

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

<p>Treatment Description</p>	<ul style="list-style-type: none"> • Acronym (abbreviation) for intervention: CPC-CBT • Average length/number of sessions: Parents and children attend weekly two-hour group sessions over a 16-week period. Parent and child interventions are conducted concurrently for the first hour and 15 minutes of the session by four group therapists while the second 45 minutes involves the integrated joint parent-child sessions. • Aspects of culture or group experiences that are addressed (e.g., faith/spiritual component, or addresses transportation barriers): Transportation, babysitting, cultural and/or religious values and beliefs, particularly as they relate to parenting practices • Trauma type (primary): physical abuse/harsh parenting practices • Trauma type (secondary): sexual abuse and domestic violence • 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 empirically supported CBT models for sexually abused children as well as those targeting families in which physical abuse and domestic violence occur. It includes three goals: 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; 2). decrease children's emotional distress by assisting them in processing their abusive experiences and developing adaptive coping skills; and 3). increase positive parent-child interactions that are necessary for beneficial developmental outcomes for children.
<p>Target Population</p>	<ul style="list-style-type: none"> • Age range: (lower limit) 4 to (upper limit) 17 • Gender: <input type="checkbox"/> Males <input type="checkbox"/> Females <input checked="" type="checkbox"/> Both <ul style="list-style-type: none"> • Ethnic/Racial Group (include acculturation level/ immigration/refugee history--e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans): 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 our treatment study. • Other cultural characteristics (e.g., SES, religion) : diverse SES and religious backgrounds • Language(s): English as a first and second language; Spanish a first language (not involved in treatment study) • Region (.e.g., rural, urban): rural and urban as we serve a 7 counties over a diverse geographic region, a many do hail from inner city areas

	<ul style="list-style-type: none"> • 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.
<p>Essential Components</p>	<ul style="list-style-type: none"> • Theoretical basis: Cognitive-behavioral • Key components: 1). Child intervention, 2). Parent intervention, and 3). Parent-child intervention.
<p>Clinical & Anecdotal Evidence</p>	<ul style="list-style-type: none"> • Are you aware of any suggestion/evidence that this treatment may be harmful? <input type="checkbox"/>Yes <input checked="" type="checkbox"/>No <input type="checkbox"/>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. <input checked="" type="checkbox"/>Yes <input type="checkbox"/>No See attached paragraph • Are there any anecdotes describing satisfaction with treatment, drop-out rates (e.g., quarterly/annual reports)? <input checked="" type="checkbox"/>Yes <input type="checkbox"/>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 attached description). 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 improve (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? <input type="checkbox"/>Yes <input checked="" type="checkbox"/>No If YES, please include citation: 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? <input checked="" type="checkbox"/>Yes <input type="checkbox"/>No If YES, please include citation: Runyon, M. K., Deblinger, E., Ryan, E., & Thakkar-Kolar, R. (2004). An overview of child physical abuse: Developing an integrated parent-child cognitive-behavioral treatment approach. <i>Trauma, Violence, & Abuse: A Review Journal</i>, 5, 65-85. • Has the intervention been replicated anywhere? <input checked="" type="checkbox"/>Yes <input type="checkbox"/>No 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 countries? (please list) We are in the process of organizing training for dissemination of treatment program in Sweden at multiple agencies; they are

presently arranging to translate treatment manual in Swedish
 • **Other clinical and/or anecdotal evidence** (not included above):

Research Evidence			Number of Participants	Sample Breakdown	Citation
	Published Case Studies	<input type="checkbox"/> Yes <input type="checkbox"/> No	N =	By gender: By ethnicity: By other cultural factors:	
	Pilot Trials/ Feasibility Trials (w/o control groups)	X Yes <input type="checkbox"/> No	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
	Clinical Trials (w/ control groups)	<input type="checkbox"/> Yes <input type="checkbox"/> No	N =	By gender: By ethnicity: By other cultural factors:	
	Randomized Control Trials	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	N = 75	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 attached for preliminary results
	Studies describing modifications	<input type="checkbox"/> Yes <input type="checkbox"/> No	N =	By gender: By ethnicity: By other cultural factors:	
	Other research evidence	<input type="checkbox"/> Yes <input type="checkbox"/> No	N =	By gender: By ethnicity:	

				By other cultural factors:	
Outcomes	<ul style="list-style-type: none"> • What assessments or measures are used as part of the intervention or for research purposes, if any? See attached • 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 posttreatment 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. <p>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 parent 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.</p>				
Implementation Requirements and Readiness	<ul style="list-style-type: none"> • Space, materials or equipment requirements? • Supervision requirements (e.g., review of taped sessions)? Weekly supervision required, direct observation of sessions and/or listening to audiotapes preferred • In order for successful implementation, support should be obtained from: 				
Training Materials & Requirements	<ul style="list-style-type: none"> • 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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If YES, what languages? We are in the process of translating materials; The manual itself is currently being and client handouts are currently being 				

	<p>translated into Swedish; the client handouts have been translated to Spanish</p> <ul style="list-style-type: none"> • Other training materials &/or requirement (not included above):
Pros & Cons/ Qualitative Impressions	<ul style="list-style-type: none"> • 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:
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Cultural Considerations

Some of our efforts toward enhancing the cultural competence/relevance of our model 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 (Deblinger) 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. A more striking finding that supports the relevance of the intervention is the fact that the investigator's current R21 involved 70% ethnic minorities, a majority who identified themselves as African-American. The findings of this study show that the intervention was beneficial for reducing child and parent distress, enhancing parenting behavior, and decreasing the use of corporal punishment. 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. 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 and worked with families to determine how some new skills might fit into their pre-existing environment and how others might not work. Boyd-Franklin (1989, 1993) cites literature indicating that African-American children are overrepresented in special education classes. Our therapists provided case management services to empower African-Americans, and all of our families, to advocate for their children at school and obtain positive results. In four cases, the plan was to extricate the children from the regular school system. After our involvement, therapists and parents were able to work with the school in order to maintain these children in the regular school system. Boyd-Franklin highlights a need to help parents understand that while certain forms of spanking may have a place in the overall disciplinary program but an exclusive reliance can be counterproductive. Our approach has been not to tell parents that they are bad or that spanking is bad, but to discuss with them non-violent alternatives to keep their children safe and to avoid any further negative consequences for themselves or their children. We have also incorporated culturally sensitive parenting materials into our protocol, such as Howard Stevenson's parenting book (Stevenson, Davis & Abdul-Kabir, 2001), articles about praise from Essence magazines, Spanish-language parenting books (Whitham, 2004), and Nancy Boyd-Franklin's book about raising black men. We have also translated our handouts into Spanish language and the protocol has been utilized with families who speak Spanish only who were not involved in the treatment studies. In sum,

we believe we have developed a culturally sensitive model and that findings of our pilot study suggest positive outcomes across ethnic groups.

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, 1999)

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)