CPC-CBT: Combined Parent-Child Cognitive Behavioral Therapy

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** CPC-CBT **Average length/number of sessions:** 16-20 sessions; CPC-CBT can be offered in individual or group formats to parents and their children. Individual sessions consist of 16-20 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 16-20 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). **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. **Trauma type** *(primary)*: Child physical abuse/inappropriate/coercive parenting/ significant parent-child conflict **Trauma type** *(secondary)*: domestic violence; Children who have experienced sexual abuse in addition to the physical abuse are not excluded.
Target Population	**Age range:** 3 **to** 18 **Gender:** ❒ **Males** ☒ **Females** ❒ **Both** **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. **Other cultural characteristics** *(e.g., SES, religion)***:** Diverse SES and religious backgrounds. **Language***(s)***:** English, Spanish, Swedish **Region** *(e.g., rural, urban)***:** rural, urban **Other characteristics** *(not included above)***:** Children and their parents (or caregivers) in families where parents engage in a continuum of coercive parenting strategies and children may present with PTSD symptoms, depression, behavioral problems and other difficulties.
Essential Components	**Theoretical basis:** CPC-CBT is grounded in cognitive behavioral theory and incorporates elements from developmental, learning, family systems, trauma, and motivational theories.

CPC-CBT: Combined Parent-Child Cognitive Behavioral Therapy

Essential Components continued

CPC-CBT is a short-term, strength-based therapy program for children ages 3-17 and their parents (or caregivers) in families where parents engage in a continuum of coercive parenting strategies. These families can include those who have been substantiated for physical abuse, those who have had multiple unsubstantiated referrals, and those who fear they may lose control with their child. Children may present with PTSD symptoms, depression, externalizing behaviors and a host of difficulties that are targeted within CPC-CBT.

Goals of CPC-CBT are to help the child heal from the trauma of the physical abuse, empowers and motivates parents to modulate their emotions and use effective non-coercive parenting strategies, and strengthens parent-child relationships while helping families stop the cycle of violence.

Key components:

Phase 1: Engagement & Psychoeducation – Engaging and motivating parents who are often not contemplating changing their parenting style or interactions with their children by using the following techniques:

- Engagement strategies
- Motivational Interviewing/consequence review
- Individualized goal setting
- Providing violence psychoeducation including educating both parents and children on:

  Different types of violence
  - The continuum of coercive behavior
  - The impact of violent behavior on children
- Providing psychoeducation for parents about:
  - Child development
  - Realistic expectations for children's behavior
- Addressing parental history of trauma exposure including its impact on:
  - Their relationships with their parents
  - Their parenting approach with their own children

Phase 2: Effective Coping Skill Building – Empowering parents to be effective by working collaboratively with them to:

- Develop adaptive coping skills
  - Cognitive coping
  - Anger management
  - Relaxation

Essential Components continued

- Assertiveness
- Self-care
- Problem solving

- Assist them in remaining calm while interacting with their children
- Develop nonviolent conflict resolution skills
- Develop a variety of problem-solving skills related to child rearing
- Develop a variety of non-coercive positive child behavior management skills.
- Learn the dynamics of their interactions with their children and what escalates anger and violence during these interactions and how to use skills to diffuse the situation.
- Assist children in developing adaptive coping skills and self- management skills (e.g., emotional regulation, assertiveness, anger mangaement, etc)

Phase 3: Family Safety – Developing a family safety plan that involves all family members:

- Learning how to identify when parent-child interactions are escalating
- Taking a cool down period in order to enhance safety and communication in the family
- Having parents and children rehearse the implementation of the family safety plan
- Introducing other safety components across the therapy

Phase 4: Abuse Clarification

- Clarification involves parent writing an abuse clarification letter and child developing a trauma narrative about the abuse experienced
    - Specifically, clinician encourages child to write about or share their abusive experiences while focusing on their thoughts and feelings associated with the abuse
    - While child is developing a trauma narrative, clinician also assists parents in processing their own thoughts and feelings while writing and revising a "clarification" letter to their children to enhance their empathy for their children and to demonstrate that they take full responsibility for their abusive behavior
- The clarification letter also serves to:
    - Alleviate the child of blame
    - Respond to the child's questions and/or worries
    - Correct the child's cognitive distortions concerning the abuse

Essential Components continued	■ The parents and children share the clarification letter and trauma narrative in joint segments, unless this process is contraindicated. However, in most cases, this process enhances the parent's empathy for the child and is a powerful therapeutic tool for strengthening the parent-child relationship. CPC-CBT is the only treatment involving at-risk parents that incorporates the trauma narrative into the clarification process. ■ Parenting Skills Training - Parenting skills training is provided across all phases: ■ Therapists help families develop effective communication skills to increase family members' feelings of validation and cooperation with one another
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)*. 4 **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** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***?** ☒ **Yes** ❒ **No** **If YES, please include citation:** Runyon, M. K., Deblinger, E., & Steer, R. A. (2010). Group cognitive behavioral treatment for parents and children at-risk for physical abuse: An initial study. *Child & Family Behavior Therapy, 32*, 196-218. **Has this intervention been presented at scientific meetings?** ☒ **Yes** ❒ **No** **If YES, please include citation***(s)* **from last five presentations:** Runyon, M. K. (November, 2014). Engaging Families to Overcome the Cycle of Violence: Challenges in Working with Child Physical Abuse. Workshop presented at the 30th Annual Meeting of the International Society of Traumatic Stress Studies. Runyon, M. K. (June 2010). Evidence-based solutions: helping children and families at-risk for child physical abuse to develop healthy outlooks and peaceful home environments. Presented at the "Seeing Child Trauma Through the Eyes of Families" Trauma Training Institute at Center for Pediatric Traumatic Stress (CPTS) at The Children's Hospital of Philadelphia. Runyon, M. K. (May, 2010). Evidence-based solutions: helping children and families at-risk for child physical abuse to develop healthy outlooks and peaceful home environments: Parts I-IV. Invited Presentation at the Children's Justice Conference, Seattle, Washington.

CPC-CBT: Combined Parent-Child Cognitive Behavioral Therapy

Clinical & Anecdotal Evidence continued

Runyon, M. K. (January, 2010). Evidence-based solutions: helping children and families at-risk for child physical abuse to develop healthy outlooks and peaceful home environments. Presented at the 24th Annual San Diego International Conference on Child and Family Maltreatment, San Diego, CA.

Bach, C., Runyon, M. K., & Thornhill, P. (January, 2010). Combined parent-child cognitive behavioral treatment: Innovative strategies for broaching sensitive subject matter in training mental health professionals and initiating engagement with families. Presented at the 24th Annual San Diego International Conference on Child and Family Maltreatment, San Diego, CA.

Are there any general writings which describe the components of the intervention or how to administer it? ☒ Yes ❒ No

If YES, please include citation:

Santa, E. J. & Runyon, M. K. (2014). Addressing ethnocultural factors in treatment for child physical abuse, Journal of Child and Family Studies, DOI:10.1007/s10826-014-9969-5

Runyon, M. K. & Mclean, C. (2014). Empowering families: Combined parent-child cognitive-behavioral therapy for families at-risk for child physical abuse. In R.M. Reece, R. F. Hanson, & J. Sargent (Eds.), *Child Abuse Treatment: Common Ground for Mental Health, Medical and Legal Professionals (pp. 67-75)*. Baltimore, MD: John Hopkins University Press.

Runyon, M. K., & Deblinger, E. (2014). *Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT): An Approach to Empower Families At-Risk for Child Physical Abuse*. New York, NY: Oxford University Press.

Runyon, M.K. & Urquiza, A. (2011). Child Physical Abuse: Interventions for Parents Who Engage in Coercive Parenting practices and Their Children. In J. E. B. Myers (Ed.), *The APSAC Handbook on Child Maltreatment (pp. 195-212)*. Los Angeles, CA: Sage Publications.

Runyon, M. K., Deblinger, E., & Cruthirds, S. (in press). Interventions for families at-risk for child physical abuse. In L. Dixon, D. Perkins, L. Craig, & C. Hamilton-Giachristis (Eds.), *What Works in Child Protection (pp.). Chichester, West Sussex*: Wiley & Sons, Inc.

Has the intervention been replicated anywhere? ☒ Yes ❒ No

Other countries? *(please list)* Sweden

CPC-CBT: Combined Parent-Child Cognitive Behavioral Therapy

Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**12 caregivers, 21 children Caregivers: 25-54 years, Children: 4-14 years **Race/Ethnicity** — Caregivers: 50% African-American, 33%, Hispanic and 16.7% Caucasian; Children: 52.4% African-American, 19% Hispanic, 19% Caucasian, and 9.5% Biracial **Gender** — Caregivers: Not specified, Children: 13 Females and 8 Males Both parents and children reported significant pre-treatment to post-treatment reductions in the use of physical punishment, with further improvements by way of reduced parental anger toward children, more consistent parenting and the reduction of the children's post-traumatic stress symptoms and behavioral problems.	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.
	N=18 families (26 adults, 25 children) Caregivers: 30-50 years, Children: 6-14 years **Gender** — Caregivers: Not specified, Children: 15 boys and 10 girls. Significantly decreased symptoms of depression among parents, less use of violent parenting strategies and less inconsistent parenting were reported after treatment. After treatment, trauma symptoms and depression among children were significantly reduced. Children also reported that parents used significantly less violence and increased positive parenting strategies after completion of the treatment.	Kjellgren , C. , Svedin , C. G. , & Nilsson , D. (2013). Child physical abuse-experiences of combined treatment for children and their parents. A pilot study. *Child Care in Practice, 19*, 275-290, DOI: 0.1080/13575279.2013.785934

Randomized Controlled Trials	**N=**60 **Gender**: Children – 32 females, 28 males Caregivers: 38 females, 6 males **Ethnicity**: 72% identified themselves as African American, Hispanic and Other backgrounds, 28% Caucasian **Other cultural factors:** Diverse SES and religious backgrounds; 55% of the participants are economically disadvantaged and the majority are single mothers. 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), children and their parents were treated with either a Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT) or parents alone 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. 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. There is another randomized controlled trial underway in Sweden.	Runyon, M. K., Deblinger, E., & Steer, R. A. (2010). Group cognitive behavioral treatment for parents and children at-risk for physical abuse: An initial study. *Child & Family Behavior Therapy, 32*, 196-218.
Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** **Child-report Outcome Measures** Children's Depression Inventory (CDI-II; Kovacs & Beck, 1982) Parent-Child Conflict Tactics Scale (CTSPA; Straus et al., 1998) KSADS PTSD Interview Alabama Parenting Questionnaire-Child Report (APQ; Frick, 1991)	

CPC-CBT: Combined Parent-Child Cognitive Behavioral Therapy

Outcomes continued	**Parent-Report Outcome Measures** Alabama Parenting Questionnaire-Parent Self-Report (APQ; Frick, 1991) Parent-Child Conflict Tactics Scale (CTSPA; Straus et al., 1998) Beck Depression Inventory (BDI; Beck et al., 1996) Parental Anger Inventory (PAI; MacMillan et al., 1988) Achenbach Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983) **If research studies have been conducted, what were the outcomes?** Outcomes associated with research studies are reported in the Research Evidence section above.
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** The materials and equipment are minimal. Therapists should have office space large enough for a family or group of families. Therapeutic books, games, and art supplies are recommended to teach parents and children skills. **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 **To ensure successful implementation, support should be obtained from:** Melissa K. Runyon, Ph.D. or another CPC-CBT Trainer
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** Runyon, M. K., & Deblinger, E. (2014). *Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT): An Approach to Empower Families At-Risk for Child Physical Abuse*. New York, NY: Oxford University Press. **How/where is training obtained?** There are several CPC-CBT training programs available. CPC-CBT training programs can be provided on-site, regionally or nationally. 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. Consultation calls providing guidance in the implementation at the model are also available. **What is the cost of training?** $2,000 to $3,000 per day per trainer; there are additional costs for consultation calls **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ❒ **No** **If YES, what languages?** Published manual with all handouts in Swedish, some handouts in Spanish

CPC-CBT: Combined Parent-Child Cognitive Behavioral Therapy

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. **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 **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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