backgrounds |
| Manuscript is being submitted |
| **Randomized Controlled Trials** | N=75 |
| **Studies Describing Modifications** | By gender:  
41 males, 34 females  
**By ethnicity:**  
17% Caucasian, 48% African-American, 21% Hispanic, 14% other  
**By other cultural factors:**  
diverse SES and religious backgrounds; 55% of the participants are economically disadvantaged and the majority are single mothers |
| In final stages; Final treatment group of trial will be completed in 01/07; See Qualitative Impressions (below) for preliminary results |
### Outcomes

**What assessments or measures are used as part of the intervention or for research purposes, if any?** See Qualitative Impressions section (below)

**If research studies have been conducted, what were the outcomes?**

Based on the pilot study mentioned above, pre- and post-pilot data were collected from a small sample of children and caregivers who participated in the 16-session pilot groups following the parent-child CBT treatment protocol. Based on this preliminary data, all participating children demonstrated significant improvements from pre- to post-treatment in the number of PTSD symptoms reported on the K-SADS. Caregivers also reported significant improvements in internalizing and externalizing behavior for all children. Caregivers also reported significant improvements in anger toward their children as well as significant improvements in consistent parenting and reductions in the use of corporal punishment. Children reported significant decreases in corporal punishment utilized by their parents as well.

Preliminary findings of the randomized trial (NIMH-funded R21 referenced above demonstrated significant within group changes from pre- to post-test for the Combined Parent-Child CBT group (described here) and a similar Parent-Only CBT group. There were significant improvements from pre to post in self-reported parental depression, parental anger, and parenting skills. Children also showed significant improvements in depression and PTSD as well as parent-reported internalizing and externalizing problem behaviors. Both parents and children reported a significant reduction in the use of corporal punishment in general. While both conditions produced significant pre- to post-test changes, it is notable that the effect size for children’s PTSD in the Combined Parent-Child condition (described here) is nearly twice that of the Parent-Only. Additionally, one of the most frequently spontaneous, hand-written complaints from parents participating in the Parent-Only condition was that they would have liked for their children to be involved in treatment and they would have liked to interact with their children during sessions.

### Implementation Requirements & Readiness

**Supervision requirements** *(e.g., review of taped sessions)*? Weekly supervision required; direct observation of sessions and/or listening to audiotapes preferred

### Training Materials & Requirements

**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.**

A detailed preliminary manual has been developed.

**How/where is training obtained?** Introductory training generally consists of two days of didactic training that includes case examples, role plays, and demonstrations.

**What is the cost of training?** $2,000-$3000 per day plus travel expenses

**Are intervention materials (handouts) available in other languages?**

☑ Yes  ☐ No
| Training Materials & Requirements continued | If YES, what languages?  
We are in the process of translating materials; the manual and client handouts are currently being translated into Swedish; the client handouts have been translated into Spanish. |
|---|---|
| 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)?**  
Motivational interviewing to increase offending parent’s compliance, provide transportation and babysitting to remove these barriers, incorporates parent and child to reduce violence in the home, to assist child in healing from the trauma, and to strengthen the parent-child relationship  
**What are the cons of this intervention over others for this specific group (e.g., length of treatment, difficult to get reimbursement)?**  
Obtaining buy-in of offending parents, case management efforts to minimize drop-outs  
**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 the CPC-CBT Culture-Specific Fact Sheet (following this General Fact Sheet), for more information. |
| Assessment Measures | **Child-Report Outcome Measures**  
Parent-Child Conflict Tactics Scale (CTSPC; Straus et al., 1998)  
Children’s Depression Inventory (CDI-II; Kovacs & Beck, 1983)  
K-SADS Post-Traumatic Stress Disorder Interview (K-SADS PTSD; Orvaschel & Puig-Antich, 1987)  
Children’s Anger Inventory (CIA; Nelson & Finch, 2000)  
Children’s Attributions and Perceptions Scale (CAPS; Mannarino, Cohen, & Berman, 1994).  
Alabama Parenting Questionnaire-Child Report (APQ; Frick, 1991)  
**Parent-Report Outcome Measures**  
Parent-Child Conflict Tactics Scale (CTSPC; Straus et al., 1998)  
Beck Depression Inventory (BDI; Beck, Steer, & Brown, 1996)  
Parental Anger Inventory (PAI; MacMillan, Olson, & Hanson, 1988)  
Alabama Parenting Questionnaire-Parent Self-Report (APQ; Frick, 1991)  
Achenbach Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983) |
| Contact Information | **Name:** Melissa K. Runyon, PhD  
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References


